ADMINISTRATION ON AGING. GLOBAL COMPARISON OF FORMAL AND INFORMAL CAREGIVING

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Abstract

Countries in regions of the world are managing aging populations differently, but each country offers lessons to be learned. Countries used as examples include Germany, Australia, Japan, Uruguay, Kenya, Hungary, and the United States. All of these countries have some type of formal, informal, or both systems in place to care for older persons. These countries, among others throughout the world, will have to confront decreasing familial caregivers together with longer life expectancy. Other issues to consider include policy formation, resource allocation, health care, and diversity.

Keywords: Global aging, health care and aging, long term care

Introduction:

Among a range of countries, the topic of aging has become increasingly discussed in terms of demographic transitions and elder care. By the year 2050, projections indicate that 60 countries will have at least two million people aged 60 years or older, up from 26 countries in 2011. As can be seen in Table 1, all regions of the world will experience an increase in the number of older adults in 2030. The developed world is presently experiencing much higher percentages of older individuals as compared to developing countries; however, this will not be the case in the future due to the demographic transition of developed and developing countries. In 2050, it is projected that the developed world will have only 22 percent of the world's oldest population (Kinsella & Philips, 2005).

Table 1: Percent of Population over 65 years by Region (2000, 2015, 2030)

Percent of Population over 65 years by Region (2000, 2015, 2030)			
Region	Year	65 years or older	80 years or older
Asia	2000	5.9	0.9
	2015	7.8	1.4
	2030	12.0	2.3
Europe	2000	14.7	3
	2015	17.6	4.7
	2030	23.5	6.4
Latin America /Caribbean	2000	5.6	1
	2015	7.6	1.5
	2030	11.5	2.5
Middle East /North Africa	2000	4.4	0.6
	2015	5.5	0.9
	2030	8.4	1.4
North America	2000	12.4	3.3
	2015	14.7	3.9

	2030	20.0	5.4
Oceania	2000	10.1	2.3
	2015	12.4	3.1
	2030	16.3	4.4
Sub-Saharan Africa	2000	2.9	0.3
	2015	3.1	0.4
	2030	3.6	0.5

Note: From "International Data Base," by U.S Census Bureau, 2006, U.S Census Bureau.

The U.S. Census Bureau defined three age categories of older individuals: elderly (aged 65 and over); the young old (aged 65-74); and the oldest old (aged 80+) (Kinsella & Velkoff, 2001). These specific age brackets are significant because the "the world's growth rate for 80-and-over population has jumped to 3.5 percent, considerably higher than that of the world's elderly as a whole (2.3 percent)". The elderly population, specifically the oldest old, is enjoying a longer life as a result of increased available resources, such as better health care. Both developed and less developed countries must consider these age brackets; however, all countries have different approaches to their aging society based upon where the country is in the demographic transition and what resources are available.

Table 2: Countries with the highest shares of 60 + population in 2011 and 2050 (percent) (among countries with 2011 population of 1 million or more)

2011		2050	
Japan	31	Japan	42
Italy	27	Portugal	40
Germany	26	Bosnia and Herzegovina	40
Finland	25	Cuba	39
Sweden	25	Republic of Korea	39
Bulgaria	25	Italy	38
Greece	25	Spain	38
Portugal	24	Singapore	38
Belgium	24	Germany	38
Croatia	24	Switzerland	37

Source: United Nations Population Division (2011).

The countries discussed throughout this article were chosen to represent the regions outlined in Table 1. These regions include: Asia, Latin America, Europe, North America, Oceania, and Africa. By researching countries located in various regions of the world, a better understanding of the transcultural trends, similarities, and differences in aging can be observed on a global level. The nation's ability to understand how their country needs to approach an aging population, together with how other countries approach an aging population, is very important to the development and improvement of formal and informal systems of health care.

