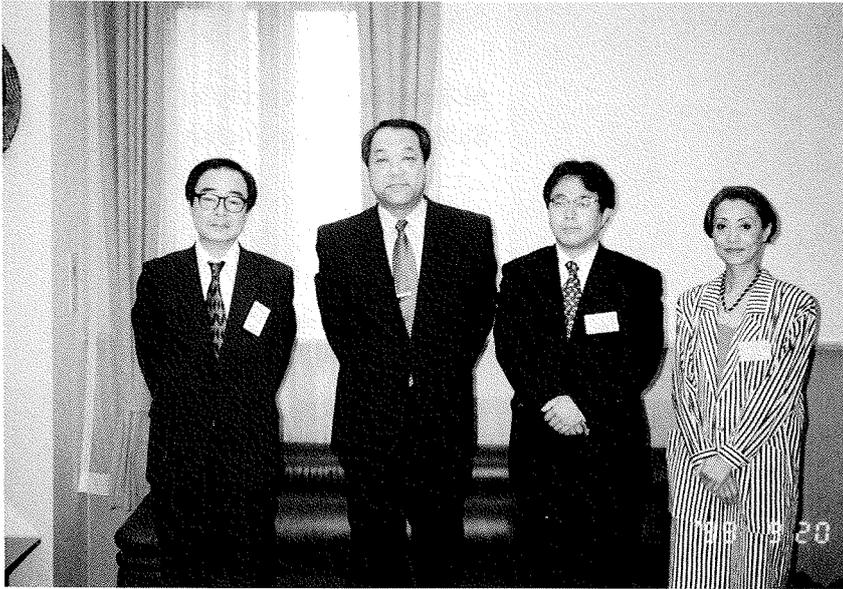


**Report on the Survey of
Aging and Health
in Asian Countries**

—— People's Republic of China ——
(Focus on Shanghai)

MARCH 2000

The Asian Population and Development Association



At Consulate General of Japan in
Shanghai
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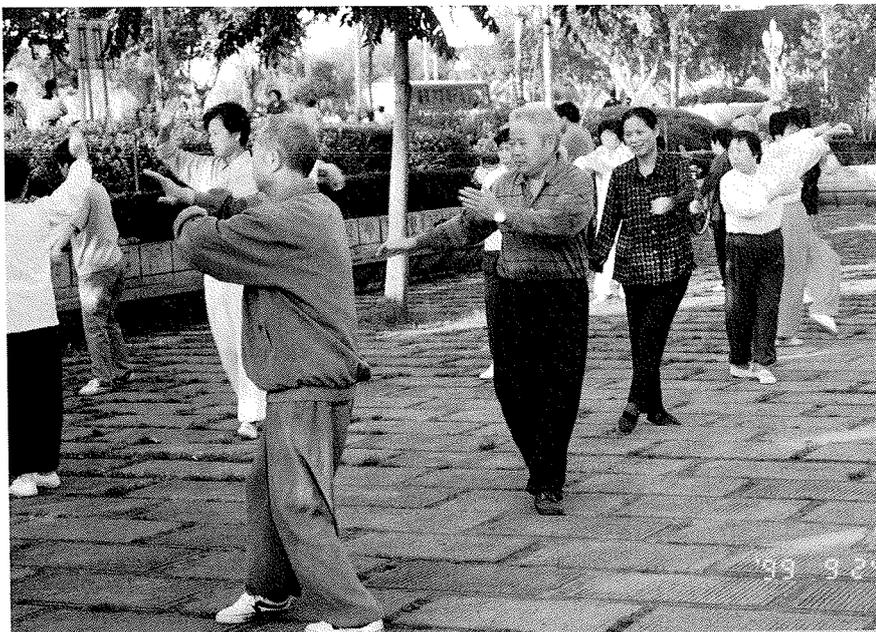


At East China Normal University
Gui Shixun, Dean of Population
Research Institute



At Shanghai University for Aged
Students learning English

At Shanghai City Xuhui District
Welfare Court



At lakeside of Xihu
In Hangzhou.
Physical exercises by Aged in the
early morning



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Foreword

This report comprises a compilation of results from a survey entitled "the Survey of Aging and Health in Asian Countries" which was conducted in the People's Republic of China in fiscal 1999 by the Asian Population and Development Association(APDA) under the consignment from the Ministry of Health and Welfare and the Japan International Cooperation of Welfare Services (JICWELS). The survey and compilation were conducted by the survey committee (Chairperson:Dr.Toshio Kuroda,Professor Emeritus,Nihon University Population Research Institute)which was created within APDA.

Population of Asian countries has shifted drastically towards aging in the recent years. Aging in the Asian region,which is larger in scale and more rapid compared to the Western countries, has exerted enormous influence on the health and social security system of each country. This survey aims to analyze in detail the present situation and issues related to population, health/health care and social security system(including social insurance) of each country in the context of aging and seeks to contribute to the solution of aging population in the Asian countries and problems that are associated with such phenomenon.

In People's Republic of China, guidance and cooperation for the overall planning of this survey were offered by Mr.Yasuyoshi Ichihashi, Concul General of Consulate General of Japan in Shanghai, Mr.Shen Zhen Xin, Director of Shanghai Municipal Committee on Aging and Dr.Ma Li Zhong, Deputy Director of Shanghai Research Center on Aging

In Japan, special guidance and assistance were offered by those concerned at the International Affairs Division of Minister's Secretariat, Ministry of Health and Welfare and at China and Mongolia Division of the Asian Affairs Bureau, Ministry of Foreign Affairs. I would like to take this opportunity to express my sincere gratitude. I shall be happy if this report proves useful to the programs for coping with the aging issue that will be worked out by the Asian countries, including People's Republic of China, and contributes to effective international cooperation by the Japanese government.

In conclusion, I would like to add that this report has been prepared under the responsibility of APDA based on interviews with ministry officers, experts and private organization staffs, and that it does not reflect the views and policies of the Ministry of Health and Welfare nor the Japanese government in any way.

March 2000

Dr.Taro Nakayama
Chairman
The Asian Population and Development Association

General Outline of People's Republic of China

1. General situation

| | Entire country | Shanghai | Zhejiang Province |
|--------------------|--|-----------------------|------------------------------|
| Land area | : 9.6 million km ² | 6,341 km ² | 1,010,800km ² |
| Capital | : Beijing | | |
| Ethnic composition | : Han (92% of entire population and 55 ethnic minority groups) | | |
| Language | : Chinese (Hanyu) | | |
| Religion | : Buddhism, Islam, Christianity etc. | | |

2. Estimated Population ¹⁾

| | | | |
|-----------------------|-------------------------------|-----------------------------|-----------------------------|
| Total population | : 1,246,240,000 (end of 1996) | 14,660,000 (end of 1996) | 44,460,000 (end of 1998) |
| Population structure | : Ages 0-14 (%) | 25.9 | 16.2 |
| | : Ages 15-64 (%) | 67.2 | 71.4 |
| | : Ages 65 and above (%) | 6.9 | 12.4 |
| Fertility rate | : 1.69% | 0.56% | 1.12% |
| Mortality rate | : 0.66% | 0.7% | 0.63% |
| Natural increase rate | : 1.04% | -0.14% | 0.48% |
| Sex ratio | : 106 | 101.6 | 106.5 |
| Life expectancy | : Male and female total | | |
| | Male | 68 | 75.18 ²⁾ |
| | Female | 72 | 79.21 |

1) China Statistical Yearbook 1997

2) 1998

3) 1990 Census

3. Economy ²⁾

| | | | |
|----------------------|----------------------------------|---------------------------------|---------------------------------|
| GDP | : \$970 billion | 336.021 billion | 498.75 billion |
| | (7,955.3 billion yuan, 1998) | yuan | yuan |
| GDP per capita | : \$780 (1998) | 2,575 yuan | 1,124.7 yuan |
| Economic growth rate | : 7.8% | 15.8% | 7.5% |
| | ('98 GDP over the previous year) | ('97 over the previous year) | ('98 over the previous year) |
| Unemployment rate | : 3.1% | 2.8% | 3.3% |

2) Ministry of Foreign Affairs, "Country name: People's Republic of China," as of June 1999
(for the entire country only)

4. Politics and administration ²⁾

Form of government : People's democratic republic
Head of state : Jiang Zemin
Parliament : People's National Congress

5. Education ³⁾

Primary education Male: 124
School attendance rate(%) Female: 117
Secondary education Male: 59
School attendance rate(%) Female: 48
Illiteracy among Male: 10
ages 15 years and above Female: 27

3) : Primary education-illiteracy rate: The World Population White Paper 1998

6. Social welfare

| | Entire Country | Shanghai ⁴⁾ | Zhejiang Province |
|--|--------------------------------|--------------------------------|--|
| 1. Medical facilities | | | |
| Hospitals | 67,911 ('98) (290,300 beds) | 477 locations (67,314 beds) | 3,341 locations('98) (103,579 beds) |
| Clinics | 235,492 | 4,604 locations | 3,817 locations |
| Maternal and child health centers | 2,748 | 12 locations | 70 locations |
| 2. Welfare facilities | | | |
| Welfare homes | | 17 locations (3,294 beds) | 58 locations (4,163 beds) |
| Homes for the elderly | | 333 locations (8,361 beds) | 2,005 locations (21,242 beds) |
| Activity centers for the elderly | | 4,540 locations | |
| Apartment houses for the elderly | | 15 locations (493 persons) | |
| Children's welfare homes | | 2 locations (943 persons) | 6 locations (793 locations) |
| Welfare homes for psychiatric patients | | 3 locations (1,429 persons) | 2 locations (317 persons) |

4) Shanghai Research Center on Aging, 1997

Executive Summary

China's Rapid Growth Over the 50 Year Period - Grand Population Planning of Population Giant -

1. Introduction: China and India from Population Perspective

After World War II, population issue emerged in the 1960s in parallel with economic development. It became quantitatively clear in the economic development programs of policymakers that rapid increase of population would create serious impediments to economic take-off. It was the Asian countries that became strongly aware of this problem.

India was one of the first countries to adopt family planning policy for restraining population increase after World War II. Later, following India, family planning is actively implemented in East Asian and Southeast Asian countries as important government policy.

What is of particular attention here is the population policy of China, a country with largest population in the world. After 50 years since the liberation, China's population policy has much significance in the context of world history. First of all, China has successfully implemented the "One-Child Policy" which might be called the final stage of family planning. This unprecedented concept in history of mankind has enormous implications as an experiment that could be carried out in the field of population policy. Secondly, China has proven that it is possible to diffuse family planning to the entire nation despite the difficulty involved in realizing this for huge population. Thirdly, the success of birth control in a country with large population such as China would contribute greatly to alleviation of population increase on a global scale.

India, the pioneer in family planning, also has a large population. Her fertility is markedly high compared to China but is showing signs of steady decline in the recent years. China's population (of 1.270 billion) and India's population (of 1 billion) amount to 2.3 billion when combined, accounting for about half (47.9%) of the 4.8 billion people living in all of the developing countries and 63% of the entire population of Asia. Therefore, the population trend in these two population giants would have enormous impact on the population of Asia as well as on the developing countries.

Shanghai most radically reflects the trend of population in China. Having been an international city since before the war, Shanghai is demonstrating strong leadership of China's development both socially and economically. The city is playing the role of the forefront city in China by implementing One-Child Policy perfectly in the field of population and by maintaining rapid economic growth. On the other hand, however, the aging issue is arising as a result of noticeable decline in fertility, and restraint of labor influx and is becoming a new challenge that stands between population and economy.

2. Demographic Transition in China: Marked Decline in Fertility Over Half-A-Century

Let us take a look at the process of demographic transition over a nearly 50-year period since the founding of the country in 1949. As shown in Table 1 and Figure 1, China has attained below replacement level of fertility after going through the process of remarkable changes. Mortality rate declined consistently with the exception of the 3-year abnormal period around 1960. Notable changes were observed in fertility. Population increase rate has therefore been determined by the trend of fertility.

Changes in vital rates can be divided into the following six phases.

The first phase is pre-modern high fertility, the 10-year period from 1949 to 1958 in which China succeeded the high fertility rate that existed prior to founding of the country. Crude birth rate was approaching 40 and total fertility rate was as high as 6.

The second phase relates to the emergency period of 3 years before and after 1960 in which natural increase rate plummeted owing to rapid increase in mortality rate and sharp decline in fertility. In particular, natural increase rate turned to negative as mortality rate exceeded fertility rate in 1960.

The third phase is that of high fertility that continued over a decade from 1962 to 1972. Fertility reached as high as 60 temporarily and total fertility rate was also high at 7.5 in 1963

The fourth phase is the phase of sharp decline from 1972 to 1980 when crude birth rate decreased nearly by half from 30 to 17 or 18.

The fifth phase is the phase referred to as population momentum. Relatively high fertility was brought about when the large generation born during the high fertility period of the third phase reached their nubility in the 1980s. During the 10-year period from 1981 to 1990, crude birth rate increased from less than 20 to slightly more than 20. However, it must be noted that the number of births given per woman in her life as seen from total fertility rate was lower than the period of fertility decline in the fourth phase. In other words, crude birth rate increased during the fifth phase even though total fertility rate decreased.

The six phase refers to the final phase of lowering fertility in the 1990s. Crude birth rate fell below 20 and total fertility rate dropped below replacement level to realize a modern fertility comparable to that of developed countries.

3. Similarities in Fertility Transition: Japan and China

Striking similarities of the changing fertility process between China and Japan despite large differences that exist between the two countries in terms of population policy (which largely affects fertility) and in socioeconomic and political background is worthy of note. The period referred to this process is about half a century that lasted from the end of World War II to the present; namely from the liberation in 1949 for China and end of the war in 1945 for Japan.

The first characteristic is the existence of period of remarkably high mortality followed by fertility boom. In Japan, natural increase rate declined over a 3 year period from a year before and after the end of the war (1944-1946) due to increase in mortality and decrease in fertility. In 1945, mortality reached an enormously high level of 29.2 and brought down the natural increase rate to a negative figure of -6.0% . Almost identical phenomenon also occurred in China where natural increase rate turned to negative figure of -4.57% owing to rapid increase of mortality in 1960.

This abnormal population dynamics observed in China over the 3-year period with 1960 as the middle year is very similar to those observed in Japan over the 3-year period with 1945 as the middle year (refer to population dynamics statistics shown in Figure 2). While these

unusual changes in population dynamics were caused by different factors, they give rise to changes that are the same in terms of population phenomena and manifest in the form of unusually high mortality rate and negative natural increase rate followed by a fertility boom. The boom lasted only 3 to 4 years in Japan but continued for nearly 10 years in China in the '60s.

The fertility boom is followed by the period of fertility decline. Japan entered a process of sharp decline that lasted for about 10 years after a short fertility boom before it stabilized. China also experienced about 10 years of high fertility which was followed by another 10 years of plummeting fertility in the '70s.

Another point worthy of note is the recovery trend of fertility that is observed after fertility decline. In Japan, crude birth rate slightly increased to 18-19 over a 10-year period from the mid-'60s to the mid-'70s, whereas in China, crude birth rate slightly exceeded 20 for nearly a decade in the '80s. The recovering trend of fertility observed in these two countries was attributable to the fact that the baby boomer generation that was born 20-some years ago reached their nubility. It is a demographic phenomenon referred to as "population momentum" or, more recently, as "population bonus."

Theoretical significance of demographic transition in Japan and China

A new pattern of demographic transition has been demonstrated by Japan in that fertility declined at unusually high speed never observed in demographic transition of the West and that fertility decline was realized prior to economic modernization or almost concurrently with economic growth. The Japanese experience was followed by phenomenal fertility decline prior to modern economic development in China despite the enormous size of the country's population.

Fertility dropped from 34 in 1947 to 17 in 1957 in Japan, and from 34 in 1969 to 17 in 1979 in China. These fertility transitions in Japan and China proved that fertility transition (i.e. demographic transition) different from that observed in the Western cultural area is another way to achieve transition process ever under different social, cultural systems and also likely to support a new transition line of demographic and economic modernization of the developing countries.

While 50% reduction of fertility over a 10-year period was an unforeseeable speed of decline at the time, the fact that it was realized in Japan and China is particularly worthy of note. However, what is worthy of note here is the fact that this rapid decline of fertility inevitably leads to aging of population.

The percentage of population aged 65 years and above is still low today (1995) at 6.1% but is predicted to increase to 16.5% in 2020 and to 22.6% in 2050 (United Nations). As for the number of productive age population per elderly person, the number is reduced by half in Japan from 4 persons in 1999 to 2 persons in 2050. In China, there are as many as 10 persons in productive age population for every person aged 65 years and above in 1999, although this figure will drop to 3 persons in 2050 (United Nations) to suggest the speed of aging that is taking place in China.

4. Characteristics of Population in Shanghai

Gigantic cities with population of more than 10 million are also referred to as mega-cities. A new characteristic of the Shanghai Mega-city lies in the fact that its factor of population increase is different from that in other mega-cities of the world. In many mega-cities, grave problems originate from influx of population from local and rural areas. Moreover, the majority of incoming population is comprised of unmarried young male and female population whose marriage and childbirth accelerate increase of urban population. In the case of Shanghai, influx is strictly restricted by government policy while fertility is maintained at extremely low level through thorough enforcement of family planning. These are the outcomes of the Chinese Government's policy to limit population in large cities.

Recent fertility in Shanghai is compared with the national average in Table 2. While the national average of fertility has already dropped to the level of developed countries, the average for Shanghai has gone down to a level that is even lower. National average of fertility (TFR) has remained below 2.0 since 1991. Meanwhile, the fact that fertility in Shanghai has fallen below 1.0 and continues to go down is worthy of note. In 1994, the national average dropped to less than 1.8 while Shanghai's figure dropped to less than one-third of national average to 0.6.

Fertility rate in Shanghai where population policy that had notable impact on fertility continued to drop from the national average level of 60% to 40%. Although it is necessary to take difference in age structure into consideration, fertility rate of 6 or so is an extremely low level. While mortality rate is also very low, the declining trend of natural increase rate has accelerated due to marked decline in fertility rate and has turned to negative since 1993.

