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Asha Jayanthi Veluswamy

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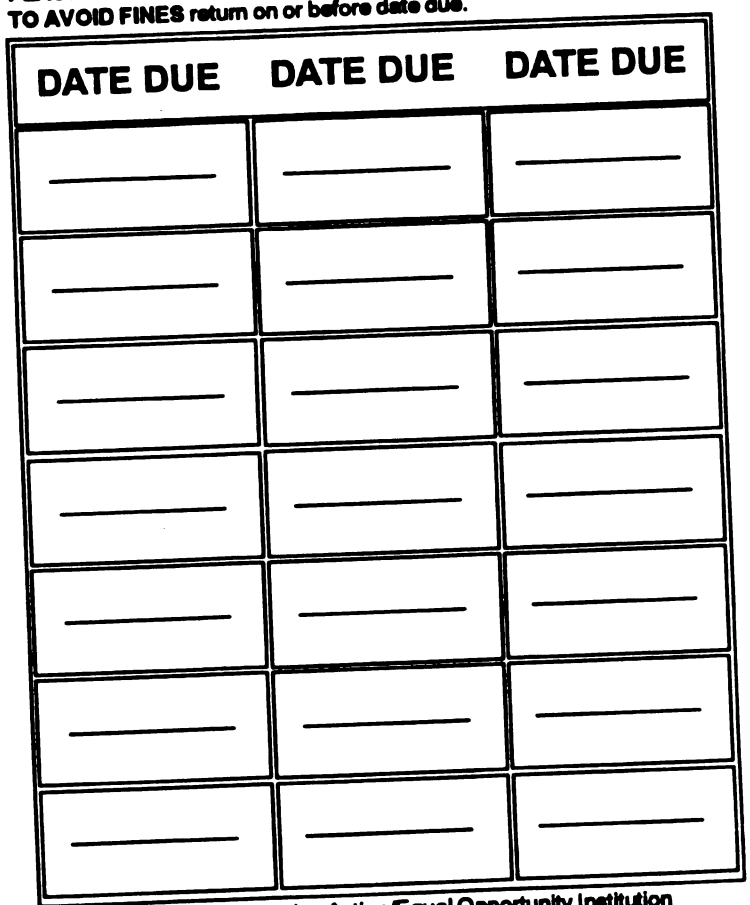

INNOVATIVE INTERNATIONAL COMMUNITY CARE STRATEGIES FOR THE ELDERLY: IMPLICATIONS FOR THE UNITED STATES

By

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ABSTRACT

INNOVATIVE INTERNATIONAL COMMUNITY CARE STRATEGIES FOR THE ELDERLY: IMPLICATIONS FOR THE UNITED STATES

By

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The United States has not been particularly receptive, as many European and Asian communities have been, to the implementation of equitable and accessible community-based care services for the elderly. This comparative analysis includes a brief history of changes that have occurred in the aging population and the development of health care delivery systems in several industrialized countries, as well as a description of innovative aging programs and what implications these paradigms of care may have for the U.S. The relative success of each aging program was based on adherence to a model developed by the author. The countries selected for examination in this study are Great Britain, Sweden, Germany, and Japan. It was concluded that comprehensive geriatric team assessments, targeting those at highest risk for institutionalization, coordinated service centers, and volunteer networks hold the most promise for emulation by the United States for care of its growing elderly population.

To my father, mother, and brother, Murali

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INTRODUCTION

OVERVIEW

The two primary aims of this paper are (1) to examine particular innovative community-based health care programs for the aging in several industrialized countries, and (2) to explore what implications or applications these innovative aging programs may have on the provision of care to the growing elderly U.S. population. In other words, what community-based health care programs or principles of community-based care, developed in different socio-political, cultural, and economic conditions, might work if implemented in or transferred to the United States?

The introduction of this comparative analysis will review the need for community-based health care programs for the elderly in view of an increasing U.S. and world aging population. Specifically, the introduction provides a brief background of the development of community-based services for the elderly and why the current health care system must respond to the burgeoning older population with its growing need for care and services. Following the introduction, chapter one will provide a condensed history of the development of health care systems and aging programs in selected industrialized nations and what demographic changes have taken place since World War II, as many industrialized countries are already experiencing a "graying of their populations."

The historical development of each country is essential in identifying which community-based programs may be applied in the United States given the varying socio-political, demographic, economic, and cultural atmospheres within different countries. Subsequently, chapter two will describe how nations with dissimilar political economies are attending to the rising needs of their elderly populations. Furthermore, this chapter includes the construction of a comparative picture of what other industrialized countries are doing to enhance care for their elderly and identifies innovative aging programs, specifically community-based health care programs, that are providing quality care and services for the elderly. The second chapter will identify which contemporary innovative aging programs are currently effective in care for the elderly in the selected focus countries, including unique informal and formal programs. And finally, chapter three will address what the United States might learn from looking at paradigms or models of community-based care in other industrialized nations already facing a large aging population. The factors likely to affect the transferability of programs from other countries to the U.S. include the historical context of the values and principles behind the various health care systems, and other socio-political, economic, and cultural considerations such as, varying systems of filial obligation and the prevalence of family caregiving, especially the extent that women play a role in the informal caregiving process.

SELECTING THE COUNTRIES

For this paper, I have chosen to focus on four industrialized countries which are currently dealing with a rapidly increasing elderly population: Great Britain, Germany, Sweden, and Japan. Originally, I had planned to include Denmark, China, and Australia however, after further research, I discovered that the four countries that I have limited my analysis to had the most innovative programs for the aging in community-based health care and had the greatest increases in their elderly populations. This is not to say that other industrialized countries have not implemented successful care services for the elderly but only that I had to narrow my focus; nevertheless, my research has shown that these four countries appear to be extremely attuned to the needs of their elderly populations which is reflected in the development of a variety of community-based services for the aged, especially in home health and ambulatory primary health care services. Notwithstanding, my research has also revealed that no one country in particular has a *completely flawless* model of care for the elderly.

DEMOGRAPHIC CHANGES IN THE U.S.

Similar to other industrialized nations, the United States has experienced an enormous growth in its older population. In fact, during the next 60 years, a "gerontological explosion" is anticipated as the proportion of the population that is over 65 grows dramatically (Angel and Hogan, 1992, p. 95). Probably the single most significant factor influencing the U.S. health care system for the next

fifty or sixty years will be the growth in the elderly population. This demographic shift, with both absolute and proportioned growth among those over age 65, has

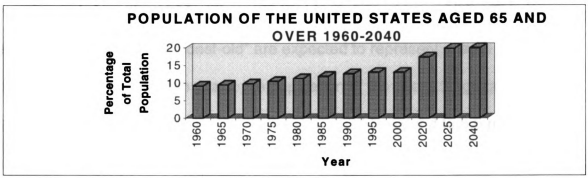

Figure 1 - Population of the United States aged 65 and over from 1960 to 2040 (projected after 1995) (Source: OECD, 1993a; OECD; 1993b; OECD, 1992a).

been occurring since the turn of the century and will continue well into the next century. This is due not only to *declining birth* and *fertility* rates but also due to *declining mortality* rates. Rising from 3.1 million people age 65 and over in 1900, and representing only 4 percent of the population, this age group accounted for 32 million people by 1990, or over 12 percent of the total U.S. population (Schulz, Borowski and Crown, 1991). As shown in Figure 1, in 1990, approximately 12.5 percent of the population was 65 and older (Lawlor, 1994). Between now and the year 2040, the proportion of those over age 65 will nearly double, expanding from approximately 12 percent to 21 percent (Angel and Hogan, 1992, p. 96, 101); at this time, more than one-fifth of the population will be 65 years of age or older.