Comparative Systems:

Several countries within different regions of the world are managing aging populations and each country offers lessons to be learned relative to its ability or inability to manage this population. The countries discussed throughout this article include the following: Germany (Western Europe), Australia (Oceania), Japan (Asia), Uruguay (Latin America), Kenya (Africa), Hungary (Eastern Europe), and the United States (North America). Each country offers different formal and informal systems of health care, specifically long term care (LTC), to the older populations in each county. As can be seen in Table 2 and Table 3, each country has different population statistics, which may effect how these systems of health care are administered. This article will present the formal and informal systems of care in the above outlined countries, followed by a discussion of these countries and what can be learned from their ability or inability to manage the aging population. For the purposes of this article, the World Health Organization (WHO) defines informal care as specific care provided by the

family and formal care as that provided by the state or the market in the form of state funded or private health insurance (WHO, 2000).

Germany

Germany offers a social insurance system to its citizens through income-related contributions paid by both employees and employers (International Reform Monitor [IRM], 2006). If an individual earns more than the defined income, the health care consumer has the option to purchase private health insurance. In 2001, over 90 percent of the population was covered by compulsory health insurance, while less then 0.2 percent of the population remained uninsured (Docteur & Oxley, 2003). Germany's estimated public spending on LTC as a percentage of gross domestic product (GDP) from 1992-1995 was 0.82 percent, as compared to 11.1 percent total national health expenditure as percent of GDP in 2003 (IRM, 2006b).

Public LTC insurance has been a part of Germany's social security system since January 1, 1995 (IRM, 2006b). The LTC insurance provides nursing and in-home benefits to people of all ages with severe disabilities (Gibson, 2003). In 1998, Germany devoted almost half of its LTC insurance program to noninstitutional services (Cueller & Wiener, 2000). The country's ability to contribute a large percentage of its LTC insurance to noninstitutional services demonstrates that Germany values informal care by family members because it performs a central role in the care of the elderly. To further the family caregiving goal, up to four weeks of respite care is provided for informal caregivers and pension credit is awarded to persons providing high levels of unpaid services (Cueller & Wiener, 2000). Caregivers providing 14 or more hours of care per week are eligible for contributions to statutory pension and accident insurance together with counseling/training and respite services (IRM, 2006b).

In 1998, approximately 550,000 individuals received pension contributions, with 93 percent being women and 55 percent between 50 and 65 years of age (Cueller & Wiener, 2000).

Care receivers have the option of accepting cash to pay caregivers, accepting professional care, or a combination of both. Since the introduction of LTC insurance in Germany, the majority of care receivers have preferred cash (71 percent in 1997), supporting the notion of familial responsibility and caregiver preference among care receivers (Theobald, 2003).

Australia

Australia offers universal health care coverage; therefore, all of its citizens have health care coverage. It is through the public health insurance system, namely Medicare, that LTC services are funded (IRM, 2006a). The Commonwealth of Australia created Australia's Aged Care System with the purpose "to support healthy aging for older Australians and quality, cost, effective care for frail older people and support of their carers" (Department of Human Services [DHS], 2003). The aged care system delivers residential (high level nursing home care and low level hostel care) and community care (informal care).

There is no obligation for family members to provide informal care; however, it is generally expected by the state that family will provide care. In fact, 75 percent of community care is provided by the family (IRM, 2006a). In order to encourage potential carers, the government offers specific allowances and payments what will be discussed below. As of 1998, 2.3 million Australians, or one in five households, provided informal care (National Alliance for Caregiving, 2003).

Australia offers carers extensive respite care through the National Respite for Carers Program (NRCP) of either residential respite or through approximately 90 community-based Carer Respite Centers (DHS, 2005). Carers also receive a "carer allowance" based on eligibility. The allowance covers carers who look after a child or adult who need additional attention as a result of a severe disability or medical condition (DHS, 2004). In addition to the "carer allowance," a carer can also be eligible for a "carer payment." The payment is

administered as an income support for carers who are unable to support themselves through full participation in the work force as a result of their carer role (DHS, 2004).

Among the numerous services offered to carers and older adults is the Aged Care Assessment Program (ACAP). Through the ACAP, Aged Care Assessment Teams (ACATs) provide expert assessment of eligibility for services and advice regarding the long term needs of the frail aged (DHS, 2003). Ultimately, Australia's formal and informal care systems intertwine to offer a full service system to older Australians.