Remarkable industrialization has taken place in Shanghai, particularly in Huangpu District, which, in turn, requires large labor input. However, population increase in large cities is strictly regulated by the government's basic policy from economic and social standpoint.

On the other hand, massive development programs require large laborforce, which is largely supplied by influx of population from rural areas. While this is a natural process for balancing supply and demand from an economic standpoint, it is accompanied by mobilization of substantial number of laborers in a country like China where labor supply is excessively large (referred to as “floating population”). Such floating population is rapidly increasing in Shanghai at the backdrop of its vigorous economic activities, increasing from 750,000 in 1984 to 1,250,000 in 1988 and to 2,810,000 in 1993. (Sun Changmin: Shanghai Population in Transition, Symposium on Demography of China, 1997, p.135)

Conclusion: Shanghai—The City that Succeeded in Restraining Population Growth and Achieving Economic Growth

With inhabitants in excess of 10 million, Shanghai’s population is comparable to that of a fairly large country in Europe. Shanghai has a total fertility rate of 1.42 is lower than Beijing and Tianjin (Fourth Population Survey, 1990) and is at the same level as the group of lowest fertility among developed countries. In addition, population influx to this megal-city is strictly regulated. Restraint of fertility and influx would result in population growth rate that is negative or close to being negative. On the other hand, Shanghai is the driving force behind the Chinese economy as colossal region of economic development.

As an example of successful economic growth based on restraining population growth, Shanghai Mega-city offers historical experiment in managing a giant city. Future strategies adopted by Shanghai will become an important subject among the international community because of its demographic conditions for most rapid acceleration of aging society.

Table 1 Status of Natural Fluctuation in National Population, 1949-1994

| Year | Total population (10,000) | Fertility rate (‰) | Mortality rate (‰) | Natural increase rate (‰) | Total fertility rate |
|------|------------------------------|-----------------------|-----------------------|------------------------------|-------------------------|
| 1949 | 54,167 | 36.00 | 20.00 | 16.00 | 6.14 |
| 1950 | 55,196 | 37.00 | 18.00 | 19.00 | 5.81 |
| 1951 | 56,300 | 37.80 | 17.80 | 20.00 | 5.70 |
| 1952 | 57,482 | 37.00 | 17.00 | 20.00 | 6.47 |
| 1953 | 58,796 | 37.00 | 14.00 | 23.00 | 6.05 |
| 1954 | 60,266 | 37.97 | 13.18 | 24.79 | 6.28 |
| 1955 | 61,456 | 32.60 | 12.28 | 20.32 | 6.26 |
| 1956 | 62,828 | 31.90 | 11.40 | 20.50 | 5.85 |
| 1957 | 64,563 | 34.03 | 10.80 | 23.23 | 6.41 |
| 1958 | 65,994 | 29.22 | 11.98 | 17.24 | 5.68 |
| 1959 | 67,207 | 24.78 | 14.59 | 10.19 | 4.30 |
| 1960 | 65,207 | 20.86 | 25.43 | -4.57 | 4.02 |
| 1961 | 65,859 | 18.02 | 14.24 | 3.78 | 3.29 |
| 1962 | 67,295 | 37.01 | 10.02 | 26.99 | 6.02 |
| 1963 | 69,172 | 43.37 | 10.04 | 33.33 | 7.50 |
| 1964 | 70,499 | 39.14 | 11.50 | 27.64 | 6.18 |
| 1965 | 72,538 | 37.88 | 9.50 | 28.38 | 6.08 |
| 1966 | 74,542 | 35.05 | 8.83 | 26.22 | 6.26 |
| 1967 | 76,368 | 33.96 | 8.43 | 25.53 | 5.31 |
| 1968 | 78,534 | 35.59 | 8.21 | 27.38 | 6.45 |
| 1969 | 80,671 | 34.11 | 8.03 | 26.08 | 5.72 |
| 1970 | 82,992 | 33.43 | 7.60 | 25.83 | 5.81 |
| 1971 | 85,229 | 30.65 | 7.32 | 23.33 | 5.44 |
| 1972 | 87,177 | 29.77 | 7.61 | 22.16 | 4.98 |
| 1973 | 89,211 | 27.93 | 7.04 | 20.89 | 4.54 |
| 1974 | 90,859 | 24.82 | 7.34 | 17.48 | 4.17 |
| 1975 | 92,420 | 23.01 | 7.32 | 15.69 | 3.57 |
| 1976 | 93,717 | 19.91 | 7.25 | 12.66 | 3.24 |
| 1977 | 94,974 | 18.93 | 6.87 | 12.06 | 2.84 |
| 1978 | 96,259 | 18.25 | 6.25 | 12.00 | 2.72 |
| 1979 | 97,542 | 17.82 | 6.21 | 11.61 | 2.75 |
| 1980 | 98,705 | 18.21 | 6.34 | 11.87 | 2.24 |
| 1981 | 100,072 | 20.91 | 6.30 | 14.55 | 2.63 |
| 1982 | 101,654 | 22.28 | 6.60 | 15.68 | 2.87 |
| 1983 | 103,008 | 20.19 | 6.90 | 13.29 | 2.42 |
| 1984 | 104,357 | 19.90 | 6.82 | 13.08 | 2.35 |
| 1985 | 105,851 | 21.04 | 6.78 | 14.26 | 2.20 |
| 1986 | 107,507 | 22.43 | 6.86 | 15.57 | 2.42 |
| 1987 | 109,300 | 23.33 | 6.72 | 16.61 | 2.59 |
| 1988 | 111,026 | 22.37 | 6.64 | 15.73 | 2.31 |
| 1989 | 112,704 | 21.58 | 6.54 | 15.04 | 2.25 |
| 1990 | 114,333 | 21.06 | 6.57 | 14.39 | 2.17 |
| 1991 | 115,823 | 19.68 | 6.70 | 12.98 | 2.01 |
| 1992 | 117,171 | 18.24 | 6.64 | 11.60 | 1.86 |
| 1993 | 118,517 | 18.09 | 6.64 | 11.45 | 1.85 |
| 1994 | 119,850 | 17.70 | 6.49 | 11.21 | 1.84 |

Reference: Family Planning in China, China Population Publications, 1997

Table 2 Comparison of Fertility Rate for Shanghai and Entire Country

| Year | Shanghai (A) | Entire country (B) | Shanghai (A) ÷ (B) |
|------|-----------------|-----------------------|-----------------------|
| 1985 | 12.7 | 21.0 | 41.0 |
| 1986 | 14.5 | 22.4 | 64.7 |
| 1987 | 15.3 | 23.3 | 65.7 |
| 1988 | 13.2 | 22.4 | 58.9 |
| 1989 | 12.5 | 21.6 | 57.9 |
| 1990 | 10.2 | 21.1 | 48.3 |
| 1991 | 7.8 | 19.7 | 39.6 |
| 1992 | 7.3 | 18.2 | 40.1 |
| 1993 | 6.5 | 18.1 | 35.9 |
| 1994 | 5.9 | 17.7 | 46.5 |

Reference: Figures for Shanghai from Sun Changmin, Shanghai Population in Transition, Symposium on Demography of China, China Population Association, October 1997, Beijing, p.129. Figures for entire country from Table 1.

Table 3 Migration in Shanghai since 1980(1980~1997)

(ten thousand)

| Year | Inmigrant | Outmigran | Netmigrant |
|---------|-----------|-----------|------------|
| 1980 | 12.90 | 5.29 | 7.61 |
| 1981 | 10.67 | 5.89 | 4.77 |
| 1982 | 8.49 | 5.34 | 3.16 |
| 1983 | 11.52 | 8.06 | 3.46 |
| 1984 | 10.16 | 7.75 | 2.40 |
| 1985 | 11.14 | 5.88 | 5.26 |
| 1986 | 12.67 | 6.29 | 6.38 |
| 1987 | 12.87 | 6.17 | 6.70 |
| 1988 | 12.16 | 6.98 | 5.17 |
| 1989 | 12.93 | 8.99 | 3.94 |
| 1990 | 12.18 | 10.72 | 1.45 |
| 1991 | 8.68 | 6.58 | 2.10 |
| 1992 | 9.24 | 6.40 | 2.84 |
| 1993 | 12.23 | 5.64 | 6.59 |
| 1994 | 13.20 | 5.42 | 7.78 |
| 1995 | 13.12 | 6.47 | 6.65 |
| 1996 | 13.01 | 6.41 | 6.60 |
| 1997 | 11.47 | 5.72 | 5.75 |
| 1982~87 | 37.59 | 8.20 | 29.39 |
| 1985~90 | 67.06 | 13.26 | 53.81 |
| 1990~95 | 72.65 | 12.19 | 60.46 |

Source: Preserted by Prof. Wang Guixin of East China Normal Univ. (Study on Population and Sutainable Development in Shanghai) Aug. 1999.

Figure 1 Population Dynamics of China since 1949

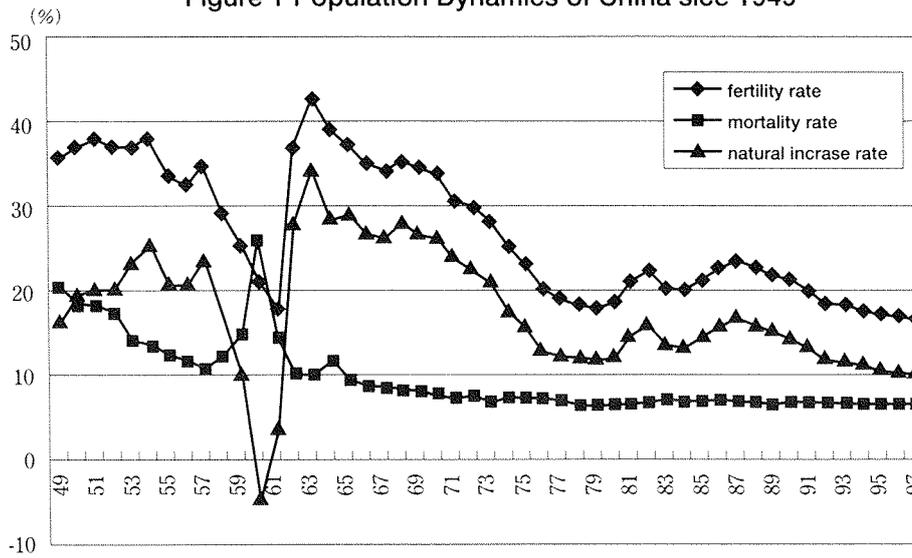
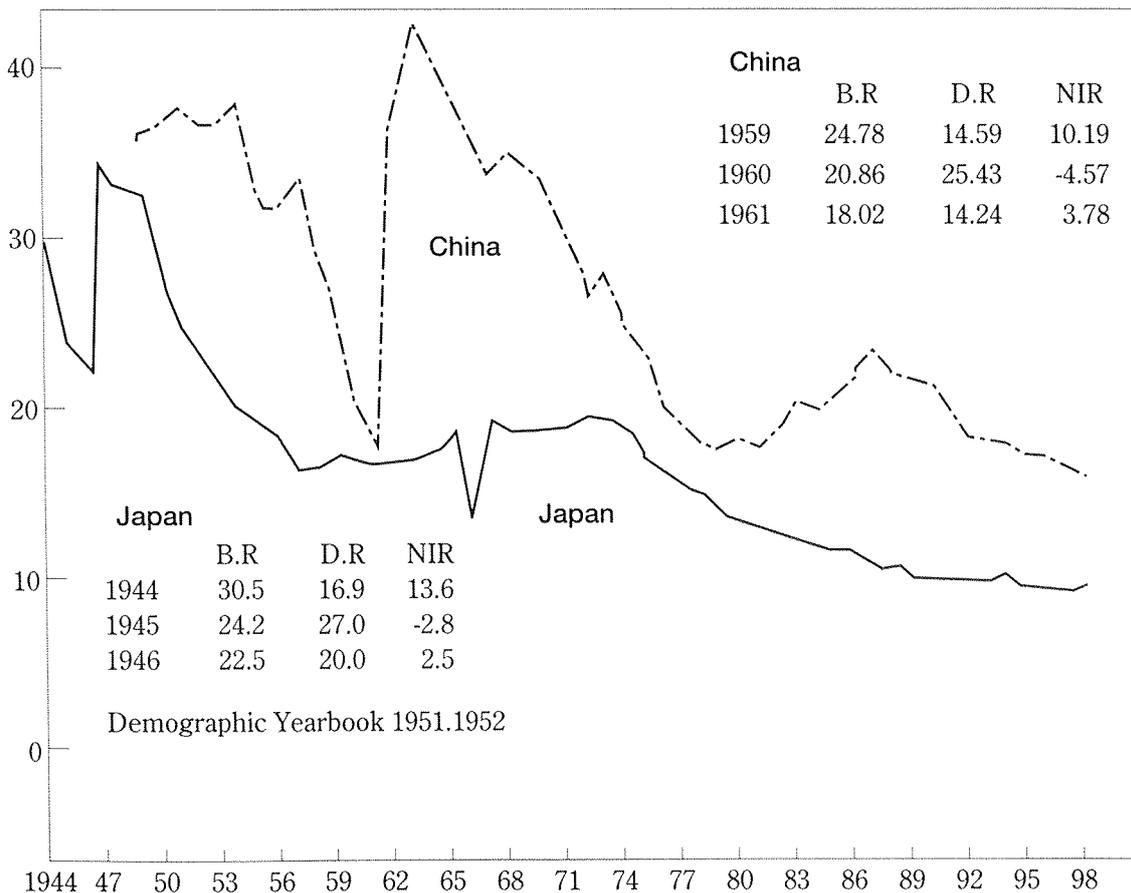


Figure 2 Fertility Transition of Japan and China (Japan : 1945-1998 China : 1959-1997)



Chapter One

Health and Medical Care in China

As have been mentioned in the previous section, according to Consul Mr. Kazuyuki Suwa of Consulate General of Japan in Shanghai, total population of the People's Republic of China (hereinafter "China") amounted to approximately 1.25 billion in 1988, a figure nearly ten times greater than that of Japan¹. The population of those aged 60 years and above was approximately 120 million (9.7% in population ratio) but is estimated to exceed 10% in population ratio when it reaches 130 million in the year 2000. The aging process is predicted to peak in 2040 when population exceeds 400 million¹. Shanghai, the subject that has been selected for this study, is the primal city of China where about the same number of people as the Tokyo Metropolis, i.e. about 10% of population in China, are concentrated.

This chapter will focus on the issues related to health and medical care under these circumstances.

1. Overview of Public Health and Health/Medical Services

According to Consul and Medical Officer Dr. Hifoshi Koga of Consulate General of Japan in Shanghai, the agency placed in charge of public health administration in China is at the highest administrative level of the Central Government, i.e. the Public Health Ministry of the State Council¹. There are also agencies such as the China Academy of Medical Sciences and the China Academy of Preventive Medicine Sciences that offer health/medical services, and hospitals directly under the Public Health Ministry and hospitals attached to medical universities under the Public Health Ministry that practice medicine¹.

To understand public health administration and health/medical service agencies on a local level, one must first have some idea about the administrative division in China consisting of 23 provinces classified as Class I regions (corresponding to prefectures in Japan), 5 autonomous regions and 4 directly-controlled cities. Hong Kong is a special administrative region that has been granted a high degree of autonomy. Provinces are divided into districts (Class II regions) and districts are divided into prefectures (Class III regions). Prefectures are divided into the smallest administrative unit of town/village that are comprised of several villages that are not regarded as administrative units¹. As for administrative bodies in charge of public health, provinces have provincial health agencies, districts have health bureaus and prefectures have prefectural health bureaus. Each of these bodies have health and epidemic prevention centers, maternal and child health centers and specialized disease prevention/treatment centers that offer services in health and medical care, while provincial people's hospitals, hospitals attached to provincial medical universities, district hospitals and prefectural hospitals have been established as medical institutions¹. On the terminal town/village level, town/village People's Government and health office play the role of administrative body and medical care body, respectively¹. Villagers' committees are formed on the village level as autonomous body of the residents and are equipped with health clinics offering health/medical services¹.

As mentioned above, public bodies are predominant suppliers of health/medical services and medical care that offer nearly 50% of hospitals and 70% of hospital beds. There are 2.4 beds per 1,000 population at hospitals and health office, and the average number of hospitalization is 13.8 days at hospitals of prefectural level and above¹.

Table 1 shows the number of hospitals and number of hospital beds. The same figures for Shanghai are shown in Tables 2 and 3. The difficulties that are being experienced by Shanghai can be inferred by comparing Shanghai with other regions of China and by taking into consideration the number of hospitals and hospital beds along with the city's population density and the aforementioned aging process,

2. Changes in Disease Structure –Increase in Adult Diseases and Decrease in Infectious Diseases—

One of the effects of aging society on the health/medical care trends is the change in disease structure. According to Economic Consul Mr. Ryu Tarukawa of Consulate General of Japan and Professors Dr. Gui Shixun and Dr. Wang Guixin of Population Research Institute of East China Normal University, aging of population in Shanghai differs from the cases observed in major cities of other countries² in that it is brought about by three causes consisting of declining fertility, extended average life expectancy and restraint of population influx². Total fertility rate in 1997 dropped to 0.97 and, combined with improvement of medical and health technology, average life expectancy in Shanghai for the same year rapidly narrowed its gap

with that of Japan by rising to 77.2 years (75.2 years for men and 79.2 years for women)². In regard to restraint of population influx (which is one of the causes), aging is said to have occurred at a faster pace in Shanghai compared to other cities because it is particularly conspicuous in urban areas and Shanghai is the largest city in China².

Disease structure also saw considerable changes as advancement of industrial structure² and expansion of private economy² were added on top of the situation described above. Table 4 shows the ten major causes of death in urban areas and Table 5 shows the ten major causes of death in rural areas of China. In addition, Table 6 and Figure 1 reveal the ten major causes of death in Shanghai. As indicated by these tables and figure, the trends observed in Shanghai are becoming similar to those seen in Japan when compared to the trends of China³ as a whole and suggest an influence of aging population. In other words, the present day Shanghai is characterized by increase in adult diseases and decrease in infectious diseases.