Currently, the subpopulation that constitutes the fastest growing sector are those aged 85 and older, referred to most commonly as the "oldest old" (Bould, Sanborn and Reif, 1989, p. 27). This trend began as early as the 1940s and has accelerated since the 1960s (Figure 2) (Rabin and Stockton, 1987). This is very significant because the "oldest-old" are expected to represent a large majority of the elderly by 2040. In ten years, the population of the over 85 age group is expected to reach 4.9 million, and by the year 2030 to extend to 8.6 million or

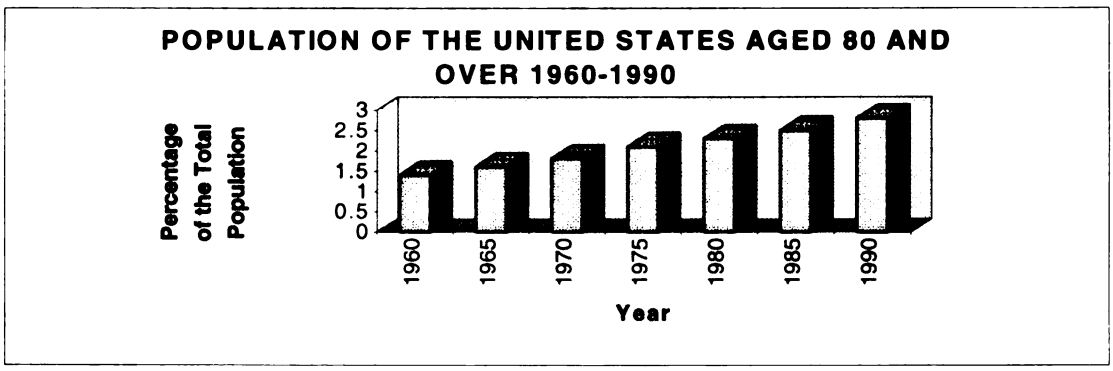

Figure 2 - Population of the United States aged 80 and over from 1960 to 1990 (Source: OECD, 1993a).

more people, or three percent of the total population (Rogers, 1992; Bould, Sanborn and Reif, 1989; OECD, 1992a). In the immediate future, the most rapid growth is projected to occur between the years 2010 and 2030, when the "baby-boomers" reach their sixties, seventies and eighties (Crystal, 1982; Grigsby, 1991).

However, the proliferation of older people is not unique to American society. Such demographic changes are occurring throughout the world, especially within industrialized nations. In fact, compared to the U.S., many countries currently have or expect to experience in the next several decades an even greater percentage of their population aged sixty-five and over. This trend in population aging has been dubbed by Chasteland (1992, p. 40) as "the graying of the planet."

NEED FOR COMMUNITY-BASED CARE SERVICES

Not only is population aging universal, but it is also unprecedented historically. Our generation is the first ever to confront such large numbers of very old people in the population. Moreover, dependency ratios have reversed; dependency is no longer equated solely with children's' dependence on their parents. The dependency ratios for those over age 65 are rapidly increasing, creating an expanding pressure for the family to provide care. The way in which health care is provided and reimbursed, who provides the bulk of the care, and the initiative or long-term goals of the care provided will be challenged by the coming wave of population aging. How is the health care system going to respond to a burgeoning older population with its needs for care and services?

Many concerns have arisen as a result of the current increase in the number of elderly people. More people are beginning to voice dissatisfaction and frustration over the lack of attention toward, and preparation for, the care of this group. Middle-aged people (especially women in the "sandwich generation")

(Reidmuller, 1984) are caught in a dilemma trying to provide care and guidance for both their children and their aging parents, as well as deal with their own aging (Torres-Gil and Douglass, 1991, p. 11). The alternatives to care outside the nursing home are poorly defined and inadequately developed (Kane and Kane, 1987; Rabin and Stockton, 1987). Also, many community-based services are not funded through Medicare, leaving the burden of costs on the individual needing care (Binstock, 1993). Finally, health care delivery personnel are finding that their education pays little attention to the problems of the elderly (Nusberg, 1984; Binstock, 1993).

Furthermore, this problem is exacerbated by the following factors:

- Longevity is increasing, mortality and fertility is decreasing (OECD, 1992a; United Nations, 1985; Furukawa and Shomaker, 1982, Lewis, 1989; Olson, 1994a).
- Inflation is consuming retirement savings and rendering meaningless many people's financial planning (OECD, 1992a; Rabin and Stockton, 1987).
- Due to the mobile nature of the population, family members often do not live near each other. Thus, for the elderly, care by a family member requires moving to a new city and leaving behind known sources of support, such as friends, institutions, and familiar climate and geography (Rogers, 1992; Furukawa and Shomaker, 1982).
- Many elderly are rejecting the option of nursing home care. The intensifying struggle to stay out of nursing homes is reinforcing their reluctance to relinquish their individuality, yet other options have not been truly examined

(Furukawa and Shomaker, 1982; Kane and Kane, 1987; Dychtwald, Zitter, and Levison, 1990b).

Consequences of the rapid growth of the senior citizen population will be an increased demand for health services and competition for resources among other age groups since the elderly utilize a disproportionate amount of services. For example, in the United States during 1992, hospitals accounted for 42 percent of the expenditures on older people; 21 percent was on physician services, 20 percent on nursing homes, and 17 percent was distributed among a wide variety of other types of care including home health care, prescription drugs, and other services. An additional 3.6 million older people received some form of long-term care in their own homes or some other residential facility. About 74 percent of dependent older persons still living in their communities received all of their care from family members or other unpaid sources; about 21 percent received both formal and informal services and only about five percent used just formal services (Binstock, 1993, p. 824-825). Informal supports involve caretaking by family members, friends, and neighbors, and other agencies, who together provide between 70 and 85 percent of all long-term care (Kane and Kane, 1987, p. 47). Conversely, formal long-term care, once equated solely with nursing home care, consists of a vast array of services that provide care in the home, in the community, and where necessary, in an institutional setting (Dobelstein, 1985, Rabin and Stockton, 1987, Kane and Kane, 1987, Roff and Atherton, 1989). Formal and informal care support services for the care of elderly people are complementary, in the sense that many elderly people who

receive formal care also receive informal care from family members and other agencies. In other words, due to the types of problems experienced by older people, both medical intervention and supportive services should be integrated. Caring cannot be confined to the medical aspects of treatment; it must be humane and comprehensive, and as such include the social context within which the elderly person lives (Papsidero, personal communication, 1994).

Although elderly people rely predominantly on informal sources of help, the demand for assistance from local public authorities and the private sector is likely to grow. The numbers of elderly persons living alone is rising. The majority of these households consist of women, who tend to be older, and thus have more health problems and a greater need for help (Wolinsky and Johnson, 1990). Furthermore, chronic diseases are prevalent among older people, especially those in the extreme age groups. Although most older people are healthier today than in the past decades, a trend that is expected to continue, there will be more frail and debilitated elderly overall as the number of older adults grows.

For the most part, the first option of the aged and their family when health care needs emerge is to choose non-institutionalized care. Although health conditions do deteriorate as one ages, most elderly people are perfectly capable of leading an independent life. It is important to note that most of the elderly are not seriously impaired and cope satisfactorily with their physical limitations or disabilities on their own.[1] Most literature has indicated that only about five to seven percent of the U.S.' elderly population are living in supervised institutional facilities (Binstock, 1993, p. 825; OECD, 1992a, p. 28). This statistic may seem

quite low, but in many countries, including the U.S., there is a growing determination to avoid premature or unnecessary institutionalization; according to Kane and Kane (1987), institutional care increasingly is viewed as the alternative rather than the primary means for care.

However, according to Scharlach, Lowe, and Schneider (1991) and Olson (1994b, p. 27), for the remainder of the elderly population, approximately seven million older Americans (approximately 20.6 percent of the total U.S. elderly population) require assistance with day-to-day tasks to remain in the community. This number is expected to increase to 13.8 million by 2030 (Pepper Commission, 1990). An elderly person may not have any particular illness but may still need help performing certain tasks in daily life due to frailty. On the other hand, an elderly person may be ill or partially disabled, yet may be able to lead an independent life most of the time. Care may also be required to reduce risks and to assist independent living. Therefore, non-disabled elderly may also need help; according to Dychtwald, Zitter, and Levison (1990a) and Rabin and Stockton (1987), while many older adults are physically and mentally fit, a larger proportion are likely to need specialized residential or home health care, help with domestic tasks, or other community-based services.