Japan

As of 2004, Japan was the second oldest country in the world at approximately 19 percent aged 65 or older. Japan implemented a LTC social insurance program in April 2000 that covers nursing home and home/community-based services, including home-helpers, adult day centers, assistive devices, and minor home remodeling for those aged 40 years or older (Gibson, 2003). Half of the LTC insurance system currently in place is financed through tax, and the remaining 50 percent comes from contributions collected from adults aged 40 years and older or from a co-payment of 10 percent of the costs of care (IRM, 2006c). Those who are aged 65 years or older and those aged 40-64 with age-related disabilities are eligible for insurance coverage (Gibson, 2003). The system explained above has been implemented with relatively no problems and, thus far, it seems to be a success (Ministry of Health, Labour and Welfare [MHLW], 2002).

Japan's culture surrounds itself with the concept of "filial piety" or taking care of one's own parents. In fact, direct relatives within three generations of relationship may be legally responsible for an elderly individual (IRM, 2006c). Contrary to the concept of "filial piety," the Japanese government has acknowledged through recent policy implementations that elderly care has shifted away from the family and toward the state. However, the government still recognizes the importance of family or informal caregiving; and therefore, introduced a measure of in-cash assistance to those caring for elderly people at home (IRM, 2006c). The assistance comes in the form of a fixed-amount grant to the families. Caregivers are also eligible for up to 1-week respite stay per month based on the level of disability of the person being cared for by the caregiver (Gibson, 2003).

Uruguay

Uruguay's population was approximately 3.5 million in 2001 (Pan American Health Organization [PAHO], 2001). The country represents the largest population of people 60 years and older in Latin America, thereby making it the "oldest" country in this region (Collymore, 2000). Uruguay is indeed the oldest country in the western hemisphere with 17.3 percent of its population over the age of 60 in 1997, followed by the United States at 16.5 percent (NIH, PAHO, U.S. Census Bureau, 1999). As is the situation in other less developed countries, rates of chronic and disabling illnesses are greater among elderly, yet the availability and utilization of health services is considerably lower as compared to developed countries.

The public health system in Uruguay consists of both a public and private sector. In terms of coverage, the State Health Services Administration (ASSE) serves 33.7 percent of the population, the Consortium of Humanities Centers and Institutes (CHCIs) 46.6 percent, the Armed Forces Health Service 4.2 percent, the Police Health Service 1.8 percent, and other institutions 1.2 percent (PAHO, 2001). Approximately 11.7 percent of the population does not have formal coverage (WHO, 2006). Uruguay does not have a reliable registry of LTC institutions or residences implemented to monitor its citizens (United Nations Economic Commission for Latin America and the Caribbean [UNECLAC], 2003). The lack of availability of a reliable registry not only makes it difficult to calculate an accurate number of institutionalized older persons, but also indicates the lack of priority given to the issue.

Due to globalization and modernization trends such as migration to urban settings and women in the work force, Uruguay is also experiencing fewer families assisting their elderly

relatives. In Latin America, family members are the primary caregivers for older persons, with a high proportion, approximately 90 percent of family caregivers, being women. Most caregivers are over 50 years old and are subject to emotional and financial problems (UNECLAC, 2003). Despite these problems, no Latin American country has a caregiver support policy or a plan for developing options for providing day care to disabled persons (UNECLAC, 2003).

Kenya

According to a 1999 census report, approximately 1.5 million people (4.8 percent of the total population) are aged 60 years and above in Kenya (Olum, 2005). Although Africa will be considered relatively young through 2050, it has been found that its youth dependency will be reduced by 57 percent while its old age dependency will increase by 93 percent by 2050 (Kalasa, 2001). Therefore, Africa's policy on aging will become an increasingly important health policy issue.

The Government of Kenya has already addressed the aging issue by implementing a National Policy on Aging together with the 9th National Developmental Plan. These measures do not specifically address health care; however, the purpose is to facilitate the needs and concerns of older persons. Kenya must depend on family support for many who need care because of the deteriorating financial and human resources for health services (Olum, 2005). As experienced by other developing countries, Kenya has noted the disintegration of the extended family support system due to urbanization and modernization, thus placing older persons in unsatisfactory conditions both in the formal and informal setting. Kenya recognizes the need for LTC programs to ensure socio-economic support and security for the elderly (Olum, 2005).