3. Maternal and Child Health Measures –One-Child Policy—

As was mentioned earlier, China has the world's largest population of approximately 1.25 billion (1998). This figure is ten times greater than that of Japan. Assuming that the world population is roughly 6 billion, 1 out of every 4.8 persons would be Chinese³. According to Dr. Zhou Jianping M.D., Executive Director of Shanghai Municipal Family Planning Commission, family planning had been proposed in Shanghai since the end of 1950s and Shanghai was the most advanced city in China in terms of promoting family planning policies by introducing a strict One-Child Policy since the 1970s. Nearly 20 years have elapsed since the introduction of the One-Child Policy—the policy has achieved enormous results but has given rise to various problems in the recent years on the other hand. As for the former, the policy succeeded in reducing the expenses of child-rearing for the government and families as a result of less children being born^{2,4,5,6}. In concrete terms, this reduction is said to correspond to 7.4 trillion yuan (about 93 trillion yen) which is equal to the country's gross domestic product (GDP) in 1997⁴. As for the latter, the problems experienced by urban areas and rural areas are different. To give two typical examples, labor shortage is becoming serious among farm households in rural areas. Meanwhile, advancement of aging in urban areas is creating a situation where each grandchild would have to support a total of 6 people (4 grandparents and parents) in the future.

Encouragement of late marriage and late birthing as well as birth control education are being practiced extensively in conjunction with the One-Child Policy. For instance, one-child policy is basically not applied to ethnic minority groups as they are placed under a protective policy¹. Furthermore, Family Planning Commission is developing enlightenment programs by promoting policies from the standpoint of improving standard of living in rural areas, increasing maternal and child health and improving women's status in addition to population control.

Should the present trend continue, the country's population is estimated to reach 1.6 billion by the mid-21st Century and gradually decrease from that point onward^{1, 2, 5, 6}.

Annual changes in average life expectancy and marriage situation in Shanghai is shown in Table 7. Annual changes in family planning situation and comparative results of districts and prefectures in family planning situation are shown in Table 8 and Table 9, respectively. At 0.96, total fertility rate in Shanghai is lower than that of Tokyo (1.1). This goes to show that the city is ahead of Japan in entering the age of decreasing birthrate.

4. Measures for the Elderly –Shanghai and Hangzhou—

As was mentioned earlier, population of those aged 60 years and above in China is about 120 million (9.7% in population ratio). It will reach 130 million in 2000 and exceed 10% in population ratio. The population of this age group is estimated to exceed 400 million by the time aging reaches its peak in 2040¹.

The term “aging level”² refers to the percentage of the elderly persons aged 65 years and above in total population. According to Professor Dr. Wang Guixin of Population Research Institute of East China Normal University, aging level in Shanghai increased from 3.61% in 1964 to 7.60% in 1982 and kept increasing to 9.38% in 1990 and to 11.43% in 1995. If the present population dynamics continue, the percentage of registered young population in ages 0 through 14 in the year 2020 will drop from 15.06% in 1996 to 3.41% while that of the elderly increases to 26.75%².

Under the social background described above, the basic law for the welfare of the elderly named the Security Law for the Elderly's Rights and Benefits was enacted in China in 1996¹. According to Professor Dr. Gui Shixun of Population Research Institute of East China Normal University, Mr. Gui Rong-an of Shanghai University for Aged, and Dr. Yang De Guang of Shanghai Teachers University, this law defines the obligation of family support for the elderly and lays down basic matters related to social security, education, training, cultural life, facility improvement and social participation of the elderly. Firstly, with regard to welfare service for the elderly, health/medical service and social education activities are implemented in addition to offering of facilities by organizations that are operated mainly by local residents based on the spirit of autonomy, self-help and mutual aid referred to as “community.” Secondly, with regard to facilities for the elderly, there are 42,000 welfare homes and home for the elderly throughout the country offering home to 785,000 senior citizens. Thirdly, about 5,000 senior universities and senior schools have been established throughout the country.

(1) University for Aged

We visited Shanghai University for Aged, which is part of the abovementioned measures, and visited its classes in calligraphy, English and piano. The University relies on the existing classrooms and the faculty of Shanghai Teachers University for its facilities and classes. Mr. Gui Rong-an, Vice-Principal of Shanghai University for Aged, stressed that the university exerts positive influence on the elderly in the following 3 areas. First, the university rejuvenates and animates the elderly both mentally and physically by enabling them to study in the same building as young people. On the other hand, it helps to remove the prejudice among young people against the elderly and generates mutual understanding. In addition, it expands the hopes and dreams the elderly have for the future by enabling them to engage in studies they were not able to take up even if they wanted to with incumbent faculty at university facilities.

The facilities related to senior education are listed in Table 10. The figures clearly indicate that the concept of University for Aged has permeated all the way down to the smallest unit of the administrative organization.

Meanwhile, at Hangzhou City in Zhejiang Province, we heard an explanation about the present situation of aging in the province and the measure that are being taken from Standing Vice President Ms. Xu Ai-Guang of Zhejiang Ma Yinchu Welfare Foundation for Population and saw the early morning exercise in the city. The elderly have the routine of engaging in their own style of exercise, individually or in groups, at the park facing the Xihu Lake from 5 to 7 in the morning. Ms. Xu Ai-Guang has a plan to build an old people's home in Hangzhou based on her experience during her stay in Japan and is intending to steadily put the plan into practice. The details of this province will be given in Section (3).

(2) Life of the elderly after retirement

Details on life of the elderly after retirement will be discussed in later chapters as this is a subject deeply connected with the pension system, health/medical care for the elderly and social welfare measures.

Meanwhile, according to Vice President and Fellow of Shanghai Academy of Social Sciences Dr. Xuejin Zuo, Office Director of Shanghai Municipal Committee on Aging Mr. Yin Zhi Gang, and Ms. Zhu Ji-Ming, Deputy Director of Shanghai Research Center on Aging, elderly people in Shanghai have relatively more economic latitude after retirement compared to their counterparts in other Chinese cities thanks to advancement of industrial structure, expansion of private economy and reduction of economic burden on families owing to population control policy, although numerous gaps exist depending on type of job held prior to retirement and region.

Figure 2 shows the cultural level of the elderly in Shanghai. The upper section illustrates the level of those aged 60 years and above and the lower section illustrates the level of those

aged 65 years and above. Figure 3 shows the industrial structure of the elderly in Shanghai. The difference between urban and rural areas is obvious. Agriculture accounts for overwhelming majority in town and prefectures while industry and state enterprises are ranked high in urban areas. Figure 4 shows the occupational structure of the elderly in Shanghai. As in Figure 3, it clearly indicates the difference between urban areas and town/prefectures and suggests the deep connection between the elderly and industry in Shanghai.

(3) Aging in Zhejiang Province

An interview with Standing Vice President Ms. Xu Ai-Guang of Zhejiang Ma Yinchu Welfare Foundation for Population revealed the following points as characteristics of aging in the Province.

- (a) Aging is occurring at a faster pace than Europe and America and is approaching that of Japan.

For instance, to compare Zhejiang Province with various countries in terms of the number of years required for the percentage of the population aged 65 years and above to increase from 7% to 14%, it was 28 years for Zhejiang Province, while it took 115 years for France, 85 years for Sweden, 45 years for United Kingdom, 70 years for the U.S. and 24 years for Japan to reach the same level.

- (b) Degree of population aging is high and is one of the highest in the country

According to the population census conducted in 1990, Shanghai ranked first among regions with percentage of elderly population exceeding 10% at 14.7%. Zhejiang Province ranked second at 10.38% and Jiangsu Province ranked third at 10.24%.

- (c) A gap in level of aging exists between urban and rural areas. In 1982, the percentage of elderly persons living in urban and rural areas was 26.4% and 73.6%, respectively. In 1995, the percentage changed to 33.3% urban areas and 66.7% rural areas. In Zhejiang Province, the percentage of elderly population was highest in cities, followed by prefectures and village in that order.

- (d) Advancement of aging among the elderly

The number of people aged 80 years and above in Zhejiang Province increased from 69,900 in 1953 to 305,300 in 1982 and to 395,300 in 1990. This means that their number increased by 158,000 between 1990 and 1998.

- (e) Speed of aging is exceeding the level of socioeconomic development

Birth rate dropped rapidly as a result of population control measures that are implemented strictly on a national scale. This is affecting the economic development of Zhejiang Province enormously and the improvement of social security system and welfare programs is unable to keep pace with the speed of aging of population. Japan's

gross national product per capita in 1970, when the population aged 65 years and above reached 7% of the entire population, was \$4,981. In contrast, gross national product per capita in Zhejiang Province when the population aged 65 years and above reached 7% of the entire population was \$434.

In view of the background described above, Zhejiang Province is implementing the following measures for its elderly population.

- (a) Establish handcraft system for the elderly and draw up a plan for the development of programs for the elderly
- (b) Enact Human Rights Security Law of People's Republic of China to protect the legal rights of the elderly
- (c) Launch programs for the elderly such as old people's homes, apartments for the elderly, day-care centers, activity centers for the elderly and universities (schools) for the aged in an effort to develop community-based welfare for old people
- (d) Implement policies for preferential treatment of the elderly
- (e) Conduct study and research of old people's issues, accept priority research subjects on provincial, domestic and international levels and offer scientific support to programs for the elderly enacted by the provincial government
- (f) Reform old-age insurance system for company employees
- (g) Develop old-age insurance system in rural areas
- (h) Open geriatric hospitals and departments specializing in geriatrics and develop local health/medical care service

Furthermore, there is a plan to take and promote the following measures with the aim of coping with the aging society of the coming 21st Century.

- (a) Develop the economy and establish the base of welfare policy for the elderly by fully utilizing the period up to the year 2010 when there is abundance of labor resources in an effort to alleviate the population pressure as aging reaches its peak
- (b) Encourage research for building the policy system for aging society and incorporate senior population projects into national economy and social development programs for

the purpose of substantiating the government projects for senior population.

- (c) Fully equip the old-age/medical security by taking into consideration the old-age/medical security system with emphasis on social security.
- (d) Complete and establish the nursing system for the elderly with emphasis on domestic nursing and develop community medical service that is actively supported and utilized by the people.
- (e) Extensively develop projects for health education, public health and disease prevention in an effort to maintain and promote health in aging society.
- (f) Give consideration to mental and cultural aspects of the daily life the elderly
- (g) Adjust industrial structure to develop industries that involve the elderly. Give consideration so that the demand of the elderly would be met as a result.
- (h) Review age definition of the elderly and upper limit of labor age.
- (i) Adjust family planning.

¹ Ministry of Health and Welfare: Social Security Systems in Asia Pacific Countries, supervised by the Ministry of Health and Welfare, White Paper on Health and Welfare (11), Gyousei, Tokyo, 1999, pp.323-326

² Dr. Wang Guixin: Shanghai—Its Population and Development, *Statistic* (50) 2:1-10, 1999

³ Trends of National Hygiene (1999): Welfare Statistics Association (ed.), Welfare Statistics Association, Tokyo, 1999, pp.420-421

⁴ Yomiuri Shimbun: Sep. 29, 1999

⁵ Kukubu, Yoshinari: People's Republic of China, Chikuma Shobo, Tokyo, 1999, pp.99-93

⁶ TIME: China's amazing half-century, Sep. 27, 1999

⁷ Management Coordination Agency: Approach Towards International Year of the Elderly, Management Coordination Agency (ed.), White Paper on Aging Society (11), Printing Bureau, Ministry of Finance, Tokyo, 1999

⁸ Trends of National Hygiene (1999): Welfare Statistics Association (ed.), Welfare Statistics Association, Tokyo, 1999, pp.32-33

⁹ TIME: Getting the lead out, July 27, 1998

Table1 Number of health institutions, beds and persons engaged by region(1997)

| Region | Health Institutions (unit) | | Beds (10000 units) | | Personnel (10000 persons) | |
|----------------|----------------------------|-------|--------------------|-------|-----------------------------|-------|
| | Hospitals | | Hospital Beds | | Medical Technical Personnel | |
| National Total | 315033 | 67911 | 313.5 | 290.3 | 551.6 | 439.8 |
| Beijing | 6577 | 673 | 6.8 | 6.6 | 16.7 | 11.9 |
| Tianjin | 3571 | 483 | 4.1 | 3.9 | 9.1 | 7.1 |
| Hebei | 20077 | 4511 | 16.6 | 14.5 | 26.3 | 21.3 |
| Shanxi | 8596 | 2630 | 11.1 | 10.5 | 17.9 | 15.0 |
| Inner Mongolia | 7571 | 1991 | 6.5 | 6.2 | 13.4 | 10.7 |
| Liaoning | 11806 | 2174 | 19.9 | 17.9 | 31.0 | 23.6 |
| Jilin | 5539 | 1439 | 9.5 | 8.8 | 17.5 | 13.5 |
| Heilongjiang | 7676 | 1999 | 12.1 | 11.5 | 23.2 | 17.8 |
| Shanghai | 5898 | 474 | 7.0 | 6.8 | 14.9 | 10.9 |
| Jiangsu | 13386 | 2620 | 17.0 | 15.9 | 32.4 | 25.5 |
| Zhejiang | 19229 | 3403 | 10.8 | 10.2 | 19.1 | 15.3 |
| Anhui | 7911 | 3203 | 12.3 | 11.4 | 18.7 | 15.2 |
| Fujian | 10059 | 1306 | 8.9 | 8.1 | 11.4 | 9.5 |
| Jiangxi | 8056 | 2310 | 9.0 | 8.2 | 14.9 | 12.0 |
| Shandong | 14627 | 3151 | 20.7 | 19.4 | 36.6 | 29.4 |
| Henan | 11733 | 3001 | 18.9 | 17.6 | 32.2 | 26.2 |
| Hubei | 11562 | 2078 | 14.5 | 13.1 | 30.2 | 23.9 |
| Hunan | 15591 | 3348 | 14.4 | 13.4 | 24.9 | 20.5 |
| Guangdong | 16195 | 2350 | 15.5 | 14.4 | 30.5 | 24.6 |
| Guangxi | 13851 | 1758 | 8.8 | 8.3 | 15.4 | 12.3 |
| Hainan | 2595 | 485 | 2.2 | 2.1 | 4.1 | 3.3 |
| Chongqing | 9816 | 2553 | 6.6 | 5.8 | 10.9 | 8.8 |
| Sichuan | 31392 | 7688 | 19.1 | 17.1 | 30.8 | 25.1 |
| Guizhou | 8955 | 1870 | 5.8 | 5.4 | 10.2 | 8.4 |
| Yunnan | 11454 | 2127 | 9.4 | 8.6 | 14.6 | 11.8 |
| Tibet | 1324 | 895 | 0.6 | 0.6 | 1.1 | 0.9 |
| Shaanxi | 10856 | 3218 | 9.5 | 9.0 | 16.1 | 13.0 |
| Gansu | 8962 | 1861 | 5.7 | 5.4 | 9.9 | 8.2 |
| Qinghai | 1903 | 592 | 1.7 | 1.7 | 2.6 | 2.1 |
| Ningxia | 1651 | 375 | 1.3 | 1.2 | 2.7 | 2.2 |
| Xinjiang | 6614 | 1345 | 7.2 | 6.7 | 12.3 | 9.8 |

Source:China Statistical Yearbook 1998, 1999 China Statistical Publishing House

Table2 Health care institutions in Shanghai(1978-1997)

| Year | Total | Hospital | Sanatoriums | Clinics | Specialized Stations | Sanitation and Disease Control Stations | Maternity and Child Care Centers | Medical Science Research Institutions | Medical Institutions of Higher Education and Secondary Medical Schools |
|------|-------|----------|-------------|---------|----------------------|---|----------------------------------|---------------------------------------|--|
| 1978 | 4823 | 388 | 53 | 4195 | 52 | 31 | 21 | 11 | 37 |
| 1979 | 5627 | 394 | 61 | 4971 | 50 | 32 | 22 | 26 | 35 |
| 1980 | 6067 | 399 | 62 | 5397 | 49 | 35 | 21 | 15 | 36 |
| 1981 | 6337 | 403 | 70 | 5651 | 45 | 34 | 21 | 17 | 36 |
| 1982 | 6445 | 408 | 70 | 5756 | 44 | 34 | 22 | 16 | 35 |
| 1983 | 6451 | 415 | 67 | 5761 | 44 | 34 | 22 | 16 | 35 |
| 1984 | 6318 | 420 | 63 | 5626 | 42 | 35 | 23 | 16 | 35 |
| 1985 | 7245 | 405 | 50 | 6567 | 45 | 32 | 22 | 16 | 37 |
| 1986 | 7306 | 419 | 47 | 6610 | 47 | 32 | 22 | 17 | 38 |
| 1987 | 7330 | 431 | 55 | 6611 | 46 | 32 | 22 | 17 | 38 |
| 1988 | 7471 | 444 | 46 | 6738 | 42 | 32 | 24 | 17 | 39 |
| 1989 | 7550 | 460 | 41 | 6810 | 43 | 33 | 23 | 17 | 35 |
| 1990 | 7690 | 462 | 40 | 6947 | 41 | 33 | 23 | 17 | 33 |
| 1991 | 7554 | 463 | 37 | 6817 | 41 | 33 | 23 | 17 | 34 |
| 1992 | 7363 | 454 | 31 | 6644 | 40 | 33 | 23 | 17 | 32 |
| 1993 | 6077 | 486 | 18 | 5377 | 34 | 35 | 13 | 18 | 33 |
| 1994 | 5606 | 497 | 13 | 4909 | 32 | 33 | 12 | 17 | 32 |
| 1995 | 5286 | 485 | 13 | 4604 | 32 | 33 | 12 | 17 | 29 |
| 1996 | 5200 | 477 | 4 | 4537 | 29 | 33 | 12 | 17 | 29 |
| 1997 | 5028 | 474 | 4 | 4367 | 30 | 33 | 12 | 17 | 28 |

Note :Since 1996,the sanatoriums without health care services are classified into clinics.
Source:'98 Statistical Yearbook of Shanghai, 1999, China Statistical Publishing House.