Research has shown that family members provide the majority of the assistance these elderly persons receive (Ciba Foundation, 1988; Kane and Kane, 1987, p. 47). In fact, national surveys indicate that more than seven million American households are actively involved in providing care for an older person in a twelve-month period (Berry, 1991, p. xi). The support provided by

family caregivers, augmented by a variety of public and private programs and services, allows disabled older persons or those needing assistance, to live in the community and to remain as independent as possible. In so doing, this support delays or prevents unnecessary institutionalization, thereby dramatically reducing emotional and financial burdens. These community-based services are an important, and sometimes overlooked, component of the health care systems in the United States and around the world.

Moreover, there are clear societal benefits, such as an age-integrated society which allows society to continue to gain from the knowledge and experience of the elderly, when elderly people are able to live out their lives independently, as productive members of the community. Communities must rise to this challenge. Above all, it must be remembered that people over age 65 make up a heterogenous group with varying attributes and needs. The level of need, income, assets, general health, and activity (in the work force or voluntary sector) all need to be taken into account. It should also be recognized that many American elderly are extremely independent and value their privacy, so independent that often they do not want outsiders coming into their private residences to provide assistance or care, even if they are in serious need of attention.

For the provision of social and community health services, the key change observed in many industrialized countries according to the Organization for Economic Cooperation and Development (OECD) (1992a) is "the need to move from a facility-based system with on-site services to a community-based system

relying on a pluralistic supply (p. 11)." The main premise underlying the issues surrounding the demand for community-based services for the elderly is the expressed desire of elderly persons to remain, as long as possible, in their own homes or communities, in other words, to "age in place". Policies need to be increasingly designed to enlarge the availability of health and social services, to change from supply-oriented approaches to client-oriented ones and to improve the fit of services, to need within a community-based system. It has only recently been acknowledged that care services for older adults need to change to community-based care while maintaining a reliable level of service for the growing segment of the elderly population.

In addition, Nusberg (1984), Olson (1994a), and Scharlach, Lowe, and Schneider (1991) have determined that the demand for formal and informal community health services can be expected to rise as more caregivers, especially family carers, express the need for respite or substitution as labor force participation rates increase among women, who are usually the primary caregivers. The decrease in availability of family carers accompanied by the increasing proportion of *very* old people among the elderly population implies additional demands for care, whether home-delivered or community-based.

Current health policy in many industrialized nations is making it possible for older adults to be able to carry on living in their own homes up to a very advanced age, even in the event of illness and disability. However, the United States has been criticized, in some states more than others, for the lack of provision and funding for community-based services that Medicaid and Medicare

provide, the lack of access of services to all elderly individuals, and associated problems involving needs assessment, particularly in the primary care setting (Papsidero-personal communication, 1994; Rabin and Stockton, 1987; Kane and Kane, 1987).

Moreover, the importance of the home to elderly people is repeatedly remarked upon in national reports and government *White Papers* (1989). Research also shows that, in general, community care options, both formal and informal, are cheaper than the alternatives, such as institutionalization (OECD, 1992a; Larue and Bayly, 1992; Landsberger, 1985; Nusberg, 1984). The combination of an aging population, the preferred choice of most elderly individuals to live independently at home, and the indication that community-based care is more cost-effective than other alternatives, has led to an increased demand for long-term care and community health care programs.

> Community-based care as the central modality for long-term care is gaining increased acceptance; it is recognized that the goal of long-term care should be to allow older persons to remain in the community as long as possible. The emphasis on community-based care, however, requires a refocusing of services and a reconsideration of goals and values, new ways of combining services, and different relationships between the client and the care providers (Papsidero, 1990, p. 318).

Overall, this implies that more tailored services, especially, in-home assistance, primary care services, and other health care services, will be needed. THE

COMPARATIVE ANALYSIS

Foremost, new avenues must be developed for providing and delivering health care services that do not compromise quality and do not introduce

another tier, another level of inequitable access, in the health care system. Additionally, the needs of both well elders and those with health problems must be addressed by health policy decisions.

There is little understanding of how existing programs actually operate, what they cost, who benefits, and how government and family interact in providing help. The changes of recent decades in health care to the aged are not completely understood. There are pervasive mythologies about the elderly, their needs and their resources. According to Nusberg (1984), Olson (1994a), and Landsberger (1985), to plan intelligibly, it is important that aging programs abroad are examined to see what implications they might have for the United states. Many countries, for example Japan, Great Britain, Germany and some welfare states, are already experiencing this "gerontological explosion," and may have important health care strategies that could be applied to The United States. However, it is essential to recognize that there are limits to importing foreign health care measures, practices, and policies due to diverse and varying socio-political, cultural, and economic conditions (Vinten-Johansen, personal communication, 1994).

Nevertheless, dissemination of "best practice" in meeting the needs of older adults should not be limited to a single state or to the United States, as is often the case today . Only a sharing of successful experience and examples in many countries will lead to a wide development of those programs essential to contented, comfortable lives for elderly persons wherever they live. In addition, according to Nusberg (1984) and Bass and Morris (Eds.) (1993), what other

industrialized countries are doing for their elderly population could enhance the dialogue about policy alternatives. Despite the many differences among industrialized countries, the problems facing the elderly and the solutions tried share striking similarities--enough to serve as a rough yardstick on which to base some generalizations of relevance to the United States.

INTERDISCIPLINARY APPROACHES

After an extensive review of the literature written about community-based care or "open care" (Little, 1982) for the aging, I have found several recent works written on community-based programs for the aging, but few that incorporate more than one discipline. I have seen very little written material addressing comparatively the historical aspects of the demographics of population aging and of health care delivery to the elderly and the impact this makes on the demand for and development of community-based services. Moreover, I have found very few works on care services, especially community-based care services, for the elderly that take a comparative international approach, tying in relevant information to the United States. Although there is much literature encompassing many aspects of services to the elderly in addition to community-based care, including economic and financial implications, housing, retirement and pensions, and legal issues, I have chosen to focus on community-based health care. Although these other issues are critical to care for the elderly, addressing them is a formidable task, one that I am not qualified to undertake.

Olson's (Ed.) (1994a) work is the most recent that I have come across and she does use a comparative international approach in addressing care issues for the elderly. However, Olson specifically addresses services for the chronically impaired elderly in several industrialized countries. Olson's compilation encompasses a multitude of care aspects including financial expenditures, housing, community services and mental health issues. The OECD (1992a) also sponsored a collaborative effort detailing certain urban policies for aging populations. Although the work is a comparative construction of international policies, it does not detail any innovative community-based programs; the OECD has concentrated most of their efforts on urban transportation, housing, and fiscal policies for the elderly. The work of Gill and Ingman (Eds.) (1994) illustrates a framework for analyzing care for the elderly in the context of "distributive justice and the welfare state to demonstrate the interactive effects between the economy, the polity and the general structure of society and the condition of the elderly (p. 1-2)." Although they do take a socio-historical approach to care for the elderly, their focus is on welfare mechanisms and social systems in selected welfare states and how these principles have interacted politically. They do not concentrate on specific programs of care for older adults.

Bass and Morris (Eds.) (1993) likewise use comparative international perspectives to portray what some other countries are doing to address informal care needs, explicitly family caregiving incentives and policies. Also identifying international responses to helping the elderly "age in place," Heumann and Boldy (Eds.) (1993a) target those support programs solely for frail and very low

income elderly, particularly subsidized housing and basic social services. Additionally, Mogey (Ed.) (1990) looks at several countries' support service networks, however, emphasis is placed on the need for social policy that deals primarily with ethics and values and support by kin and family caregivers.

Nusberg's (1984) work through the International Federation of Aging (IFA) deals directly with aging programs that have been successful abroad, but there has been much health care policy reform since this work was published. Although published in 1984, most of her research took place in the late 1970s. Since that time, Germany has become unified, Sweden's fiscal policies on health care expenditures have been modified, and Great Britain has altered many provisions and policies of the National Health Service. Furthermore, the elderly population has grown considerably since the late 1970s. Nusberg also examines a variety of international aging programs, focusing mostly on retirement and pensions, housing, and mental health. Her recognition of community services and health care programs, while extremely worthwhile, is very brief and could be developed further and expanded upon in more detail.