Although Kenya has initiated governmental policy reforms to address aging, implementation of new public programs was a priority due to Kenya's increased poverty, malnutrition, HIV/AIDS, and decreasing life expectancy - 60 years in 1993 to 51 in 1998 (Bedi et al., 2004). The key participants in Kenya's health system are the Ministry of Health, non-government organizations (NGOs), private for-profit health systems, and local government authorities. At each level of care, curative, prevention and promotional services are offered (Bedi et al., 2004). "The public sector has a dominant representation in health centers (79%), subhealth centers (92%), and dispensaries (60%) while the NGOs' lead in health clinics, maternity and nursing homes (94%) and medical centers (86%)" (Bedi et al., 2004, p. 27). The government finances approximately 50 percent of health care costs and private arrangements, such as insurance or out-of-pocket spending, account for 42 percent, while NGOs, missions and donors, among other institutions, finance 6 percent (Bedi et al., 2004).

Hungary

Hungary has the population of approximately 10 million people that is expected to decrease to approximately 7.5 million by 2050. As the number of the working population decreases in Hungary, the number of people 60 years or older will double, moving the dependency ratio from 8.2 percent in 2000 to an expected 12.5 percent in 2050 (WHO, 2006a). Hungary offers free access to health care for all citizens, thereby indirectly benefiting the elderly. Hungary's health care system is primarily funded through the Health Insurance Fund (HIF), which receives contributions from employers and employees, and deficits are covered by state funds (Goglio, 2005).

Hungary also offers a well-developed home health care and home social-assistance system (Burns & Cekota, 2002). However, Hungary only has one nursing-home bed for every 140 individuals over the age of 65, increasing the unmet demand for nursing home placement and in-patient geriatric care (Burns & Cekota, 2002). The services offered by the government are supplemented by traditional informal caregiving. Many elderly live with their children or grandchildren who are legally obligated to care for their older relatives (Burns & Cekota,

2002). "Family members caring for the elderly relatives are entitled to a "care fee" which makes them eligible for social insurance as determined by The Act of Social Assistance." (Aman, Buchele & Kalisch, 1998, p. 171).

The United States

In 2004, the United States ranked 38th in the world's oldest countries. The U.S. is relatively young with 12.4 percent of the population over the age of 65, as compared to European standards where 19 of the 20 oldest countries in the world are located in Europe (Kinsella & Philips, 2005). However, by 2050 the U.S. is expected to observe 9 percent increase in the percentage of people over the age of 60 as a result of the aging baby boomer generation - those born between 1946 and 1964 (UN, 2006). Additionally, the U.S. spends more of its GDP on health care, at 15.2 percent, as compared to any other developed nation (WHOSIS, 2006).

The U.S. offers universal health care coverage to its citizens over the age of 65 and those disabled under the age of 65 through the Medicare program. Under Medicare, a portion of nursing home care is covered for a short period of time followed by either a private insurance or out-of-pocket payment method (IRM, 2006d). Under the Medicaid program, long term nursing home care is available after the recipient has spent down all income and assets thereby allowing them to qualify for Medicaid.

The aging of the population in the U.S. will put a strain on the current health care system and on informal caregivers throughout the country. Caregiving prevalence estimates were 24 to 27.6 million in 1997 (Arno, Levine, & Memmott, 1999). Using midrange figures, the national economic value of informal caregiving in 1997 was $196 billion (Arno, Levine, & Memmott, 1999). The U.S. enacted the Family and Medical Leave Act of 1993 (FMLA) which offers 12 workweeks of unpaid leave. In addition to the FMLA, the National Family Caregiver Support Act (NFCSA), authorized by the Older Americans Act of 2000, allows states to provide a continuum of caregiver services that best meet caregivers and individual needs. These may include information, assistance and other services (Administration on Aging, 2003). Medicare and Medicaid also offer limited home care services to caregivers in the form of home nursing services, social services, counseling, medications, physical and occupational therapy, household services, and nutritional services.

Table 3: Family Caregiver Policy

Country	Caregiver Support Strategy	Respite Care	Cash Payments to Caregivers	Linkage to Public Pension
United States	Partial	Yes	Yes*	No
Germany	No	Yes	Yes	Yes
Australia	Yes	Yes	Yes	Yes
Uruguay	-	-	-	-
Kenya	Yes	-	-	-
Japan	No	Yes	No	Yes**
Hungary	-	-	-	-

Note: From "The Road to Recognition: International Review of Public Policies to Support Family and Informal Caregiving," by Feinberg, L. & Montgomery, A., 2003, Family Caregiver Alliance.