Table3 Personnel of health care institutions and hospital beds in Shanghai(1978-1997)

| Year | Personnel of Health care Institution (10000persons) | Medical Professionals | | | | | Hospital | | | |
|------|---|------------------------------|-------------------------|-------------------------|--------------------------|--------------|---------------|-----------------|-----------------------------------|------|
| | | Traditional Chinese Medicine | Western Medicine Senior | Western Medicine Junior | Senior and Junior Nurses | Beds (10000) | In Hos-pitals | In Sanato-riums | In Other Health Care Institutions | |
| | | | | | | | | | | |
| 1978 | 11.91 | 8.50 | 0.61 | 1.36 | 1.39 | 2.23 | 5.47 | 4.68 | 0.30 | 0.49 |
| 1979 | 12.60 | 8.88 | 0.58 | 1.63 | 1.38 | 2.12 | 5.56 | 4.78 | 0.34 | 0.44 |
| 1980 | 13.19 | 9.41 | 0.64 | 1.76 | 1.53 | 2.24 | 5.80 | 4.94 | 0.42 | 0.44 |
| 1981 | 13.49 | 9.57 | 0.68 | 1.79 | 1.90 | 2.22 | 5.84 | 4.99 | 0.47 | 0.38 |
| 1982 | 13.88 | 9.88 | 0.68 | 1.93 | 2.11 | 2.29 | 5.43 | 5.11 | 0.46 | 0.36 |
| 1983 | 14.09 | 10.09 | 0.70 | 2.05 | 2.12 | 2.35 | 6.00 | 5.20 | 0.45 | 0.35 |
| 1984 | 14.35 | 10.24 | 0.70 | 2.11 | 2.04 | 2.44 | 6.16 | 5.34 | 0.47 | 0.35 |
| 1985 | 14.36 | 10.42 | 0.68 | 2.15 | 2.02 | 2.51 | 6.02 | 5.32 | 0.30 | 0.40 |
| 1986 | 14.74 | 10.71 | 0.70 | 2.21 | 2.00 | 2.66 | 6.22 | 5.47 | 0.30 | 0.45 |
| 1987 | 15.15 | 11.00 | 0.69 | 2.35 | 2.01 | 2.81 | 6.38 | 5.60 | 0.37 | 0.41 |
| 1988 | 15.49 | 11.46 | 0.69 | 3.19 | 1.52 | 3.00 | 6.29 | 5.89 | 0.38 | 0.52 |
| 1989 | 15.68 | 11.65 | 0.68 | 3.62 | 1.43 | 3.15 | 6.87 | 6.04 | 0.31 | 0.52 |
| 1990 | 15.85 | 11.84 | 0.67 | 3.68 | 1.47 | 3.27 | 6.96 | 6.21 | 0.32 | 0.43 |
| 1991 | 15.97 | 11.92 | 0.67 | 3.84 | 1.37 | 3.38 | 7.01 | 6.31 | 0.31 | 0.39 |
| 1992 | 15.93 | 11.82 | 0.67 | 3.86 | 1.34 | 3.39 | 7.07 | 6.42 | 0.28 | 0.37 |
| 1993 | 15.67 | 11.53 | 0.64 | 3.91 | 1.19 | 3.37 | 7.12 | 6.75 | 0.19 | 0.18 |
| 1994 | 15.33 | 11.20 | 0.62 | 3.92 | 0.98 | 3.35 | 7.20 | 6.81 | 0.17 | 0.22 |
| 1995 | 15.15 | 11.06 | 0.61 | 3.89 | 0.87 | 3.40 | 7.10 | 6.69 | 0.16 | 0.25 |
| 1996 | 15.04 | 10.95 | 0.58 | 3.85 | 0.79 | 3.45 | 7.00 | 6.73 | 0.05 | 0.22 |
| 1997 | 15.02 | 10.89 | 0.57 | 3.81 | 0.74 | 3.48 | 7.00 | 6.78 | 0.02 | 0.20 |

Note: Since 1985 the personnel and the beds of rear bases set up outside city, have been excluded from this table.

Other health care institutions include clinics, specialized prevention and health institutions, sanitation and antiepidemic stations, health centers for women and children and medical research institutions.

Source: '98 Statistical Yearbook of Shanghai.

Table4 Death rate of 10 major diseases in urban areas in China(1997)

| No. | Cause of Death | As % of Total Deaths |
|-----|---|----------------------|
| | Total | 91.76 |
| 1 | Malignant Tumour | 22.71 |
| 2 | Cerebrovascular Disease | 22.63 |
| 3 | Heart Trouble | 16.77 |
| 4 | Respiratory Disease | 14.09 |
| 5 | Trauma and Toxicosis | 6.18 |
| 6 | Digestive Disease | 3.10 |
| 7 | Internal System,Nutrition, Metabolite and Immunity Disease | 2.66 |
| 8 | Urinary Disease | 1.49 |
| 9 | Mental Disease | 1.16 |
| 10 | Neuropathy | 0.97 |
| | Male Totale | 92.62 |
| 1 | Malignant Tumour | 25.45 |
| 2 | Cerebrovascular Disease | 22.33 |
| 3 | Heart Trouble | 15.45 |
| 4 | Respiratory Disease | 13.53 |
| 5 | Trauma and Toxicosis | 7.05 |
| 6 | Digestive Disease | 3.41 |
| 7 | Internal System,Nutrition, Metabolite and Immunity Disease | 1.99 |
| 8 | Urinary Disease | 1.42 |
| 9 | Mental Disease | 1.00 |
| 10 | Infectious Disease (Excluding Pulmonary Tuberculosis) | 0.99 |
| | Female Total | 90.68 |
| 1 | Cerebrovascular Disease | 23.00 |
| 2 | Malignant Tumour | 19.31 |
| 3 | Heart Trouble | 18.41 |
| 4 | Respiratory Disease | 14.78 |
| 5 | Trauma and Toxicosis | 5.09 |
| 6 | Internal System,Nutrition, Metabolite and Immunity Disease | 3.48 |
| 7 | Digestive Disease | 2.72 |
| 8 | Urinary Disease | 1.58 |
| 9 | Mental Disease | 1.37 |
| 10 | Neuropathy | 0.94 |

Note :Statistics in the table cover full or partial areas of 35 cities including Beijing.
Source:China Statistical Yearbook 1998.

Table5 Death rate of 10 major diseases in rural areas of China(1997)

| No. | Cause of Death | As % of Total Deaths |
|-----|---|----------------------|
| | Total | 91.47 |
| 1 | Respiratory Disease | 23.38 |
| 2 | Cerebrovascular Disease | 17.82 |
| 3 | Malignant Tumour | 17.12 |
| 4 | Trauma and Toxicosis | 11.67 |
| 5 | Heart Trouble | 11.48 |
| 6 | Digestive Disease | 4.39 |
| 7 | Newborn Baby Disease | 1.46 |
| 8 | Urinary Disease | 1.41 |
| 9 | Pulmonary Tuberculosis | 1.39 |
| 10 | Infectious Disease (Excluding Pulmonary Tuberculosis) | 1.35 |
| | Male Total | 92.71 |
| 1 | Respiratory Disease | 22.15 |
| 2 | Malignant Tumour | 19.44 |
| 3 | Cerebrovascular Disease | 17.41 |
| 4 | Trauma and Toxicosis | 12.63 |
| 5 | Heart Trouble | 10.42 |
| 6 | Digestive Disease | 4.73 |
| 7 | Pulmonary Tuberculosis | 1.61 |
| 8 | Urinary Disease | 1.48 |
| 9 | Infectious Disease (Excluding Pulmonary Tuberculosis) | 1.43 |
| 10 | Newborn Baby Disease | 1.41 |
| | Female Total | 89.92 |
| 1 | Respiratory Disease | 24.91 |
| 2 | Cerebrovascular Disease | 18.32 |
| 3 | Malignant Tumour | 14.26 |
| 4 | Heart Trouble | 12.80 |
| 5 | Trauma and Toxicosis | 10.48 |
| 6 | Digestive Disease | 3.79 |
| 7 | Newborn Baby Disease | 1.51 |
| 8 | Urinary Disease | 1.33 |
| 9 | Internal System,Nutrition, Metabolite and Immunity Disease | 1.27 |
| 10 | Infectious Disease (Excluding Pulmonary Tuberculosis) | 1.25 |

Note : Statistics in the table cover 79 countries,including counties in Beijing.
Source:China Statistical Yearbook 1998.

Table6 Death rate of 10 major diseases in Shanghai

| No. | Total City | | District | | Country | |
|-----|-----------------------------------|---------------------|-----------------------------------|---------------------|-----------------------------|---------------------|
| | Cause of Death | AS % of Total Death | Cause of Death | AS % of Total Death | Cause of Death | AS % of Total Death |
| 1. | Circulation Diseases | 33.82 | Circulation Diseases | 36.39 | Circulation Diseases | 25.91 |
| 2. | Tumor | 25.90 | Tumor | 26.87 | Respiratory System Diseases | 25.84 |
| 3. | Respiratory System Diseases | 16.52 | Respiratory System Diseases | 13.48 | Tumor | 22.89 |
| 4. | Damage and Poisoning | 6.55 | Damage and Poisoning | 5.92 | Damage and Poisoning | 8.49 |
| 5. | Digestive System Diseases | 2.78 | Endocrinasthenia | 2.78 | Digestion Diseases | 3.40 |
| 6. | Endocrinasthenia | 2.41 | Digestive System Diseases | 2.58 | Infiction and Parasite | 3.11 |
| 7. | Psychosis | 2.33 | Psychosis | 2.51 | Psychosis | 1.76 |
| 8. | Infictious and Parasitic Diseases | 2.17 | Infictious and Parasitic Diseases | 1.87 | Genitourinary Diseases | 1.56 |
| 9. | Genitourinary Diseases | 1.21 | Genitourinary Diseases | 1.10 | Endocrinasthenia | 1.28 |
| 10. | Nervous System Diseas | 0.75 | Nervous System Diseas | 0.82 | Nervous System Diseas | 0.53 |

Source:'98 Statistical Yearbook of Shanghai.

Table7 Life expectancy and marriage registration in main years in Shanghai

| Indicators | 1978 | 1980 | 1990 | 1996 | 1997 |
|--|-------|-------|-------|-------|-------|
| Life Expectancy(year) | 73.35 | 73.33 | 75.46 | 76.11 | 77.20 |
| Male | 70.69 | 71.25 | 73.16 | 74.07 | 75.18 |
| Female | 74.78 | 75.36 | 77.74 | 78.21 | 79.21 |
| Marriage Registration Perrnitted(10000couples) | 8.97 | 16.82 | 10.77 | 8.96 | 8.84 |
| District | 4.11 | 10.10 | 6.19 | 6.56 | 6.82 |
| County | 4.86 | 6.72 | 4.58 | 2.40 | 2.02 |
| First marriage(10000persons) | | 33.07 | 19.49 | 14.98 | 15.12 |
| Remarriage(10000persons) | | 0.57 | 2.04 | 2.31 | 2.57 |
| Divorce(10000persons) | | | 3.27 | 4.93 | 5.46 |

Source:'98 Statistical Yearbook of Shanghai.

Table8 Family Planning in Shanghai(1978-1997)

| | | (1,000 persons) | | | | | | | |
|-----------------|--------|----------------------|--------------------|-----------------------------------|--|-----------------------------------|---|---|------|
| Year | Births | Births Under Control | Birth Control Rate | Married Women at Childbearing Age | The Number of Couples with One-child Certificate | Coverage of One-Child Certificate | Number of Married People Adopting Contraception | Coverage of Married People Adopting Contraception | |
| Total | 1978 | 11.60 | 9.77 | 84.3 | 146.93 | | 127.01 | 86.4 | |
| | 1979 | 13.05 | 11.43 | 87.6 | 154.30 | | 133.40 | 86.5 | |
| | 1980 | 13.00 | 11.88 | 91.4 | 162.30 | 36.67 | 74.6 | 143.05 | 88.1 |
| | 1981 | 18.11 | 16.79 | 92.7 | 180.42 | 54.79 | 86.2 | 152.22 | 84.4 |
| | 1982 | 20.75 | 19.19 | 92.5 | 191.89 | 77.03 | 94.8 | 164.31 | 85.6 |
| | 1983 | 17.80 | 19.26 | 97.0 | 197.98 | 94.87 | 98.7 | 173.56 | 87.7 |
| | 1984 | 16.28 | 16.12 | 99.1 | 206.83 | 109.73 | 99.2 | 184.74 | 89.3 |
| | 1985 | 15.43 | 15.33 | 99.4 | 219.61 | 118.56 | 54.0 | 189.54 | 86.3 |
| | 1986 | 17.24 | 17.09 | 99.1 | 230.81 | 132.93 | 56.3 | 198.87 | 86.2 |
| | 1987 | 19.03 | 18.88 | 99.2 | 242.77 | 147.03 | 60.6 | 212.48 | 87.5 |
| | 1988 | 16.53 | 16.43 | 99.4 | 251.52 | 158.93 | 63.2 | 223.74 | 89.0 |
| | 1989 | 15.91 | 15.81 | 99.4 | 261.73 | 171.13 | 65.4 | 235.97 | 90.2 |
| | 1990 | 13.12 | 13.06 | 99.6 | 268.05 | 181.94 | 67.9 | 245.59 | 91.6 |
| | 1991 | 10.08 | 10.05 | 99.7 | 270.95 | 188.10 | 69.4 | 249.70 | 92.2 |
| | 1992 | 9.37 | 9.35 | 99.8 | 274.42 | 192.63 | 70.2 | 252.96 | 92.2 |
| | 1993 | 8.40 | 8.38 | 99.8 | 274.44 | 195.51 | 71.2 | 253.45 | 92.4 |
| | 1994 | 7.63 | 7.62 | 99.8 | 272.90 | 196.23 | 71.9 | 252.90 | 92.7 |
| | 1995 | 7.11 | 7.09 | 99.7 | 270.35 | 193.09 | 71.4 | 250.49 | 92.7 |
| | 1996 | 6.79 | 6.76 | 99.6 | 267.81 | 182.78 | 68.3 | 247.42 | 92.4 |
| | 1997 | 6.42 | 6.39 | 99.6 | 266.64 | 162.87 | 61.1 | 245.67 | 92.1 |
| District | 1978 | 3.99 | 3.61 | 90.5 | 68.81 | | | 62.77 | 91.2 |
| | 1979 | 4.48 | 4.35 | 97.0 | 70.65 | | | 63.91 | 90.5 |
| | 1980 | 5.19 | 5.12 | 98.6 | 74.31 | 22.79 | 85.6 | 66.32 | 89.2 |
| | 1981 | 7.50 | 7.42 | 99.0 | 81.67 | 31.74 | 94.2 | 69.45 | 85.0 |
| | 1982 | 10.20 | 10.08 | 98.8 | 88.92 | 42.41 | 98.5 | 74.40 | 83.7 |
| | 1983 | 10.63 | 10.60 | 99.7 | 93.74 | 51.55 | 99.6 | 79.83 | 84.7 |
| | 1984 | 10.40 | 10.38 | 99.9 | 100.11 | 61.68 | 99.7 | 87.00 | 86.9 |
| | 1985 | 9.86 | 9.84 | 99.8 | 113.87 | 70.74 | 62.1 | 94.34 | 82.8 |
| | 1986 | 10.20 | 10.17 | 99.7 | 120.43 | 79.11 | 65.7 | 100.01 | 83.0 |
| | 1987 | 11.10 | 11.06 | 99.7 | 127.53 | 87.60 | 68.7 | 107.75 | 84.6 |
| | 1988 | 9.79 | 9.76 | 99.7 | 132.38 | 94.30 | 71.2 | 114.29 | 86.3 |
| | 1989 | 9.80 | 9.76 | 99.6 | 146.70 | 107.35 | 73.2 | 129.43 | 88.2 |
| | 1990 | 7.74 | 7.71 | 99.6 | 150.59 | 113.86 | 75.6 | 135.79 | 90.2 |
| | 1991 | 5.35 | 5.33 | 99.7 | 151.96 | 116.83 | 76.9 | 137.94 | 90.8 |
| | 1992 | 4.89 | 4.88 | 99.8 | 155.33 | 119.52 | 77.0 | 140.81 | 90.7 |
| | 1993 | 5.37 | 5.36 | 99.7 | 191.72 | 145.12 | 75.7 | 175.48 | 91.5 |
| | 1994 | 4.87 | 4.86 | 99.8 | 191.72 | 145.24 | 75.8 | 176.10 | 91.7 |
| | 1995 | 4.54 | 4.52 | 99.6 | 189.57 | 142.33 | 75.1 | 174.25 | 91.9 |
| | 1996 | 4.39 | 4.37 | 99.6 | 187.67 | 135.00 | 71.9 | 171.81 | 91.6 |
| | 1997 | 4.56 | 4.53 | 99.5 | 200.34 | 127.04 | 63.4 | 183.17 | 91.4 |
| County | 1978 | 7.61 | 6.06 | 81.0 | 78.12 | | | 64.24 | 82.2 |
| | 1979 | 8.57 | 7.09 | 82.7 | 83.65 | | | 69.40 | 83.1 |
| | 1980 | 7.81 | 6.76 | 86.7 | 87.99 | 13.88 | 61.7 | 76.73 | 87.2 |
| | 1981 | 10.61 | 9.37 | 88.3 | 98.76 | 23.05 | 77.2 | 82.77 | 83.3 |
| | 1982 | 10.55 | 9.11 | 86.4 | 102.97 | 34.62 | 90.7 | 89.91 | 87.3 |
| | 1983 | 7.17 | 6.66 | 92.9 | 104.23 | 43.32 | 97.6 | 94.18 | 90.4 |
| | 1984 | 5.88 | 5.74 | 97.7 | 106.72 | 48.05 | 98.4 | 97.73 | 91.6 |
| | 1985 | 5.57 | 5.19 | 98.6 | 105.77 | 47.82 | 45.2 | 95.20 | 90.0 |
| | 1986 | 7.04 | 6.92 | 98.3 | 110.38 | 53.82 | 46.4 | 98.86 | 89.6 |
| | 1987 | 7.93 | 7.82 | 98.6 | 115.23 | 59.43 | 51.6 | 104.73 | 90.9 |
| | 1988 | 6.74 | 6.67 | 99.0 | 119.14 | 64.63 | 54.3 | 109.45 | 91.9 |
| | 1989 | 6.12 | 6.06 | 99.0 | 115.03 | 63.78 | 55.4 | 106.54 | 92.6 |
| | 1990 | 5.27 | 5.34 | 99.5 | 117.46 | 68.08 | 58.0 | 109.80 | 93.5 |
| | 1991 | 4.73 | 4.72 | 99.7 | 118.99 | 71.27 | 59.9 | 111.76 | 93.9 |
| | 1992 | 4.48 | 4.47 | 99.9 | 119.09 | 73.11 | 61.4 | 112.15 | 94.2 |
| | 1993 | 3.02 | 3.02 | 99.9 | 82.72 | 50.39 | 60.9 | 77.97 | 94.3 |
| | 1994 | 2.76 | 2.76 | 99.8 | 81.18 | 50.99 | 62.8 | 76.80 | 94.6 |
| | 1995 | 2.57 | 2.57 | 99.8 | 80.78 | 50.77 | 62.8 | 76.23 | 94.4 |
| | 1996 | 2.40 | 2.39 | 99.6 | 80.14 | 47.78 | 59.6 | 75.61 | 94.4 |
| | 1997 | 1.86 | 1.86 | 99.7 | 66.30 | 35.83 | 54.0 | 62.50 | 94.3 |

Source: '98 Statistical Yearbook of Shanghai.