OBJECTIVES OF STUDY & STATEMENT OF PROBLEM

It is my intention to add to the work of Nusberg, Olson, Bass and Morris, and Gill and Ingman by addressing both a historical and community health science perspective. More importantly, I will focus exclusively on innovative informal and formal community-based health services for the elderly. First, I will show how the historical aspects of the health care delivery systems and

demographic population changes in each chosen country have aided in, and hindered, the implementation of successful care services for the elderly. I will argue that it is essential to look at the delivery of formal and informal health care services in the larger context of the development of either an individualistic, collectivist, welfare, or mixed market system. Furthermore, due to the differences in culture, politics, and economics, not all health care policies are appropriate for import to the U.S. This historical background of "the big picture" will provide a basis necessary to comprehending each countries' unique approach for the provision and delivery of community-based services for the aged. These historical differences are significant in identifying whether or not other community-based models or principles of care may work in the United States.

Next, I will identify and examine certain community-based programs for the aged, such as in-home assistance, home health care and primary health care services, that I have found both successful and innovative in the specified country. Finally, I will assess the utility of this information and identify what implications or applications these programs for the elderly could have on the availability and provision of health care services for the aging in the United States. Although the United States health care system is based more on privatization and individualistic grounds, different from the collectivist and welfare nature of many of the systems being studied, I will argue that other industrialized nations, specifically Great Britain, Germany, Japan, and Sweden, may have

some valuable contributions to the approaching "American crisis" of caring for a rapidly increasing elderly population.

The United States has not been particularly receptive, as many European communities have been, to the development and implementation of equitable and accessible community-based care services, and long-term care services in general, for the elderly. Many factors, peculiar to the United States, including various financial, cultural, and policy-oriented considerations, interact to complicate, although not make impossible, the availability and extension of community services for the elderly in the current health care system (and social care system). On the one hand, many U.S. policy makers are not thoroughly convinced, due to conflicting reports and studies (Olson, 1994b), that community-based health care services are more cost effective or "cheaper" than many institutional or more formal services. On the other hand, several European studies (OECD, 1992a; Olson, 1994a) have indicated that community care is, on the whole, more cost-effective than institutional services. Although, it is widely recognized that "aging in place" and allowing the elderly to remain in their own communities as long as possible is a much better alternative to institutionalization, as seen by the low institutionalization rates, cost factors, profit motives, and a low priority for care of the elderly seem to play key roles in the lack of organization of a continuum of community-health care services for the aging U.S. population.

[1] About one-third of all non-institutionalized people aged 85 and over in the U.S. are independent, while another one-third need limited assistance in performing daily activities. At the same time, one-third of the total require substantial aid from others (Longino, 1988).

CHAPTER ONE
THE HISTORICAL CONTEXT

As addressed earlier in the introduction, I will first provide a brief history of the demographic aging population of Great Britain, Sweden, Germany, and Japan. This information is meant to serve as a basis for understanding how demographic history and elderly health status translated to health care needs. Next, I will briefly describe a short history of the development of health care systems in each country, including the U.S. I will also include an account of the delivery of health services and the development of social or community-based services for the elderly. Most importantly, however, this chapter will give a historical overview of some important factors, including social, political, economic, and cultural considerations, that will be essential in identifying which community-based services could possibly be successfully transferred to or implemented in United States.

GREAT BRITAIN

DEMOGRAPHY

The aging of the British population is now well advanced. The growth in Britain's aging population, however, did not occur quite as suddenly as it has in

Sweden and Japan. The growth in the population of the British elderly has occurred gradually over time since postwar years.

In the past 50 years, the number of people aged 65 and over has more than doubled to just over nine million (16 percent of the population) as of 1994 (Figure 3) (Population Reference Bureau, 1994). If this trend continues, the population aged 65 and over is projected to increase steadily well into the next century, to over 11 million (18 percent of the total population) in 2021 (OECD, 1992a; Population Reference Bureau, 1994). If fertility remains low and life expectancy continues to improve, it could reach 20 percent by 2025 (Joshi, 1989; OECD, 1992a; Schulz, Borowski, and Crown, 1991). The largest rises between now and 2021 are expected in the numbers of those aged 75 and over and 85 and over: 30 percent and 98 percent respectively (Coleman and Salt, 1992). This is an increase of almost 50 percent in 30 years. The number of those 85 and over are projected to rise from 695,000 in 1986 (Figure 4) to 1,146,000 in 2001 (OECD, 1993b; Grigsby, 1991). It is also expected that, by 2021, women will outnumber men in the 85 and over age group (as of 1994, life expectancy for British men is 73, and for women, 79) (Coleman, 1993) by approximately 2.5 to 1, so the British world of advanced old age is predominantly a woman's world. According to Malcolm Dean (1992, p. 294), Britain is now being called the "granny state," since by 2025, the British population over 65 is projected to grow by 25 percent, the majority composed of women.

The British aging population trend is likely to continue well into the next century. Due to this expansion of older people and especially those in the

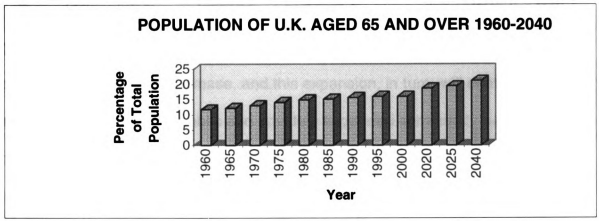

Figure 3 - Population of the United Kingdom aged 65 and over from 1960 to 2040 (projected after 1995) (Source: OECD, 1993b; OECD, 1992a).

"oldest-old" age group, Britain, like other industrialized societies, has experienced a significant growth in the need for care over the course of this century. The biggest challenge facing Britain is the doubling of the number of over 85 individuals between 1980 and 2000, which is expected to create even

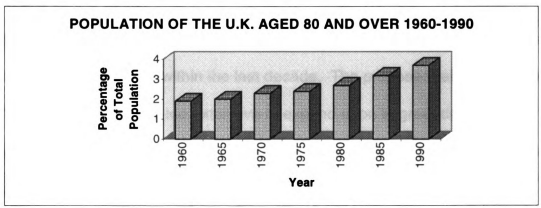

Figure 4 - Population of the United Kingdom aged 80 and over from 1960 to 1990 (Source: OECD, 1993a).

further additional demands for services and care for older adults. With the British government's aim of assisting older people to live in their own homes, the elderly population continues to increase, and this expansion, in turn, will continue to increase the demand for public and privately supported community-based health care services for the British aging population.

THE EVOLUTION OF THE NATIONAL HEALTH SERVICE

A national health insurance system that covered the health care of most of the working population was initiated early in the century, but it was not until 1948 that Britain established its National Health Service, or the NHS. World War II changed many public attitudes and fostered the belief that the postwar social order should include "health care as a right for all." Funds for the NHS, then and now, come from national insurance contributions, and from general taxation. All health care is supported by taxation, apart from small payments for drugs, vision care, and similar items.

However, since 1948, NHS policies have undergone numerous amendments and revisions, especially within the last decade. The proposed reforms for the NHS are quite extensive, too extensive to expand upon in great detail. Nevertheless, in general, most of the NHS reforms are, on a grand scale, trying to change the British health system from one of a welfare state, to one of managed markets and competition (Light and May, 1993).

THE CHANGING ROLE OF THE NHS IN CARE FOR THE ELDERLY

With the proportion of elderly people in the population growing annually, there has been increased pressure on the geriatric hospital and district nursing services (Ham, 1992). The number of elderly people attending hospital as out-patients has risen, and in general, the Department of Health's (DH) policy is to help elderly people to remain in the community as long as possible. This means increasing the availability of services such as day centers, home health care, and nutrition services (Meals-on-Wheels). These services are the responsibility of local authority social services departments rather than health authorities. Many of these services were implemented as a result of *The White Paper*. The report, published in 1981, was concerned specifically with the needs of elderly people, and provided comments on ways in which services should be developed. The *White Paper* explicitly stated that "Care in the community must increasingly mean care by the community." As far as health services were concerned, the *White Paper* noted the crucial role played by community health and family practitioner services in assisting elderly people.