Discussion:

All countries discussed above have some type of formal, informal, or both systems in place to care for older persons. Each country uses only a fraction of the percentage of GDP

allocated to health expenditures for LTC. Less developed countries, such as Kenya and Uruguay, have a less developed system of care for their elderly populations as a result of inadequate resources to address aging. These less developed countries ultimately have to distribute their resources to other issues such as basic public health including basic health care, disease prevention or control, or sanitation, as opposed to LTC.

The review of the current literature supports the notion that no country has the "answer" to dealing with aging population. All countries are simultaneously dealing with less familial support of elderly family members as a result of modernization and globalization. As discussed above, not all countries researched offer the same support for caregivers, and some countries do not offer any formal support. Countries such as Australia have extensive measures implemented, while other countries are considering new initiatives.

It is suggested that just because an intervention strategy works in one country, the measure may not necessarily be implemented successfully in another country. Many different social standards, including but not limited to language, cultural diversity, customs, beliefs, religion, and values must be considered when implementing a measure to address health care services. In addition to social standards, a country must also be economically able to implement certain health care measures. For example, a country must consider whether it has the financial means to add a LTC program and take into consideration whether that same measure fits with the social standards of the society in which it will be implemented. Many countries have adopted policy reforms but have not allocated resources to implement these reforms.

Governments may eventually come to the point where many options are offered for the elderly and their caregivers. All countries will need an aging strategy together with a caregiver support strategy. The elderly will need access to quality and cost effective formal health care that may consist of skilled nursing, home health care, or hospice. The field of geriatrics will also become increasingly important as elderly individuals with comorbidities have an increased need for primary and specialty health care as they age. Additionally, family or informal caregivers need a system of respite care and support from the community and government.

Caregivers should be offered cash payments or allowances as used in Australia. Moreover, caregivers should have some linkage to public pension plans, considering that their absence in the formal workforce would prevent them from obtaining a pension or even social security benefits. Caregivers can also benefit by receiving tax credits for their dependent family member and the option of making their family member a dependent under the caregiver's health insurance policy. By using these measures, both caregivers and care receivers would greatly benefit.

Conclusions:

Research suggests that globalization or the blending of cultures directly affects each country studied, thereby introducing a pluralistic approach to elder care. As discussed, globalization is observed in terms of a decrease in familial support for elderly family members. Countries that are attempting to implement policy reforms relative to aging or LTC must consider the cultural diversity of its people because diversity may increase or decrease the degree of adaptation of the policy relative to social standards, as discussed above. The proportion of young and old individuals may also effect policy adaptation as social standards within these age brackets conflict.

The aging world will also produce an intergenerational struggle for resources, as the increasing elder population will monopolize a large amount of resources, thus reducing the allocation of revenue to other programs. The leaders of these countries that are facing this resource struggle will have to allocate resources in the best possible way to improve and maintain the health of the population as a whole. Their competition for resources and ability

to finance policy reforms create a very important social, economic, and political dynamics. In order to balance this delicate dynamics, leaders must be open to public debate to better understand the issues relative to aging.

In addition to resource struggles between generations, population shifts through migration and immigration are also significant. For example, just as young and old generations will compete for resources, the U.S. population as a whole will compete for resources with the country's estimated 8-9 million illegal immigrants (Center for Immigration Studies, 2006). Migration and immigration can also reshape the demographics of a country, thereby directly effecting how a country must manage an aging population.

Society will struggle with the concept of continued aging because as the life expectancy increases, quality of life does not necessarily increase together with life expectancy. Countries throughout the world may be faced with deciding what resources individuals should be entitled to and at what age. Ultimately, the issue comes down to keeping people alive, but at what cost to society? The same issue will surface debates on human rights and euthanasia, among others. Overall, countries experiencing aging population must formulate their policies in a manner that addresses various concerns. Each policy will require thoughtful formulation that must benefit the older populations within the country and the families or caregivers of the older population.

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