Table9 Family planning in districts and counties in Shanghai(1997)

| District | (10,000 Persons) | | | | | | |
|-----------------------|------------------|-----------------------------------|--|---|--------------------|---------------------------------------|--|
| | Births | Married Women at Childbearing Age | Number of Couples with One-child Certificate | Number of Married People Adopting Contraception | Birth Control Rate | Coverage of One-Child Certificate (%) | Coverage of Married People Adopting Contraception(%) |
| Total | 6.42 | 266.64 | 162.87 | 245.67 | 99.59 | 61.1 | 92.1 |
| Urban District | 4.56 | 200.34 | 127.04 | 183.17 | 99.52 | 63.4 | 91.4 |
| Huangpu | 0.10 | 4.61 | 3.16 | 4.08 | 98.85 | 68.5 | 88.4 |
| Nanshi | 0.24 | 8.43 | 6.49 | 7.53 | 99.12 | 77.0 | 89.2 |
| Luwan | 0.14 | 6.85 | 4.54 | 5.98 | 99.01 | 66.2 | 87.3 |
| Xuhui | 0.34 | 13.70 | 9.07 | 12.49 | 99.53 | 66.2 | 91.2 |
| Changning | 0.25 | 12.12 | 8.24 | 10.86 | 99.55 | 68.0 | 89.6 |
| Jing'an | 0.14 | 6.78 | 4.73 | 5.84 | 99.01 | 69.7 | 86.2 |
| Putuo | 0.32 | 16.44 | 10.94 | 14.96 | 99.21 | 66.5 | 91.0 |
| Zhabei | 0.25 | 13.35 | 8.90 | 12.00 | 99.68 | 66.7 | 89.9 |
| Hongkou | 0.31 | 16.18 | 10.80 | 14.64 | 99.58 | 66.7 | 90.5 |
| Yangpu | 0.44 | 18.79 | 12.85 | 17.10 | 99.54 | 68.4 | 91.0 |
| Pudong New Area | 0.73 | 32.32 | 19.16 | 30.10 | 99.66 | 59.3 | 93.1 |
| Minhang | 0.29 | 11.46 | 6.52 | 10.79 | 99.86 | 56.9 | 94.2 |
| Jiading | 0.29 | 11.07 | 5.46 | 10.37 | 99.97 | 49.3 | 93.7 |
| Baoshan | 0.34 | 15.43 | 9.09 | 14.41 | 99.48 | 58.9 | 93.4 |
| Jinshan | 0.38 | 12.81 | 7.09 | 12.02 | 99.58 | 55.4 | 93.9 |
| County | 1.86 | 66.30 | 35.83 | 62.50 | 99.74 | 54.0 | 94.3 |
| Nanhui | 0.49 | 16.31 | 10.69 | 15.43 | 99.80 | 65.5 | 94.6 |
| Fengxian | 0.34 | 11.81 | 5.60 | 11.20 | 99.77 | 47.4 | 94.8 |
| Songjiang | 0.32 | 11.46 | 5.68 | 10.71 | 99.75 | 49.6 | 93.5 |
| Qingpu | 0.30 | 10.56 | 5.41 | 9.86 | 99.90 | 51.2 | 93.3 |
| Chongming | 0.41 | 16.16 | 8.45 | 15.30 | 99.51 | 52.3 | 94.7 |

Source: '98 Statistical Yearbook of Shanghai.

Table 10 Education for the Elderly in Shanghai (1996)

Senior Universities for the Second Half of 1996 (Second Half, City Level Senior Universities)

| Name of school | Number of schools (locations) | Percentage among total number of classes (%) | | Percentage among total number of students (%) | |
|---|-------------------------------|--|-----|---|------|
| Shanghai Senior Leader University | 1 | 18.8 | 31 | 18.8 | 1138 |
| Shanghai University for the Aged | 1 | 28.7 | 47 | 27.5 | 1666 |
| Shanghai Senior University | 1 | 36.0 | 59 | 34.9 | 2114 |
| Shanghai University for Retired Workers | 1 | 16.5 | 27 | 18.8 | 1133 |
| Total | 4 | 100% | 164 | 100% | 6051 |

Senior Universities for the Second Half of 1996 (Second Half, District and Prefecture Level Senior Universities)

| Name of school | Number of schools (locations) | Percentage among total number of classes (%) | | Percentage among total number of students (%) | |
|---|-------------------------------|--|-----|---|-------|
| District Senior Leader University | 10 | 21.6 | 109 | 26.1 | 4354 |
| Bureau Senior Leader University | 9 | 8.9 | 45 | 5.9 | 990 |
| Corporate Senior Leader University | 4 | 11.9 | 60 | 9.9 | 1644 |
| Unit Senior Leader University | 3 | 4.4 | 22 | 3.0 | 493 |
| Shanghai University for the Aged Branch | 13 | 38.1 | 192 | 38.4 | 6406 |
| District University for the Aged | 4 | 12.7 | 64 | 12.0 | 1994 |
| District School for the Aged | 3 | 2.4 | 12 | 4.7 | 787 |
| Total | 46 | 100% | 504 | 100% | 16668 |

Senior Universities for the Second Half of 1996 (Second Half, Subdistrict Level Senior Universities)

| Name of school | Number of schools (locations) | Number of classes (%) | Number of students (%) |
|---------------------------------|-------------------------------|-----------------------|------------------------|
| Subdistrict School for the Aged | 201 | 815 | 39342 |

Senior Branch Universities Operated by Resident Councils and Village Councils for the Second Half of 1996

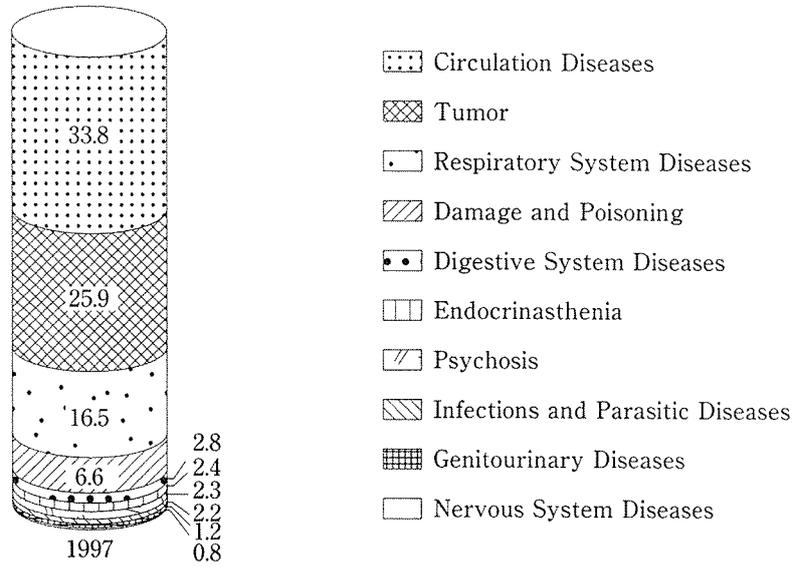
| Name of school | Number of schools (locations) | Studying hours | Percentage among total number of students (%) | |
|--|-------------------------------|---|---|-------|
| Resident Councils and Village Councils | 1584 | Attended every week or every other week | 46.2 | 35772 |
| | | Attended one class every week | 63.8 | 41673 |
| Total | 1584 | | 100% | 77445 |

Shanghai Broadcast University for the Aged in the Second Half of 1996

| Classification | Number of schools (locations) | Percentage among total number of students watching television(%) | |
|----------------|-------------------------------|--|--------|
| Registered | 2323 | 38.6 | 71723 |
| Unregistered | | 61.4 | 114311 |
| Total | 2323 | 100% | 186034 |

Source:Shanghai Aged Population Atlas,1997

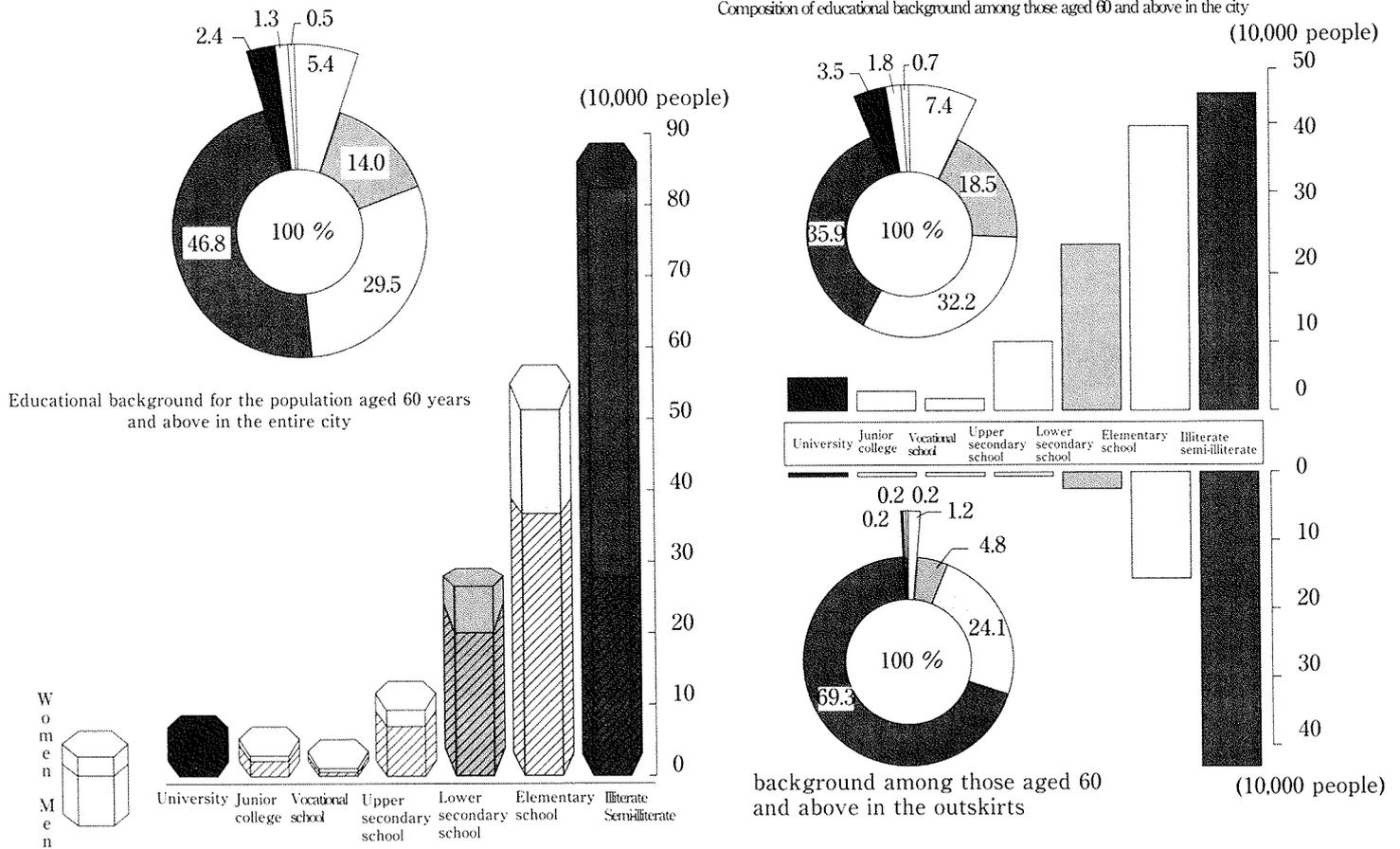
Figure1. Death rate of 10 major diseases in Shanghai



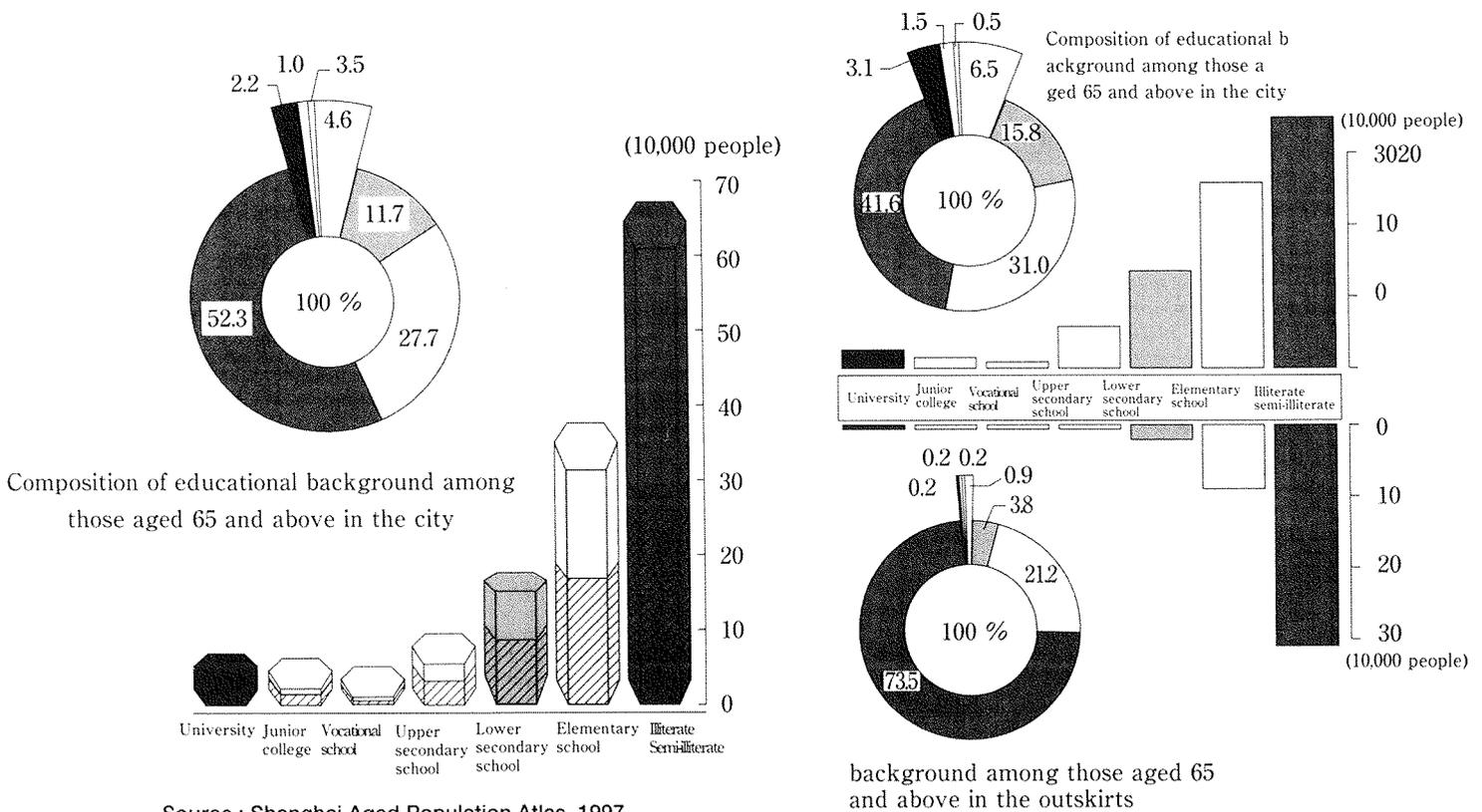
Source : '98 Shanghai Yearbook of Shanghai

Figure 2 Educational level of the elderly population in Shanghai (1990)

1990 Census: Educational background among the elderly population by sex in Shanghai (ages 60 and above)
(Educational background)
Composition of educational background among those aged 60 and above in the city