For the most part, however, the future of care for older adults rests primarily on the outcome of developments in the informal sector "because the state has always played a relatively minor role in direct care provision, though it has exerted a powerful covert influence in maintaining the primacy of the family (Walker and Warren, 1994)." As far as the formal sector is concerned, the state has dominated both direct care provision and funding for the whole postwar period, with the private (for-profit) and voluntary (nonprofit) organizations

occupying very minor roles. However, in recent years this pattern of formal care has begun to change. Responsibility for social care in Britain has rested primarily with local authorities (funded by a mixture of central grant and local taxation) while the NHS is concerned with medical treatment (funded entirely from general taxation and administered by central government) (Maynard, 1993). Of course, the distinction between care and treatment is not always easy to make, especially when, as in Britain, there is a system of community-based general practitioners and allied services (Freer and Williams, 1988, p. 143).

DEVELOPMENT OF COMMUNITY CARE IN BRITAIN

In Britain, the favored option of successive post-war governments of different political persuasions has been "community care" (Hunter, 1993; Means and Smith, 1985). "This political consensus was sustained, in part, by the ambiguous and largely symbolic nature of the term 'community care', but, more importantly, it enabled the state to both promote the primacy of the family in caregiving and minimize its own role to that of a casualty or last resort service (Walker and Warren, 1994, p. 137)."

However, the political consensus regarding community care has unraveled since the postwar years. Several initiatives have since been proposed to reform Britain's community care services, especially recently. In 1981, 1984, and 1993, reforms were proposed to increase the number of and access to community care services, not only for the elderly, but also for the disabled and mentally ill. During the last 20 years or so, the British government, specifically the

Department of Health and Social Security (DHSS), has increasingly emphasized the need to provide community care for the elderly, and to achieve a major shift away from institutional health care provided mainly in hospitals (Hunter, 1993).

The "new" framework that now supports community care policies involves the development of a network of coordinated services tailored to the needs of individuals. The main policy change was for local authorities to become responsible as "lead agencies" for assessing individual need, designing care arrangements, and ensuring that services are delivered (Walker, 1993, p. 137). Of certain significance is that the Social Services Department tried to make maximum use of private and volunteer services, and not rely so much on the public sector.

Most importantly, these policies embrace services that enable people to continue living at home, whether in a family home or in supported housing. These services include NHS community health services such as health visitors, district nurses, community psychiatrist nurses, plus day care ,education centers, Meal-on-Wheels, and home helpers. The impact on community care developments in medicine and health care policy and practice are creating additional pressures to increase community-based and home-based health care provisions.

AID TO THE ELDERLY THROUGH "KIN" AND FAMILY CAREGIVING

Britain's system of family care is relied upon foremost in care for the elderly. As in most family caregiving situations, it is the wife or daughter who is the

principle caregiver and provides the majority of care. However, the demographic trends of increasing elderly population growth coupled with the increase in female participation in the British work force is creating a shortage of available caregivers. The percentage of women, aged 15 to 59, involved in paid work positions has consistently risen from the 1960s to the 1990s, 46.1 percent to over 66 percent respectively (OECD, 1993a).

Of unique importance, however, is Britain's recent untraditional approach to care for the elderly to rely more on private and informal sources of help (instead of public and formal sources), but not necessarily familial sources of help. The British Government and social service agencies now acknowledge that there might be a conflict of interest between caregivers and care recipients that is not recognized by the proposals to improve care for the elderly. The failure to address this dilemma stems from the assumption underlying both the *White Paper* and the *Griffiths Report* (1988) that the family should in all circumstances be the primary source of care. However, according to Qureshi and Walker (1989), this confidence in "familism" is sometimes misplaced; family care can be both the best and the worst form of support. Antagonism in family relationships can often

> lead to resentment on the part of caregivers and provide a basis for potential abuse of the older person. If policy makers continue to assume that the family is always the soundest basis for care, they will overlook existing conflicts in the caring relationship and be guilty of imposing some potentially destructive relationships on both caregivers and care recipients . (Walker, 1993, p. 149).

Nevertheless, the position of the informal caregiver is still increasingly recognized by policy makers. It is neither practical nor desirable to decrease or eliminate the imperative role that family caregivers provide in the care of older adults. The British government's 1989 policy statement makes it clear that

> the reality is that most care is provided by family, friends, and neighbors. The majority of carers take on these responsibilities willingly, but the government recognizes that many need help to be able to manage what can become a heavy burden. Their lives can be made much easier if the right support is there at the right time, and a key responsibility of statutory service proprietors should be to do all they can to assist and support carers. Helping carers maintain their valuable contribution to the spectrum of care is both right and a sound investment. Help may take the form of providing advice and support as well as practical services such as day, domicillary, respite, and in-home care (Secretaries for State of Health, 1989).

Factors, such as the shifting of community care policies for the British elderly into the hands of the private and informal sectors and the rising female participation in the work force, are likely to have an effect on the need and availability for family caregivers. In the future, it is conceivable that post-1993 NHS community care reforms will further increase the amount of community services, in both the private and public sectors, to keep pace with the expansion of the British elderly population.

SWEDEN

DEMOGRAPHY

In terms of population, Sweden is a small country, approximately the size of California. Of its 8.8 million people, about 1.5 million or 18 percent are aged 65 or older; 4 percent of the population are aged 80 and older (Population

Reference Bureau, 1994; OECD, 1993a). Few other countries have such a large proportion of elderly in the population and Sweden's average life expectancy is among the highest in the world-80.1 years for women, and 74.1 years for men (Population Reference Bureau, 1994; OECD, 1993a). In comparison with other industrialized countries, Sweden "is the oldest country in the world" with approximately 24 percent of the total population over 60 and 4.4 percent over 80 (Golini and Lori, 1990, p. 327; OECD, 1993a; Coleman, 1993).

This aging trend has continually been rising since postwar years, however, rapid growth in the numbers of elderly began in the early 1960s (Figure 5). By the year 2040, the OECD projects that 23 percent of Sweden's population will consist of those aged 65 and older. This percentage, almost one-quarter of the total population is very significant, keeping in mind the smaller size of Sweden.

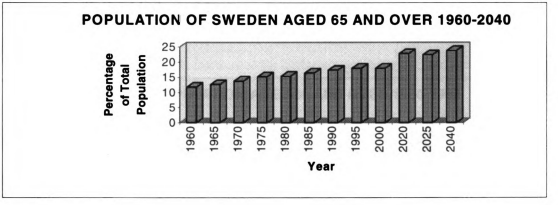

Figure 5 - Population of Sweden aged 65 and over from 1960 to 2040 (projected after 1990) (Source: OECD, 1993a; OECD, 1993b; OECD, 1992a).

Moreover, the numbers of the very oldest in the population are continuing to rise, as they have done for some time, as shown in Figure 6. According to the OECD (1993a) and the United Nations (1994) those individuals aged 80 and over in Sweden have increased by 50 percent since 1970 and by 31 percent since 1980. Over the next decade, the percent ratio of elderly people aged 85 to 89 years is expected to increase by over 40 percent, and those aged 90 and over by more than 75 percent (OECD, 1993a; Sundstrom and Thorslund, 1994a).

With such a notable increase in Sweden's population of older adults within the last decade, especially within the last 5 years, Sweden is already experiencing an elderly population almost one-quarter of the total population. This momentous "demographic transition" has provided an impetus for the Swedish health system to develop a variety of community-based services and other social services for their elderly residents.

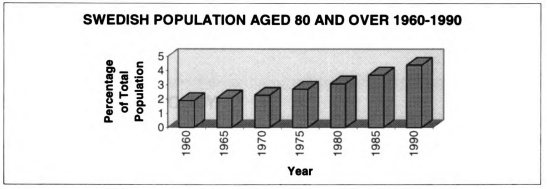

Figure 6 - Swedish population aged 80 and over from 1960 to 1990 (Source: OECD, 1993a).

DEVELOPMENT OF THE SWEDISH HEALTH CARE DELIVERY SYSTEM

Medical services in Sweden were carefully planned and developed in the 1960s and 1970s. The health sector, historically mainly a collective and public enterprise, became thoroughly integrated and operated by the regional county councils with their own tax-raising power. Sweden's health system, in place now, is a predominantly socialized one, backed by public financing. Essentially, Sweden provides tax-supported health services and benefits for all citizens, runs government-owned hospitals, and has developed standardized compensation schemes for health providers (Duffy, 1992; Heidenheimer and Elvander, 1980).

On average, the Swedish public sector taxes about half of a person's income. To pay for extensive health and welfare benefits, Sweden has one of the world's highest tax rates (Gaensler, Jonsson, and Neuhauser, 1982). All Swedes are covered by compulsory health insurance. This insurance pays for all physician care and hospital services, except for modest co-payment fees per physician visit. On the whole, health care and its delivery are shaped by local input; control over decision making is decentralized.

SWEDISH OLD-AGE POLICY

The great majority of the Swedish population strongly supports taxation for elderly care, medical care, and related programs. According to public opinion, when people are asked to choose between expenditures that mainly benefit the younger generations and those that primarily benefit the elderly, people aged 30

and upward tend to choose those expenditures that benefit older adults (Sundstrom and Thorslund, 1994a). Moreover, Sweden's health care programs and policy initiatives reflect the Swedish perspective that the elderly "have the right to independent integrity...to live their lives on their own terms (OECD, 1992a, p. 15)."

Sweden has been able to provide comparatively good funding for a well-managed social welfare policy, not the least in the field of old-age care. But of equally great interest are the explicit goals under which the "old-age care system" has operated. The most important of these are specified in the *Social Services Act* which went into effect in 1982 (Johansson and Thorslund, 1991a). This is a framework of legislation which emphasizes the right of the individual to receive municipal services at all stages of life. All those who need help for their day-to-day existence have the right to claim assistance if their needs cannot be met in any other way. Care for the chronically ill is provided in nursing homes or at a patient's residence at no extra charge (Johansson and Thorslund, 1991a). The key concepts under the act are "self-determination" and "normalization;" the individual should be able to choose among the various types of aids and services, while the system makes it easier for the elderly to continue living in their normal environment.

One characteristic feature of Swedish social welfare policy, distinguishing it from that of many other industrialized countries, is its general nature. A comparatively small proportion of the public sector social programs are means-tested. Many forms of support are available to everyone in a given category,

regardless of income. Everyone who has reached age 65 receives an old age pension, and everyone with children receives child allowances.

In 1983, a new *Health and Medical Services Act* came into effect (Little, 1982). According to this act, health care and medical services are available to all members of society, thus ensuring a high standard of general health care for all on equal terms. The elderly receive the necessary medical care within the publicly operated medical care apparatus and as part of the same social insurance system as younger people. Nearly all medical care is operated by public authorities, and a larger proportion of doctors work in the public sector than in private practice.

Most importantly, however, in Sweden, as in many other countries, the concept of care of the elderly has changed. The earlier belief, held from the 1950s until the early 1980s, that escalating needs within the elderly population could be satisfied by the provision of more residential places has been replaced by a new belief, namely, that by reducing dependence on institutional residence in favor of elders remaining at home, both humanitarian and economic benefits can be reaped (Thorslund, Norstrom, and Wernberg, 1991).

The most recent significant change is the *Bill on Caring Services* for the elderly adopted by parliament in 1988 (Cates, 1993). Its purpose is to improve the responsibility and coordination of medical and social services. In the past, county councils were responsible for health/medical services, long-term medical care, nursing home, and home nursing care. Local municipalities were

responsible for social services, home help, and housing for the elderly persons. Often confusion emerged among elderly individuals and family concerning whether an agency of the municipality or county council was responsible to provide a needed service. It is suggested that inserting long-term medical care, nursing home, and home help into one agency (municipality) will reduce the confusion outlined above and reduce fragmentation, and improve both the continuity and quality of care (Cates, 1993).

CARE FOR THE ELDERLY AND COMMUNITY-BASED SERVICES

More recently, Sweden has encouraged a tremendous increase in community-based services such as home health care, nutrition programs, other related community-based services, including an increase in the number of general practitioners and district nurses (Sundstrom and Thorslund, 1994b). Prior to 1990, less than ten percent of public expenditures for elderly medical and social services were for this type of care. Currently, about 38 percent goes towards social insurance and social welfare programs (OECD, 1992b). In the early 1980s only about half as many persons received health care in their homes as compared to those receiving long-term health care in institutions. According to Thorslund, Norstrom, and Wernberg (1991), over 15 percent of the elderly population age 65 and over now receives regular home help. This involved a complete redirection of health care policy and allocation from institution-building towards mobile and community services. This change is having a profound

impact on the lives of the very old, as care and treatment is shifting from hospitals to the home by visiting health professionals.

In the mid-1980s there were serious talks about closing down all remaining old age homes, but this stirred up controversy and the government recently backed away from this plan. However, it still sticks to its plan to diminish institutional housing while increasing community care services. To facilitate this policy initiative, a number of services, such as senior centers, service apartments and in the home environment assistance, have been developed and more are in the planning stages.

FILIAL OBLIGATIONS AND FAMILY CAREGIVING

The family support system in Sweden is still important and in effective use. It may be that the role of family caregiving and support has changed from that in which it provided most of the heavy everyday help, to a new role of organizing and supplementing the formal support system (Tornstam, 1989). A rather large proportion of the care given to the elderly today is given by the family, such as the spouse, children, neighbors, relatives or other friends. In general, elderly who live with their children are generally cared for by them without much external support; it is when the elderly live alone that the outside help and systems of care have tended to replace the family (Cates, 1993).

However, according to Habib, Sundstrom, and Windmiller (1993), it appears that with the growth of formal care, the extent of family support has declined in Sweden compared to earlier periods around the 1950s. While family support is

still important, their findings suggest that some substitution is occurring between family caregiving and formal services. A reason for this shift might be due to the increasing labor participation of women, especially wives and daughters, who are usually the primary caregivers in Swedish society. Along the same lines, Tornstam (1989, p. 62) also predicts that caregivers, the vast majority women, are likely to become less and less available in the future. His research shows that in 1930 around 10 percent of the married and 60 percent of the unmarried women were in the labor force; the corresponding figures in the year 2000 will be around 90 percent for both married and unmarried women. It is very likely that with fewer informal family caregivers, the demand for community-based services for the elderly is likely to increase, for both formal and informal care.

GERMANY

DEMOGRAPHY

As in most countries of the industrialized hemisphere, the proportion of old people in Germany has been dramatically increasing within the last decades. Since the reunification of Germany in 1990, the government has been struggling to cope politically, socially, economically, and culturally with the consequences of this development. As of 1994, Unified Germany's total population has reached 81.2 million; of the total population, 15 million or approximately 18.5 percent are age 65 and over (Population Reference Bureau, 1994).

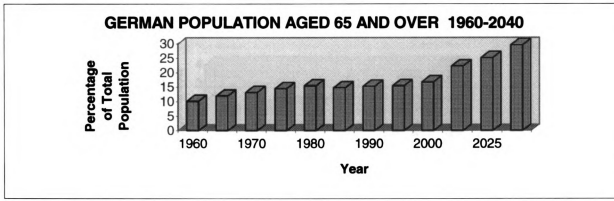

Figure 7 - German population aged 65 and over from 1960 to 2040 (projected after 1990) (Source: OECD, 1993a; OECD, 1992a).

Since the early 1960s, the proportion of elderly people aged 65 and over to the total population has steadily been increasing (Figure 7). Moreover, the "oldest-old" have also steadily increased in number. According to the United Nations, in 1950, only about one percent of the total German population was 80, and over, and in 1990, this percentage rapidly grew to 3.9 percent (Figure 8). More importantly, however, future projections indicate that the "oldest old" will reach over 5.5 percent of the total population by 2025 (United Nations, 1994). The number of the very old will probably increase even more than that of the "young old," while the number of persons older than 70 is expected to rise to 16.5 percent of the population in the year 2020, with 20 percent of them over the age of 80 (Gold for the Old, 1994; Deutschland, Deutschland, alter alle, 1989).