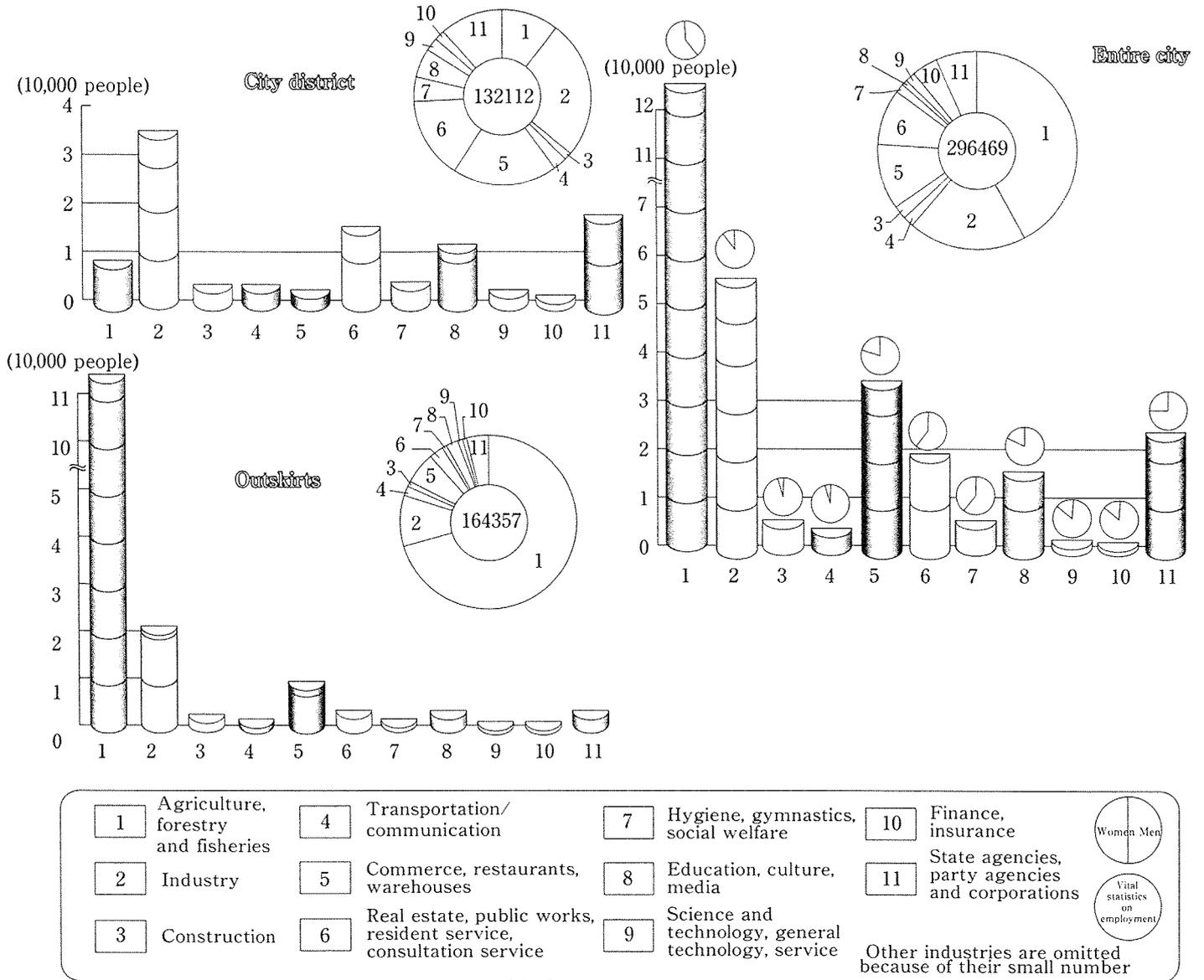
Composition of educational background among those aged 60 and above in the entire city



Source : Shanghai Aged Population Atlas 1997

Figure 3 Trade structure of Shanghai's elderly population in economic activities (1990)

1990 Census: Trade structure of working elderly population (ages 60 and above)



1990 Census: Industrial structure of working elderly population (ages 65 and above)

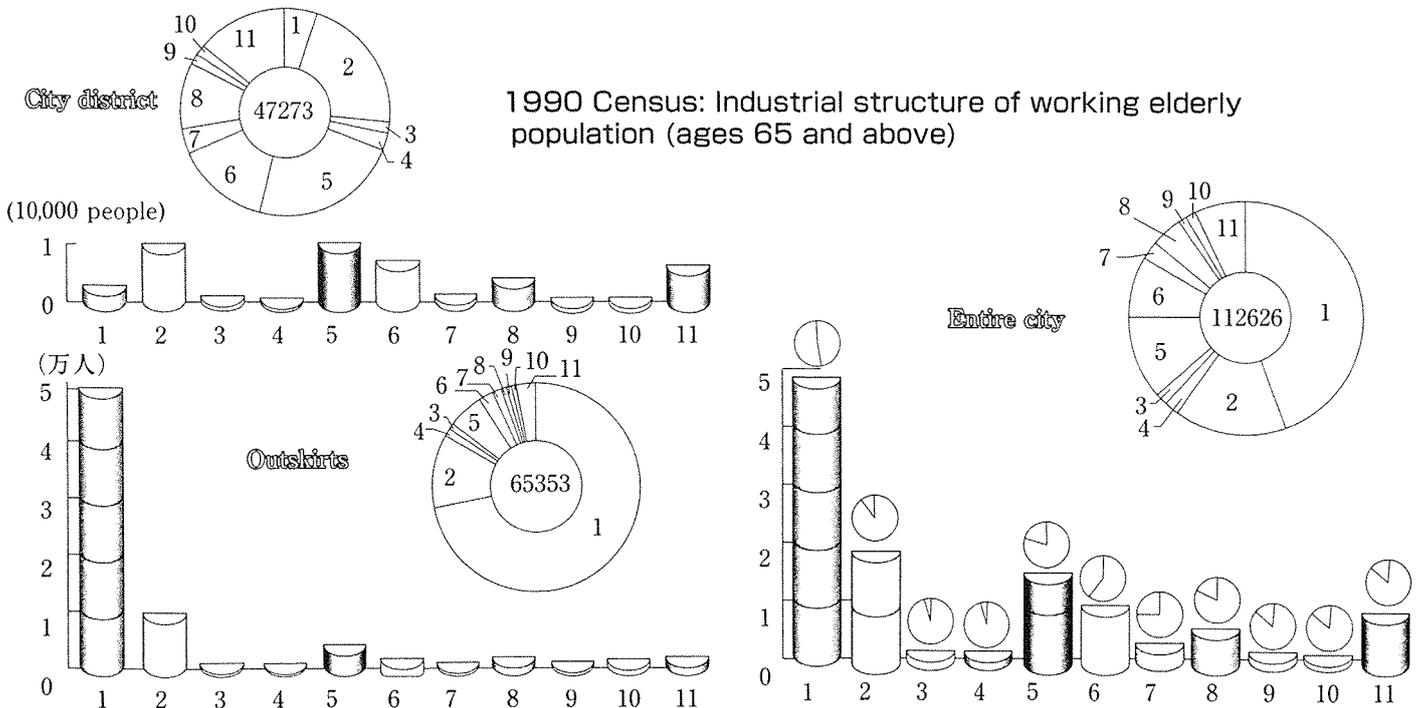
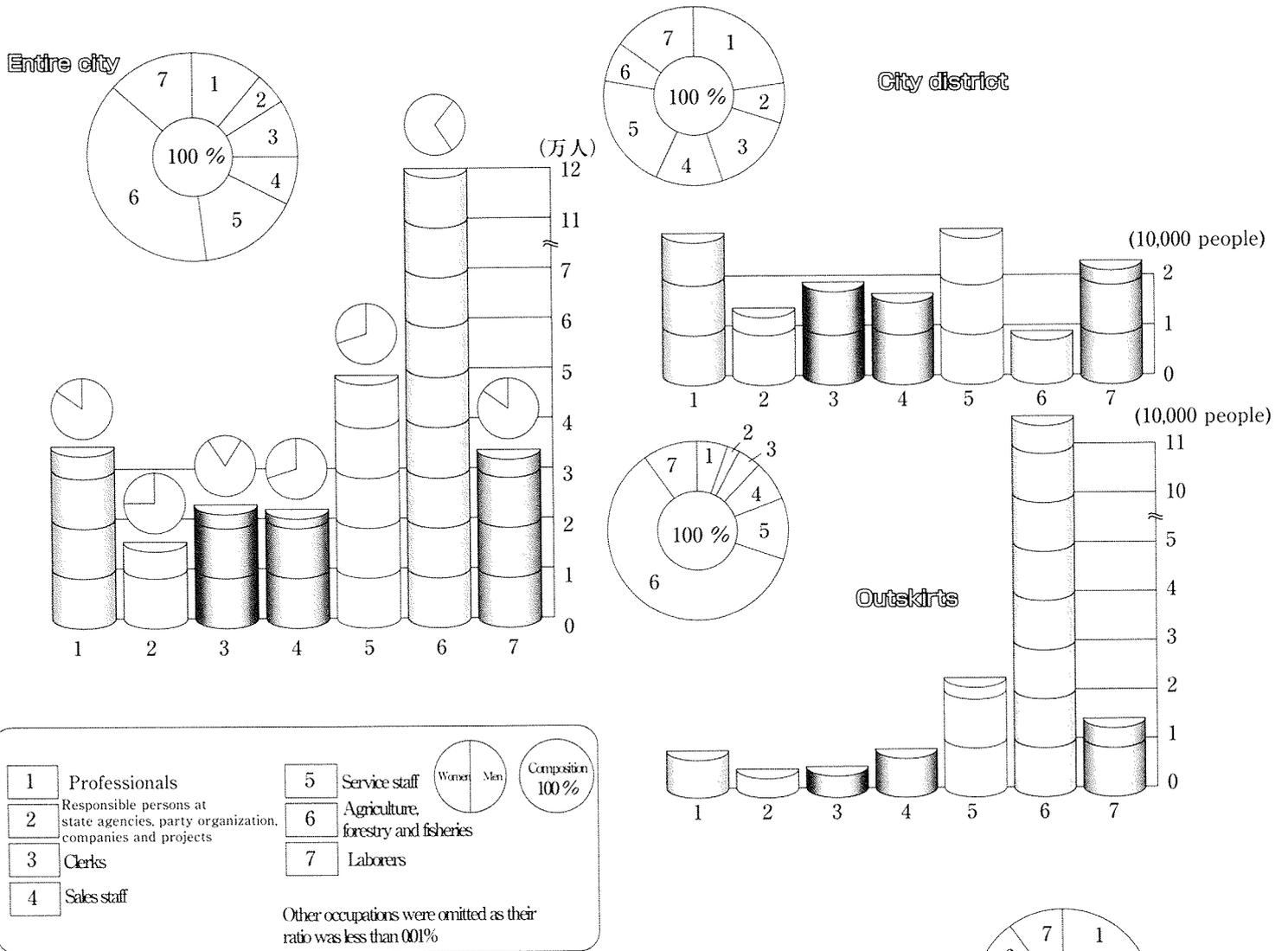
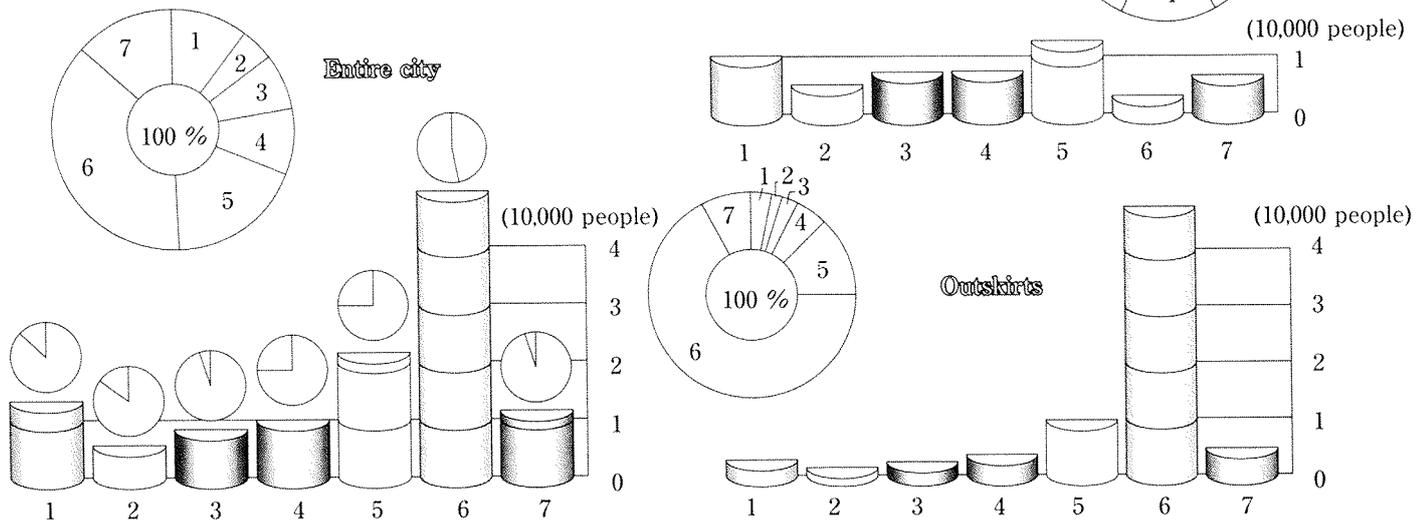


Figure 4 Occupational structure of Shanghai's elderly population in economic activities

Occupational composition of the elderly in the 1990 Census (ages 60 and above)



Occupational composition of the elderly in the 1990 Census (ages 65 and above)



Source : Shanghai Aged Population Atlas, 1997

Chapter Two

Social Security Measures for the Elderly in Shanghai

1. Direction of Basic Measures

Mr. Yin Zhi Gang, Office Director of Shanghai Municipal Committee on Aging explained the overall picture of measures that are implemented in Shanghai for the elderly. This chapter will report on its content and on the materials that were presented at that time on the People's Republic of China's Security Law for the Elderly's Rights and Benefits.

(1) Basic Policy of Measures for the Elderly in China

The basic policy of social measures for the elderly in China has been stipulated as the People's Republic of China's Security Law for the Elderly's Rights and Benefits (August 29, 1996) (hereinafter referred to as "Security Law"). The Security Law is comprised of 50 articles and 6 chapters (namely General Rules, Family Support, Social Security, Participation in Social Development, Legal Responsibilities, Appendix) and indicates the direction of socially protecting the rights of the elderly and promoting programs for their benefit.¹

General Rules describe the basic policy of the law, stipulating that the elderly shall be defined as those aged 60 years and above (Article 2), that the State and the society shall provide social security system for the elderly while improving their condition of livelihood, health and participation in social development (Article 3), that discrimination, insult and abuse of the elderly shall be prohibited (Article 4), that respective People's Governments shall carry out projects for the elderly in the context of national economy and social development programs (Article 5), that education on respect and support for the elderly shall be made available extensively (Article 7).

Basic policy of measures for the elderly in China is described in Article 3 of the Security Law as content that shall be realized in society as “five securities.” Five securities are comprised of “the elderly can have enough support” (support), “the elderly can have medical insurance” (medical care), “the elderly can contribute their shares” (social participation), “the elderly can have chance to study” (learning) and “the elderly are able to have entertainment” (recreation) and develops measures in each of these five areas.

While support for the elderly includes economic support, looking after daily affairs and psychological consolation (Article 11), family members are positioned as main providers of such support (Article 10). However, in the event where an elderly person does not have income due to lack of labor ability, and either does not have a supporter or the supporter lacks supporting capacity, that person may seek relief from the local People’s Government if he or she lives in an urban area (Article 23) or be guaranteed by the rural group organization in five areas of assistance consisting of food, clothing, housing, medical care and funeral expenses if he or she lives in a rural area. In addition, it provides that the State shall establish endowment insurance (pension system) and guarantee basic livelihood of elderly persons (Article 20) and that their amount shall be increased according to economic development, improvement of living standard and improvement of wage level (Article 21). Moreover, efforts are being made by the People’s Government in the area of investment towards senior welfare projects and placement of welfare facilities for the elderly (Article 33).

In respect to medicinal care for treatment and prevention of senior disease treatment, providing that the State shall guarantee basic medical care for the elderly through provision of medical insurance system (Article 25), that medical institutions shall afford facility for senior medical care and give priority to those aged 70 years and above in offering medical care (Article 27) and that the State shall carry out research and training in geriatrics with the aim of improving prevention, treatment and research of old age diseases (Article 28).

Concerning social participation, it states that the State and society shall give importance to knowledge, skills and experience of the elderly and enable them to demonstrate their special skills (Article 40) and that they shall respect social demand as well as will and ability of the elderly and enable them to participate in activities such as: 1) teaching youth and children about tradition; 2) instruction of culture and technology; 3) consultation; 4) development and application of technology; 5) management and productive activities; 6) social and public service; 7) protection of social order and cooperation of civil strife; and 8) other social activities (Article 41). In addition, income earned by the elderly through participation in labor is protected by law.

As regards learning, it provides that the elderly have the right to continuing education (Article 31) and that the State encourages the establishment of various schools for the aged (Article 31). As a result, active efforts are being made toward universities for the aged as mentioned in the previous chapter.

As for recreation, it states that the State and society shall seek improvement of spiritual and cultural life through activities in the area of culture, physical education and entertainment (Article 32) and makes reference to preferential treatment and assistance for the elderly with regard to sightseeing, field trip and use of public transportation (Article 36).

(2) Challenges faced by social security measures for the elderly in Shanghai

Shanghai is a region in which rapid aging is occurring particularly compared to other regions in China. In 1996, the percentage of population aged 65 years and above in Shanghai was 12.4%, considerably higher compared to national average of 6.9%. The percentage of the elderly population in Shanghai is also expected to increase at significantly high rate in the future. Furthermore, the percentage of old-old aged population is increasing as a result of “aging among the aged” phenomenon in which average life expectancy has gone up to the level similar to those among the European countries (75.2 years for men, 79.2 years for women, 1997), resulting in phenomenon aspects of aging population quite similar to that found in Japan. Therefore, the city is faced with the aging problems similar to those in Japan in areas such as medical care and nursing care, although the still developing nature of its economy, as rapid as it may be, and the lack of consistency between the degree of economic development and aging are considered to be issues different from those taking place in Japan and Europe.