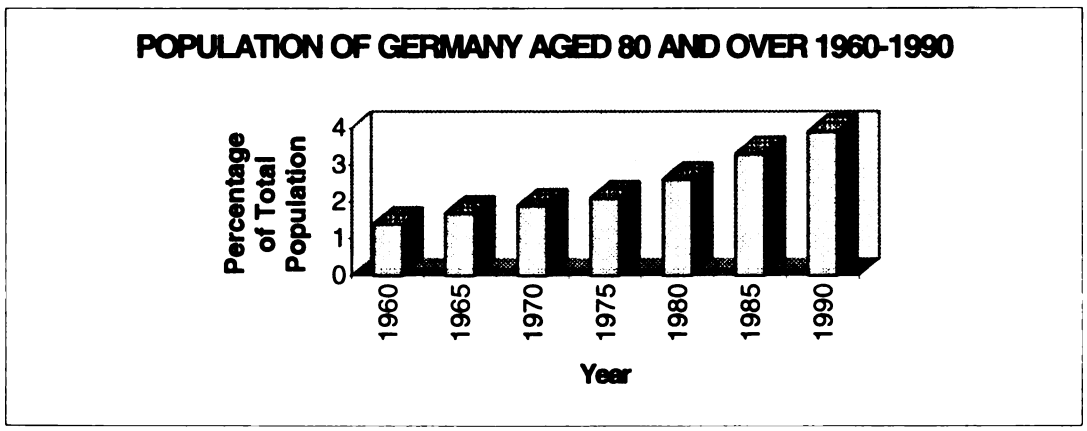

Figure 8 - Population of Germany aged 80 and over from 1960 to 1990 (Source OECD, 1993a).

The number of German elderly who require aid is rising relatively and absolutely due to population growth and since chronic diseases are concentrated in old age. The implications or consequences of these demographic changes has unequivocally had and will continue to have an immense impact on the provision of services to the elderly in Germany. If all indicated projections for future population growth prove accurate, the number of elderly who will need care provided by community-based services, will be likely to rise proportionally.

THE GERMAN HEALTH CARE SYSTEM

Germany's system of universal national health insurance, the basis of which was laid in 1883, ranks as one of the world's oldest and, by many measures, the world's most successful (Knox, 1993). According to the OECD (1992b) and Knox (1993), the overriding lesson of the German experience is simply that it is

feasible to provide high-quality health care though a universal, affordable, and equitable financing mechanism, with "impressive durability."

To understand how the German system works, why it is successful, or why the Germans are engaged in revising the system, it is important to examine how it evolved. In particular, it is necessary to comprehend something about the controlling idea behind the German health system: *social solidarity*. The term means "The collective agreement to share the risks and costs of a necessary good, in this case, health care, so that the rich subsidize the poor, the healthy support the sick, the young pay for the old, workers help the unemployed, and single and childless couples subsidize families and children (Knox, 1993, p. 19)." However, health care is different from what the U.S. call "welfare" programs designed solely to redistribute from rich to poor. Instead, health care programs redistribute very broadly, in such a way that everyone who pays into the system understands that he or she may someday benefit.

The principles of health care have not changed fundamentally since 1883 despite several reform acts. German health care is an insurance system with a primary purpose to finance medical treatment for the labor class so as to enhance worker employability. It is a statutory system which is funded by workers and their employers. Health insurance pays for medical prescriptions as well as treatment of and hospitalization for curable illnesses.

Germany's universal health insurance plan is grounded in a "social contract" that places a strong emphasis on the provision of medical care to all citizens by private ambulatory care physicians who largely have clinical autonomy, but who

have relinquished their economic freedom to the professional associations that negotiate on their behalf with insurance organizations known as "sickness funds." Germany's health system is administered by private nonprofit organizations, authorized by law to wield power on behalf of payers and providers. The federal government intervenes only when it concludes that the broader interests of society are being neglected (Iglehart, 1992a).

Therefore, the private organizations that have the legal authority to administer Germany's health insurance plan, 1,128 sickness funds and 18 regional associations of physicians, operate within a strict framework of federal and state regulation, but not government domination (Knox and Straub, 1993). To the United States, which values collaboration between the private and public sectors and favors a limited role for government, Germany's century-old experience is an impressive demonstration of the accommodation of private interests to the broader public good to achieve what is in the U.S. "an elusive but oft-stated goal: providing all citizens with access to an adequate level of medical care at a socially acceptable cost (Iglehart, 1992a)."

GERMANY'S SOCIAL WELFARE SYSTEM

The German social welfare system , or more commonly known as, "the conservative or corporatist model of social welfare", utilizes the "subsidiary principle" (Iglehart, 1992a): the public sector intervenes only when the individuals and their families are incapable of providing for themselves. The determination of when this point is reached, however, is unclear. Although the entire German

population is now covered under health insurance, there is no similar provision for long-term care for the elderly. In fact, the voluntary sector is primarily responsible for the organization and delivery of formal services, with the economically needy subsidized by the state (Leaper, 1991).

Although since 1956 there also has been statutory health care for pensioners, the group of secured risks is still confined to potentially treatable illnesses. Thus, health insurance tends to exclude the special health needs of old age by restrictively interpreting its financial obligations toward the elderly.

GERMANY AND LONG-TERM HEALTH CARE FOR THE ELDERLY

Traditionally, much of the delivery of care services for the elderly has been organized as a form of local community assistance, in part provided by various groups in the voluntary sector. The emphasis has been on ambulatory care, and on services which combine household assistance with personal and with basic nursing care (Landsberger, 1985). Much of the work is of low intensity; it combines volunteer, low-paid and part-time efforts into outreach networks; and it is conducted as a form of community service (Kirchgassler, 1990). In the past, these services have been carried, at least in part, as marginal burdens within the regular health insurance system. Germany has, however, been applauded and looked to as a model for their development of coordination and management agencies, *Sozialstationens*, that have drastically improved the organization and delivery of community care services for the elderly.

According to several authors, it seems that politicians and economists in Germany are well aware that measures will have to be taken to increase publicly supported long-term care services, especially community-based services, and to control the cost of caring for elders (Knox, 1993; Eekelaar and Pearl, 1989; Heinemann-Knoch, 1994; Kirchgassler, 1990). A long-term insurance plan, long contemplated as a way of moving elders out of acute care hospitals into cheaper settings or provisions to be cared for at home, is now being ardently pursued. At the same time, Germany conducted extensive political debate, prior to reunification, about a long-term care insurance program in the mid-1980s, and many expected such legislation to pass before the federal elections of 1987, but the issue was derailed because of factional and party politics (Means and Smith, 1985).

The health care system in Germany, in comparison to Great Britain, Japan, and Sweden, is likely the most deficient, next to the U.S., in provisions for long-term and community care services for the aged. Long-term care was and, with some exceptions, still is explicitly excluded from health care insurance, similar to the U.S. Those individuals, in need of long-term health care services, whether in an institution or at home, have to, for the most part, rely on informal or unpaid family help or in many cases have to pay for formally delivered services themselves. Only those who live below the legally defined minimum income level are eligible for social welfare and social assistance for long-term care.

FILIAL OBLIGATIONS AND FAMILY CAREGIVING

Familial sources of help have maintained a crucial role in elder care over the years. Caring and politics for the aged have developed as a part of Christian charity and welfare for those poor and ill individuals who could not afford to take care of themselves nor had any kin to aid them (Alstenstetter, 1974; Levy, 1992). Over the centuries, caring was also universally viewed as the "natural" task of women. Moreover, as an integral role of the female in the family, it was assumed that such efforts did not require training. Since 1961, with the passage of the *Social Welfare Act*, courses were set up for care of the elderly, aimed at housewives whose children had grown up. Since then, the profession of caregiving for the elderly (*Altenpflegerin*) has been developing, although there are still no formalized job training requirements (Heinemann-Knoch, 1994; Knox and Straub, 1993).