Another characteristic of Shanghai is the extremely high percentage of retirees among the elderly owing to advancement of urban form of labor and increase in number of those employed by companies, which, in turn, have given rise to major problems in areas such as guarantee of livelihood through pension system and improvement of medical insurance system. Such lowering of family functions is exerting challenge to the principle of family support in various ways and is considered to be an important task in Shanghai’s future policy concerning the elderly.

2. Pension System

Dean Dr. Gui Shixun of Population Research Institute to East China Normal University explained in detail the reform of pension system for corporate retirees in Shanghai. This chapter will focus on the content of this presentation.

(1) Background of pension reform for corporate workers

Shanghai, with its large corporate retiree population, is largely dependent on the pension system in terms of “offering enough support for the elderly.” However, the ratio between employees on service and age-limit retirees has changed from 2.6: 1 (4.8: 1 nationwide) in 1995 to 1.94: 1 in 1998². The reform of this system is regarded as a policy with overriding priority as the amount of pension payment will continue to increase as a result of rapid population aging.

While the pension system for state enterprise employees and public servants had already been put in place in the 1950s, it was unable to adapt to the situation in Shanghai where retiree population increased due to rapid aging and corporate diversification that ensued economic development. The challenges confronting Shanghai include: 1) the fact that expenses were paid by the State and companies, not by individuals; 2) gap in amounts paid between old companies having many retirees and new companies having few retirees that resulted from the system being managed on a company basis and simultaneous collection and payment; 3) accrual of right to receive pension according to length of experience in the same company hindering movement of labor between companies; 4) extension of pension receiving period resulting from early retirement age compared to average life expectancy; and 5) lack of structural measures against inflation. The reform of pension system for corporate retirees was launched in the late 1980s to cope with these problems.

(2) Reform of pension system for corporate retirees

Reform of pension system in Shanghai can be divided into two periods, i.e. the establishment of pension fund that took place between 1984 and 1991 and building of multi-layered pension system that occurred from 1991 onward.

During the first period, a pension fund was established and the gap between companies resulting from time of inauguration was corrected through centralized control of the expenses paid by companies according to certain percentage of wages at the fund. The year 1991 marked the launching of a full-scale pension system reform by the national government through conclusion of the pension reform. The direction of introducing a “pension insurance method” that requires payment from the employees as well as government and companies was indicated as the policy of this reform in an effort to establish a multi-layered pension system in addition to the basic pension. In Shanghai, this was followed by passing of the old-age insurance reform bill by the Shanghai Committee of the People’s Congress in 1993 and introduction of the new system starting in 1994. The new pension system was a three-layer system that added supplementary pension and savings pension to the basic pension which is paid on a uniform basis (certain percentage of average monthly wage of all workers for the previous year) and required payment from individuals in addition to government and companies. It is believed to be a declaration of the basic approach of promoting the spirit of self-help and implementing pension payment in accordance with the payment period and

amount of premium, which is a characteristic of pension insurance. In addition, the amount of expenses to be borne was decided based on long-term plan with adjustments between generations being made by preparing for further aging expected to occur in the future.

Each employee purchasing pension insurance will have a “personal account” and all premiums paid by individuals will be entered into an “account notebook” for this personal account. The amount borne by companies is set at 22.5% of the total wages paid to their employees in the previous fiscal year (25% at the onset of the system). A part of this amount is entered into personal account and the remainder is paid to the pension fund. The amount entered into personal account corresponds to 16% of the wage paid during the previous fiscal year for personal payment and corporate payment combined. At state enterprises, the system was launched by setting personal payment at 3% and the companies covering the remaining 13% with the aim of making smooth transition into the new system. A temporary measure of increasing personal payment by 1% every 2 years until it reaches 8% has been adopted, and the percentage already reached 6% in 1999. Since this cumulative amount entered into personal account will become the basis for determining the amount of pension paid after retirement, the same assessment can be performed even after employees move to companies having different percentage of individual and corporate payment. The subject of pension system reform was expanded from government agencies and state enterprises to a wide range of companies including private enterprises, foreign-affiliated corporations and private businesses. Moreover, the state government sought integration of pension system for corporate retirees in 1997. A reform was also carried out in Shanghai in 1998 by changing the system that index-linked the amount of pension payment to commodity prices to the system that increased pension payment by 40-60% of the increase in wages for active workers during the previous year. Furthermore, “socialization of pension,” which is an effort to unify the payment of pension by companies so that companies can pay the pension premium they collected to the “social insurance body” which, in turn, pays the pension to each retiree. Thus, the direction is to smoothly introduce system reform according to wide-ranging nature of companies and eventually create a system unified in terms of allotment, payment level, fund management and investment, although the allotment of companies remains as a major issue as it is related to future economic development.

(3) Reform of old-age insurance in rural areas

In rural areas, livelihood security for the elderly had been mainly offered through family support that was supplemented by governmental social security projects. However, “offering enough support for the elderly” in rural areas became a subject requiring consideration as the wave of aging and nuclear family also spread to these areas. In Shanghai, a new system of pension insurance was introduced in 1996. Under this system, payment of pension is made possible by establishing a pension fund and requiring those aged 18 years and above with labor income to pay 5% of previous year’s average income as individually-paid premium. The government and companies pay 15% of total wages paid during the previous year.²³

3. Medical Insurance System

Vice President of Shanghai Academy of Social Sciences Dr. Xuejin Zuo gave a detailed explanation about the reform of medical insurance under way in Shanghai. The content of this explanation will be the main theme of this section.

(1) Background on reform of medical insurance for the elderly

Aging among the elderly that is taking place in Shanghai, along with rapid increase in elderly population, has given rise to increase in patients accompanied by increase in overall medical expenses. Until 1995, medical services for outpatients, inpatients and prevention had been provided through two medical insurance systems—namely “public expense medical care” (for employees and retirees of government agencies and divisions) and “senior insurance medical care” (for employees and retirees of state enterprises and group companies).³ One of the possible causes for skyrocketing medical expenses was the fact that neither hospitals nor patients were troubled by rising medical expenses since employees were not paying the premium in either case (senior insurance medical care also paid 50% of medical expenses for dependent lineal relatives). Rapid increase in medical expenses created disparities in the amount of premium paid by companies (as was the case in the pension system), giving rise to a problem of some companies not being able to afford the payment.²

(2) Reform of medical insurance system for corporate employees in Shanghai

Medical insurance reform in Shanghai started in 1996 when a reform was carried out with regard to the inpatient medical expenses for corporate employees. A medical insurance fund was established and each company contributed 4.5% of total wages it pays its employees to this fund. In the event its employee or retiree is hospitalized, a base amount set according to the rank of medical institution was paid as hospitalization and medical expenses. Base amount was set at 2,500 yuan for municipal hospitals, 2,000 yuan for district and prefectural hospitals and 1,500 yuan for regional hospitals. Eighty-five percent of payments exceeding this amount was paid by the fund and the remaining 15% was paid by companies and individuals. The amount paid by individuals was 8% for the employees and 4% for the retirees. While the percentage was not so high, reduction effect of medical expenses from the patient side was sought by introducing a mechanism in which larger hospitalization and medical expenses would lead to increase in the amount paid by the patient. Self-payment system was also introduced for public expense medical care. The rates of such payment were 8% for employees and 4% for retirees in the case of inpatients, 10% for employees and 5% for retirees in the case of outpatients.

This was followed by enforcement of outpatient emergency medical insurance for corporate employees. Each company pays 1% of total wages it pays its employees to the

fund and pays 70% of outpatient medical expenses from this fund. The company and individual pay the remaining 30%. The percentage of self-payment is 10% for employees and 5% for retirees. The task of the future is to unify the public expense medical care and senior insurance medical care. Establishment of the new medical insurance system is scheduled to take place by the end of 1999.²

(3) Reform of medical insurance system in rural areas

In rural areas, efforts had been made to reduce the burden on individuals by sharing the payment of medical expenses through mutual aid-oriented medical insurance called “cooperative medical services.” After entering the 1980s, however, some organizations were dissolved due to shortage of funds. For this reason, reform of medical insurance system has also become necessary in rural areas, and improvement of medical insurance system is under way at various levels in accordance with the situation of each farming village.²

4. Social welfare measures

The report in this section is based on explanation about measures taken in Shanghai for the elderly by Office Director of Shanghai Municipal Committee on Aging Mr. Yin Zhi Gang, about research concerning measures for the elderly and advanced approaches that are taking place in Shanghai by Deputy Director of Shanghai Research Center on Aging Ms. Zhu Ji-Ming, and about the approach towards services for the elderly in Xuhui District by Deputy Director Mr. Xu Ling of Shanghai City Xuhui District Committee on Aging.

(1) Family support and social support

While the basic principle with emphasis on family support is stipulated in the Security Law, elderly people who cannot receive family support due to lack of child, lack of income and lack of job (referred to as “Elderly Lacking Three”) qualify for social support and are supposed to receive guarantee in five areas consisting of food, clothing, habitat, medical care and funeral (five areas of assistance). However, substantiation of welfare facilities has become necessary as capacity of families in supporting the elderly has declined due to increase in nuclear families. Cases where family is able to take care of the elderly financially but cannot look after them in daily affairs are also increasing. In addition, nursing care through family support is the premise even though increase in elderly population, particularly that of the latter elderly, will inevitably give rise to increase in number of those that require nursing care. The fact that this will turn into a major problem in the future with the lowering of family support capacity was recognized by all experts that responded to the survey.

(2) Facility welfare measures

Facilities that admit the elderly in Shanghai can be divided into “social welfare institutions for the elderly” and “homes for the elderly.” According to the 1999 edition of the Shanghai Economic Yearbook, welfare institutes and homes for the elderly exist at 20 locations (4,209 beds) and 371 locations (15,994 beds), respectively. Despite such rapid increase in number of beds (an increase of 3,000 beds from the previous fiscal year), there is need for prompt improvement of facility as shortage continues to exist.

Welfare institutions run by municipal, district and prefectural governments and institutions correspond to homes for the aged in Japan. Only the Elderly Lacking Three used to be admitted and all expenses were borne by the government. At present, however, self-payment has been introduced to these institutions and their doors are open to all elderly persons. By having the function of care houses, these institutions are starting to play the function of living quarters for the elderly who have difficulty living on their own even though they have children or have sufficient pension. Moreover, as will be reported in the case study, they are believed to be multi-functional homes for the elderly that also have the function of nursing homes in this sense. Homes for the elderly are built on a regional basis (subdistricts, towns, villages) and are small in scale (Number of beds per facility averages at about 43. The same figure for welfare institutions is 210.)

(3) In-home welfare measures

Shanghai is placing emphasis on provision of community service centers on subdistrict level. While they are welfare centers offering a wide range of regional services not only to the elderly but to all members of the community, they particularly play the function of offering services to the elderly, disabled persons and destitute persons that require support. They offer services such as food delivery and personal assistance for the elderly and their work is basically supported by volunteers. However, social measures to be taken against such problem is considered to be a major theme of future measures for the elderly with emerging the problem of decline in in-home nursing care function as a result of weakening family support function. The fact that financial burden cannot be increased significantly through reliance on nursing care measures owing to inconsistency between economic development and aging appears to lie at the bottom of this issue.

Deputy Director of Shanghai Research Center on Aging Ms. Zhu Ji-Ming introduced an example of activity still in experimental stage called “Mutual Aid Group for Livelihood and Nursing Care” in which elderly persons in good health offer nursing care as volunteers and accumulate their hours that could be used for their own nursing care in the future. There is no doubt that in-home nursing care measures in Shanghai still face challenges in terms of securing manpower, forming organizations and procuring funds.

5. Case study

(1) Welfare institutions

We visited a welfare institution in Shanghai and were explained about its management and services. Its content will be reported in this section.

Facility studied: Shanghai City Xuhui District Welfare Court

Outline of the facility

Site area: 3,920m², building area 4,220m²

7 stories high, total of 170 beds

First floor: dining room etc.

Second floor: nursing bed for bedridden elderly (22 persons as of the survey date)

Third through fifth floors: 4-person rooms

Six through seventh floors: 2-person rooms

Activity room and separate bath for men and women located on each floor

In building the facility, 5 million yuan out of the total cost 13 million yuan was paid by the government and the remainder was covered by donations from Shanghai-born expatriates living in Taiwan and Hong Kong. Those aged at least 60 years and free of infectious and mental diseases are qualified for admission into this facility. Since income and existence of children are not part of the criteria, anyone having difficulty living at their home can basically come here to live. The amount of self-payment differs between 4-person and 2-person rooms (priced 500 yuan and 1,100 yuan, respectively). The cost of 4-person room can easily be covered by pension. according to the financial capacity. Each person wishing to enter the facility selects the type of rooms.

The number of people living at the facility was 165 as of the survey date (oldest person was 97 years old, youngest person was 62 years old, average age was 82 years) and 80 persons were on the waiting list. This facility is also offering in-home care services such as food delivery, bathing and blood pressure measurement for the elderly persons living at their homes in the community and those on the waiting list seemed to be given priority in receiving these services. There are 44 staff workers that had received certain training at the Civil Administration Bureau. Since those requiring nursing care are also admitted to the facility, a 24-hour nursing system has been put in place and 5 doctors are registered at the dispensary.

The facility is eager in its efforts toward improving health and creating purpose of life in addition to assistance in daily life such as offering of food and individually-offered rehabilitation programs. It offers activities in calligraphy, knitting, singing and health as part of its group hobby programs, placing emphasis on such programs within the facility in addition to purpose of life and health improvement activities it offers to the community.

Due to shortage of land in the urban district of Shanghai, the facility is a 7-storied building built on a relatively small piece of land. For this reason, only about 20 persons are living on each floor with small units being created on each floor. In addition, instances in which healthy persons were helping persons requiring care was observed as a result of wide variety of elderly persons living within the same facility.

(2) Welfare measures for elderly and measures for elderly requiring care/elderly with senile dementia

As mentioned earlier, the reality in Shanghai is that nursing measures for the elderly has yet to be tackled in a comprehensive manner. While it is clear that their basic policy places emphasis on family support and that home nursing by family members is placed at the center, provision of nursing service through both home and facility has become an issue in Shanghai following decline of supporting function among family members. However, shortage of facilities admitting elderly persons exists—despite the priority being given to them—as they are unable to keep pace with the rapid aging taking place. According to an explanation by Deputy Director of Shanghai City Xuhui District Committee on Aging Mr. Xu Ling about the welfare activities that are taking place on district level, activities of community service center for the elderly living in their homes are centered around improvement of health and purpose of life and do not include organized efforts with regard to in-home nursing care service. Judging from the condition of population aging and trends of household structure, some kind of measure will most certainly have to be taken for nursing the elderly in need of such service and will remain as a task for the future as indicated by several experts.

Placing emphasis on maintaining healthy and active life for the healthy elderly, welfare measures for the elderly in Shanghai has been promoting health and purpose of life on the principle of self-help. The results can be rated highly in this respect. In Japan, “prevention of nursing care,”—an approach that would prevent the elderly from requiring nursing care through health improvement and purpose of life activities—is attracting renewed attention following the introduction of the “long-term care insurance system”, and the development of measures for its social support has been the challenges today. It appears that there is much to learn from Shanghai’s approach in areas such as social support and the attitude of the society as a whole with regard to maintenance and improvement of overall quality of life, as exemplified by self-help efforts of the elderly and promotion of health and purpose of life activities.

¹ Xiuying, Li: Study on Development Status of Social Welfare Measures in China, Asia Women’s Exchange/Research Forum, Kitakyushu, 1999

² Ji-Ming, Zhu and Ma Li-Zong: Medical and Pension Reform in China, Aging, Spring 1999, 44-49, 1999

³ Japan Aging Research Center: Aging in Cities Social Measures Against Aging Series 1, Shanghai/Singapore, Tokyo, 1998

Table1 NUMBER OF RETIRED AND RESIGNED PERSONS (YEAR-END)

(10000 persons)

| Year | Total | State-owned Units | Urban Collective Owned Units | Other Ownership Units |
|------|-------|-------------------|------------------------------|-----------------------|
| 1978 | 314 | 284 | 30 | |
| 1980 | 816 | 638 | 178 | |
| 1985 | 1637 | 1165 | 467 | 5 |
| 1986 | 1805 | 1303 | 496 | 6 |
| 1987 | 1968 | 1424 | 538 | 6 |
| 1988 | 2120 | 1544 | 568 | 8 |
| 1989 | 2201 | 1629 | 562 | 10 |
| 1990 | 2301 | 1742 | 566 | 11 |
| 1991 | 2433 | 1833 | 588 | 12 |
| 1992 | 2598 | 1972 | 609 | 17 |
| 1993 | 2780 | 2143 | 596 | 41 |
| 1994 | 2929 | 2249 | 619 | 60 |
| 1995 | 3094 | 2401 | 621 | 72 |
| 1996 | 3212 | 2515 | 616 | 81 |
| 1997 | 3351 | 2638 | 622 | 92 |

Table2 SOCIAL INSURANCE AND WELFARE FUNDS FOR RETIRED AND RESIGNED PERSONS

| Year | Social Insurance and Welfare Funds (100million yuan) | Funds of State-Owned Units | Funds of Urban Collective Owned Units | Funds of Other Ownership Units | Per Capita Funds (yuan) | State-Owned Units | Urban Collective Owned Units | Other Ownership Units |
|------|--|----------------------------|---------------------------------------|--------------------------------|-------------------------|-------------------|------------------------------|-----------------------|
| 1978 | 17.3 | 16.3 | 1.0 | | 551.0 | 574.0 | 333.0 | |
| 1980 | 50.4 | 43.4 | 7.0 | | 714.0 | 781.0 | 465.0 | |
| 1985 | 149.8 | 119.2 | 30.2 | 0.4 | 961.0 | 1070.0 | 687.0 | 888.0 |
| 1986 | 194.7 | 161.6 | 32.5 | 0.6 | 1131.0 | 1310.0 | 675.0 | 1090.0 |
| 1987 | 238.4 | 200.5 | 37.1 | 0.8 | 1263.0 | 1470.0 | 718.0 | 1333.0 |
| 1988 | 320.6 | 256.4 | 62.5 | 1.7 | 1571.0 | 1731.0 | 1173.0 | 2429.0 |
| 1989 | 382.6 | 309.7 | 71.1 | 1.8 | 1773.0 | 1955.0 | 1258.0 | 2000.0 |
| 1990 | 472.4 | 87.8 | 2.2 | 2099.0 | 2281.0 | 1557.0 | 2095.0 | |
| 1991 | 562.0 | 99.4 | 2.9 | 2342.0 | 2529.0 | 1723.0 | 2417.0 | |
| 1992 | 695.2 | 118.1 | 4.3 | 2764.0 | 3010.0 | 1974.0 | 2857.0 | |
| 1993 | 913.7 | 144.9 | 16.0 | 3399.0 | 3661.0 | 2405.0 | 5517.0 | |
| 1994 | 1218.9 | 1022.0 | 169.6 | 27.3 | 4269.0 | 4654.0 | 2789.0 | 5353.0 |
| 1995 | 1541.8 | 208.1 | 37.5 | 5120.0 | 5575.0 | 3356.0 | 5682.0 | |
| 1996 | 1817.8 | 1537.9 | 230.8 | 49.1 | 5765.0 | 6257.0 | 3729.0 | 6377.0 |
| 1997 | 2068.3 | 252.3 | 57.8 | 6303.0 | 6826.0 | 4076.0 | 6682.0 | |

Note: The expenses years were on the lower side for medical treatment cost in social insurance and welfare funds for the retired and resigned persons in the years before 1986 was calculated in that of the staff and workers at their posts. Therefore the total funds in these.

Table3 ELDERLY REQUIRD "FIVE AREAS OF ASSISTANCE"
IN RURAL AREAS IN SHANGHAI

| Year | (person) | | |
|------|----------|---------------|-------|
| | In home | Welfare court | Total |
| 1990 | 771 | 2999 | 3770 |
| 1991 | 980 | 2946 | 3926 |
| 1992 | 712 | 2963 | 3675 |
| 1993 | 570 | 2912 | 3482 |
| 1994 | 848 | 2956 | 3804 |
| 1995 | 1089 | 2884 | 3973 |
| 1996 | 1305 | 2846 | 4151 |

Note : Shanghai Aged Popalatin Atlas (1997)

Table4 INSTITUTIONS OF SOCIAL WELFARE FOR ELDERLY
(1980—1997)

| Year | Social Welfare Institutions | | |
|------|-----------------------------|------|---|
| | Homes | Beds | Person Housed (year-end) (person) |
| 1980 | 9 | 1555 | 1337 |
| 1981 | 9 | 1621 | 1312 |
| 1982 | 9 | 1525 | 1495 |
| 1983 | 10 | 1644 | 1491 |
| 1984 | 10 | 1948 | 1635 |
| 1985 | 10 | 1727 | 1630 |
| 1986 | 10 | 1697 | 1648 |
| 1987 | 10 | 1991 | 1770 |
| 1988 | 13 | 2189 | 1790 |
| 1989 | 14 | 2418 | 2012 |
| 1990 | 15 | 2679 | 2019 |
| 1991 | 14 | 2687 | 2138 |
| 1992 | 14 | 2776 | 2431 |
| 1993 | 14 | 2874 | 2554 |
| 1994 | 15 | 2931 | 2648 |
| 1995 | 15 | 3006 | 2722 |
| 1996 | 17 | 3294 | 2866 |
| 1997 | 21 | 4012 | 3441 |

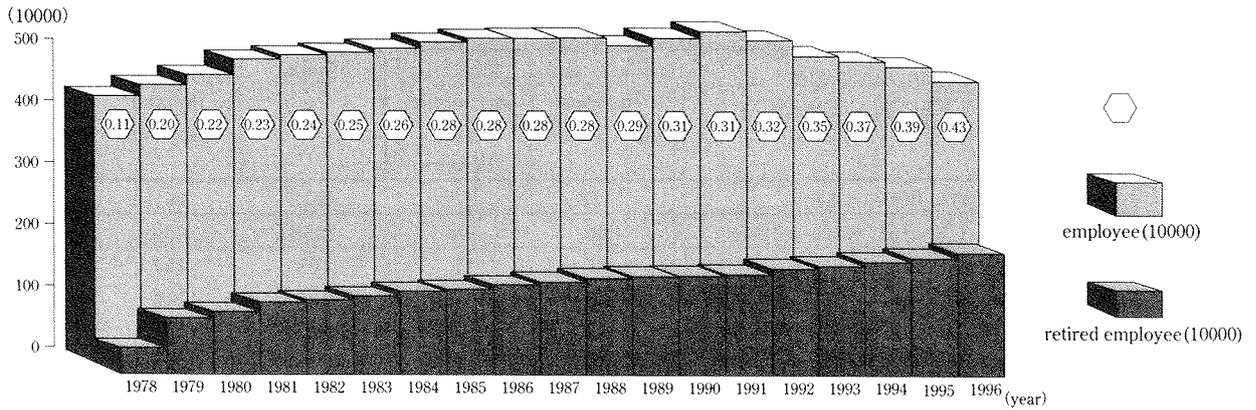
Table5 BASIC STATISTICS OF WELFARE HOMES
(1997)

| Name of Welfare Homes | Staff and Workers (persons) | Medical Personnel and Nurses | Beds | Person Housed (persons) |
|-----------------------------------|-----------------------------|------------------------------|------|-------------------------|
| Social Welfare Homes (21) | 1433 | 208 | 4012 | 3441 |
| Shanghai No.1 Social Welfare Home | 648 | 95 | 1498 | 1286 |
| Xuhui | 90 | 7 | 163 | 157 |
| Huangpu | 23 | 2 | 120 | 118 |
| Nanshi | 117 | 11 | 433 | 400 |
| Changning | 80 | 9 | 220 | 102 |
| Hongkou | 64 | 6 | 200 | 196 |
| Putuo | 91 | 12 | 204 | 199 |
| Zhabei | 33 | 3 | 200 | 187 |
| Yangpu | 76 | 12 | 254 | 254 |
| Baoshan | 45 | 5 | 150 | 147 |
| Minhang | 84 | 34 | 298 | 297 |
| Jinshan Petro-chemical District | 20 | 3 | 50 | 42 |
| Fengxian | 43 | 8 | 202 | 55 |
| Nanhui | 19 | 1 | 20 | 1 |

Table6 CHAPTER 17 SPORTS AND HEALTH 351
17-14
HOMES FOR THE ELDERLY RUN BY SOCIETY
(1980-1997)

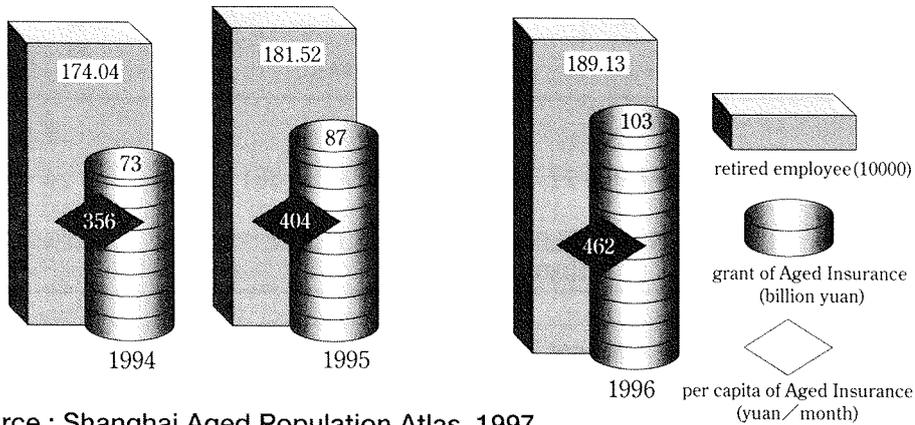
| Year | Urban | | | Rural | | |
|------|-------|------------------------|-------------------------------|-------|------------------------|---------------------------|
| | Homes | Person Housed (person) | Collective Fund (10,000 yuan) | Homes | Person Housed (person) | Collective Fund(104 yuan) |
| 1980 | | | | 42 | 630 | 16 |
| 1981 | | | | 53 | 762 | 23.1 |
| 1982 | | | | 58 | 1022 | 29.1 |
| 1983 | 4 | 42 | 0.7 | 90 | 1402 | 55.2 |
| 1984 | 14 | 139 | 3 | 135 | 2328 | 93.5 |
| 1985 | 38 | 301 | 9.5 | 161 | 2737 | 337 |
| 1986 | 70 | 552 | 39.2 | 179 | 2894 | 228.8 |
| 1987 | 94 | 884 | 60.4 | 183 | 3378 | 260.8 |
| 1988 | 108 | 1058 | 61.9 | 185 | 3696 | 408.3 |
| 1989 | 168 | 1444 | 83.6 | 181 | 3685 | 438.5 |
| 1990 | 150 | 1495 | 106.5 | 182 | 3536 | 431.6 |
| 1991 | 162 | 1842 | 132.8 | 179 | 3921 | 515.7 |
| 1992 | 142 | 2119 | 158.8 | 178 | 3916 | 522.5 |
| 1993 | 214 | 3602 | 535.9 | 117 | 2763 | 585.3 |
| 1994 | 266 | 5228 | 781.1 | 67 | 1610 | 380.3 |
| 1995 | 295 | 6613 | 819.2 | 35 | 792 | 342.2 |
| 1996 | 325 | 8112 | 906.9 | 8 | 249 | 71 |
| 1997 | 315 | 9036 | 1189.1 | 8 | 259 | 89.2 |

Figure 1 Number of Retired Employee and Employee in Shanghai (1979~1996)



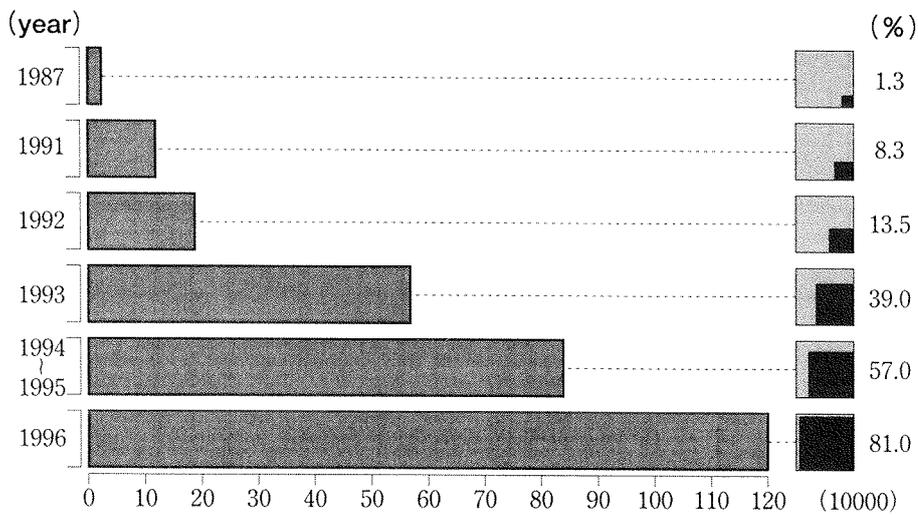
Source : Shanghai Aged Population Atlas, 1997

Figure 2 Aged Insurance of Urban in Shanghai



Source : Shanghai Aged Population Atlas, 1997

Figure 3 Number of Aged Insurance of Rural in Shanghai



Source : Shanghai Aged Population Atlas, 1997

Chapter Three

Survey Members and Itinerary

1. Survey Members

Committee in Japan

| | |
|------------------|--|
| Toshio Kuroda | Director Emeritus, Nihon University Population Research Institute |
| Hidesuke Shimizu | Professor and Chairman, Dept. of Public Health and Environmental Medicine, Jikei University School of Medicine |
| Yasuo Hagiwara | Professor, Social Work Research Institute, Japan College of Social Work |
| Hitomi Karube | Assistant Professor, Dept. of Preventive Medicine, School of Medicine, Kitasato University (member of the field survey team) |
| Katsuo Naito | Lecturer, Social Work Research Institute, Japan College of Social Work (member of the field survey team) |
| Tsuguo Hirose | Executive Director and Secretary General, Asian Population and Development Association (APDA) |
| Masaaki Endo | Project Manager, APDA (member of the field survey team) |
| Osamu Kusumoto | Senior Researcher, APDA |
| Chiharu Hoshiai | Manager of International Affairs, APDA |
| Yuko Kato | Chief of International Affairs, APDA |

2. Cooperators (Survey in China ; September 19-25, 1999)

Consulate General of Japan in Shanghai

Mr. Yasuyoshi Ichihashi Consul General
Dr. Hitoshi Koga Consul and Medical Attache
Mr. Ryu Tarukawa Consul
Mr. Kazuyuki Suwa Consul

Shanghai Municipal Committee on Aging

Mr. Shen Zhen Xin Director
Mr. Yin Zhi Gang Office Director

Shanghai Research Center on Aging

Ms. Zhu Ji-Ming Deputy Director
Dr. Ma Li-Zhong Deputy Director

Shanghai Academy of Social Sciences

Dr. Xuejin Zuo Vice President and Fellow
Dr. Changmin Sun Director, Institute of Population & Development Studies
Dr. Hu Suyun Assistant Professor, Institute of Population & Development Studies

Shanghai Geriatrics Institute

Dr. Wang Zan-Shun M.D. Director

Shanghai Municipal Family Planning Commission

Dr. Zhou Jianping M.D. Executive Director
Ms. Qu Zhipi Office Director

Population Research Institute to East China Normal University

Dr. Gui Shixun Dean
Dr. Wang Guixin Professor
Ms. Li Xiuying Guest Professor

Shanghai Teachers University

Dr. Yang De Guang President

Shanghai University for Aged

Mr. Gui Rong-an Standing Vice President

Shanghai City Xuhui District Welfare Court

Ms. Lu Mei Ling Director

Shanghai City Xuhui District Committee on Aging

Mr. Xu Ling Deputy Director

Zhejiang Ma Yinchu Welfare Foundation for Population

Ms. Xu Ai-Guang Standing Vice President

Zhejiang Family Planning Commission

Mr. Xu Ba Da Director General

Mr. Yan Zhang Fa Vice Director

Study schedule: September 19 (Sun) through Sep. 25 (Sat) 1999

| Date | Outline of the study |
|---------------|---|
| Sep. 19 (Sun) | <ul style="list-style-type: none"> - Departed from Narita at 10:10 and arrived in Shanghai at 12:30 (JL791) - Discussed the outline of the study with Mr. Ma Li-Zhong, Deputy Director at Shanghai Research Center on Aging who is serving as the local coordinator |
| Sep. 20 (Mon) | <ul style="list-style-type: none"> - Visited Consulate General of Japan in Shanghai. Courtesy visit to Consul General Mr. Yasuyoshi Ichihashi. Was explained about economic development in Shanghai from Economic Consul Mr, Ryu Tarukawa and about Japan's international cooperation to China from Consul Mr, Kazuyuki Suwa. - Visited Shanghai Research Center on Aging. Was explained about aging of population in Shanghai and measures that are taken from Mr. Yin Zhi Gang, Office Director of Shanghai Municipal Committee on Aging. Was explained about life of the elderly in Shanghai from Ms. Zhu Ji-Ming, Deputy Director at Shanghai Research Center on Aging. |
| Sep. 21 (Tue) | <ul style="list-style-type: none"> - Visited Shanghai Academy of Social Sciences. Heard explanation from Dr. Xuejin Zuo, Vice President of Shanghai Academy of Social Sciences about urbanization and social security in Shanghai. Heard explanation from Dr. Wang Zanshun, Director, Shanghai Geriatrics Institute about medical care for the elderly. - Visited Shanghai Municipal Family Planning Commission. Was explained about family planning and maternal and child health in Shanghai from Executive Director Dr. Zhou Jianping M.D. |
| Sep. 22 (Wed) | <ul style="list-style-type: none"> - Visited Population Research Institute to East China Normal University and was explained about welfare for the elderly from Dean Dr. Gui Shixun. - Visited Shanghai University for the Aged and heard explanation about the outline of the university for the aged from Standing Vice President Mr. Gui Rong-an. Was explained about establishment and operation of university for the aged from Dr. Yang De Guang, President of Shanghai Teachers University. Visited classes at the university for the aged. - Visited Shanghai City Xuhui District Welfare Court. Heard explanation from Director Ms. Lu Mei Ling about operation and activities of the court and visited the facilities. |
| Sep. 23 (Thu) | <ul style="list-style-type: none"> - Moved from Shanghai to Hangzhou in Zhejiang Province. - Was explained about the population and measures taken against aging society in Zhejiang Province from Ms. Xu Ai-Guang, Standing Vice President of Zhejiang Ma Yinchu Welfare Foundation for Population. |
| Sep. 24 (Fri) | <ul style="list-style-type: none"> - Moved from Hangzhou to Shanghai. - Mr. Katsuo Naito returned to Japan, departing from Shanghai at 14:15 and arriving in Narita at 18:00 (JL792) - Visited the Huangpu Economic Development District |
| Sep. 25 (Sat) | <ul style="list-style-type: none"> - Collection of data - Ms. Hitomi Karube and Mr. Massaki Endo returned to Japan, departing from Shanghai at 14:15 and arriving in Narita at 18:00 (JL792) |

List of Collected Documents

1. '98 Shanghai Economic Yearbook, 1999, '98 Statistical Yearbook of Shanghai, Economy Yearbook of Editional and Publishing Agency
2. Shanghai Aged Population Atlas, 1997, Shanghai Science and Technology Agency
3. '98 Statistical Yearbook of Shanghai, 1999, China Statistical Publishing Agency
4. China Statistical Yearbook 1998,1999, China Statistical Publishing House
5. Shanghai Almanac of Population and Family Planning, 1999, Shanghai Science and Technology Agency