This suggests that families in Germany have been forced to take on increasing burdens of care. Until recently, about 80-90 percent of elderly had been dependent on family care but since the 1980s, this percentage has been plummeting. One reason for this decline may be due to the rising number of German women who are joining the labor force, mostly part-time. The female participation in the labor force aged 15 to 59 had remained steady at approximately 49 percent from 1960 to 1979, but within the past 13 years, has risen to over 60.5 percent as of 1990 (OECD, 1993a). This dramatic increase has had a negative impact on family caregiving for the aged which, again, is

primarily delegated as a "women's role," or burden. This also means that women risk their economic stability and diminish their own income in old age.

Overall, in Germany, many factors have led to a decline in the number of family caregivers. Generational changes in behavior, the rising percentage of divorce, greater quantity and quality of female employment, job mobility, women's emancipation, and the breakdown of the extended family all have already diminished the potential for family care. These will have even greater effects on care for the elderly in the future as well as increase the demand for better quality formal services. Although formal community-based services are growing, they will need to be further increased to meet the needs of the increasing number of elderly, especially those who are poor or have few family contacts.

JAPAN

DEMOGRAPHY

Since the beginning of Japan's modernization in 1868, it has maintained a relatively young age structure, with an elderly population (65 and older) of less than five to six percent (Palmore, 1975). Because of this, the need for old-age welfare support and assistance was limited or not in much demand. However, the percentage of young people began to decrease due to a change in Japan's fertility rate which declined rather rapidly following Japan's postwar baby boom (Jones, 1988); in 1990, there were only 1.57 children per married female (OECD, 1993b, p. 13; Nishio,1994; United Nations, 1994) compared to 1950, when the

fertility rate for women age 15 to 49 was 3.65 (Okimoto and Yoshikawa, 1993, p. 84-85). This trend, coupled with advancing life expectancy (Japan's life expectancy is now the highest on earth-in 1994, 76 for males and 82 years for females) (Population Reference Bureau, 1994; Curb, Reed, Miller, and Yano, 1990), has significantly affected Japan's age structure.

Japan's percentage of elderly Japanese reached 14 percent in 1994 (Figure 9), attaining this level in only 25 years (Population Reference Bureau, 1994). Consequently, the population of Japan is aging faster than any on earth (Neville, 1992; Dentzer, 1991). Furthermore, it has been projected that, by the year 2020, only 25 years from now, the proportion of those over 65 within the Japanese population will climb to 25.2 percent (Utsonomiya and Yoshikawa, 1993, p. 82).

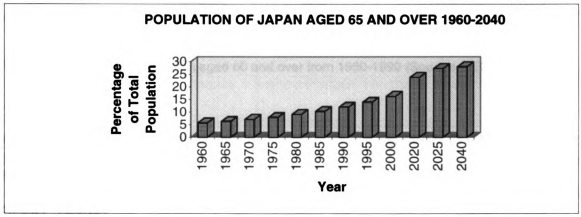

Figure 9 - Population of Japan aged 65 and over from 1960 to 2040 (projected after 1995) (Source: OECD, 1993a; OECD, 1992a).

Japan will have the oldest age structure in the world by 2020, if predictions hold true (OECD, 1992a, United Nations, 1994).

Not only will it have the oldest society in terms of people over the age of 65 years but it will also have an extremely high proportion of the society in the very old age group, 80 and older (Figure 10). If predictions hold true, the proportion of those older than 75 years of age is expected to increase to the 11.3 percent

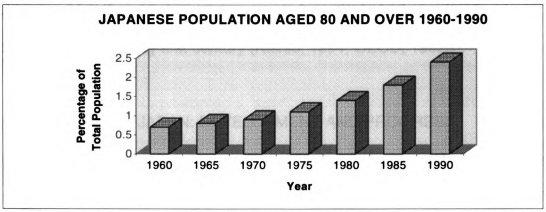

Figure 10 - Japanese population aged 80 and over from 1960-1990 (Source: OECD, 1993b).

level by 2020. Further, those aged 75 and older are expected to constitute approximately one-half of the total elderly population (United Nations, 1994; OECD, 1993a).

There is one additional demographic trend which is likely to increase the difficulty of Japan's adjustment to the social process of aging: there is a marked regional variation in the distribution of the aged population. According to the Ministry of Health and Welfare (1990), unlike the already aged rural regions

(surpassing the national average by 3 to 5 percent), populated industrial areas (below the national average by 2 to 3 percent) will grow old very rapidly until the national average reaches the predicted 22 to 23 percent by 2020. Consequently, the problems and adjustments of an aged population will be acutely concentrated in and around the industrial or more urban centers of Japan. Moreover, any solutions that have been found, or are in planning stages, will not only need to be undertaken by central government, but also by particular cities in which the elderly are concentrated, particularly during the first two decades of the twenty first century (Nishio, 1994; OECD, 1992a).

HEALTH CARE IN JAPAN: DEVELOPMENT AND PROGRESS

Surprisingly, the years of war with the United States did not hinder the continued expansion of the universal health insurance system. In fact, as Japan moved toward the entry into the Pacific War, the extension of health coverage was encouraged by the rationale "Healthy People, Health Soldiers." The Japanese Government recognized the impending need for vast amounts of human capital and viewed the extension of health care benefits as the necessary means by which to improve the military capability of the populace (Nishimura and Yoshikawa, 1993)." In other words, the health of the nation as a whole was not a primary concern to policy makers as was the health of the soldiers, who would enable the Japanese to strengthen their fighting forces during the war. Whatever the reasoning, previously underserved communities were given access to health care.

Between 1943 and 1945, much of Japan's health system was not functioning, especially at the end of the war. On August 12, 1945, Japan officially surrendered, ending a four year war, and marking the beginning of a new philosophy in the Japan's health system.

In 1946, the enactment of the new Japanese constitution was announced. It read, as *Article 25:*

> All people shall have the right to maintain the minimum standards of wholesome and cultured living. In all spheres of life, the State shall use its endeavors for the promotion and extension of social welfare and security, and of public health (Nishimura and Yoshikawa, 1993, p. 14).

Therefore, under the Japanese constitution, the maintenance of minimum standards of living is considered a "right", not a "privilege", of each Japanese citizen. Article 25 is said to have provided the basis for a large portion of Japan's postwar health and welfare policy making.

Between 1947 and 1948, however, during Japan's occupation by the Supreme Command of the Allied Powers (SCAP), some revisions and amendments in the health system took place as recommended by the *Wandel Report* and the Japanese Advisory Council on Social Security. They outlined a new philosophy for postwar health and welfare policy, under the *National Health Insurance Law*. Japan's efforts to adopt a universal health insurance system resumed, but with a different guiding principle: protection of the neediest (Powell and Anesaki, 1990; Yoshikawa and Utsonomiya, 1993).

In December 1958, the *National Health Insurance Law* underwent further revisions and was amended, officially making coverage mandatory and universal

for all Japanese. Though actually an amendment, many regarded the 1958 changes as an entirely "new" National Health Insurance Law. Whatever the political incentives, the Japanese universal health insurance system (*Kai Hoken*) was fully enacted nationwide in 1961. Despite several structural adjustments, this system is still in operation today.

UNIVERSAL HEALTH INSURANCE

One of the greatest strengths of Japan's health care system, aside from its surprisingly low cost (Crawford, 1991), is its guarantee of comprehensive medical care for virtually every member of the population. The country's 122 million residents enjoy complete freedom in choosing providers of medical care under an extensive "safety net" provided by Universal Health Insurance (Powell and Anesaki, 1990; Nishimura and Yoshikawa, 1993).

In addition to complete access, the Japanese system is characterized by equity in the provision of medical care (Martin, 1989). All patients, rich or poor, are assured equal access to all medical services, due in large part to a uniform fee schedule for reimbursement (Iglehart,1992b). This system provides nearly all health care services to the Japanese population. Private health insurance policies are not necessary to pay medical bills, but for supplemental purposes. According to Kinoshita, private insurance is not yet popular, but there may be a larger market for it in the near future, particularly for long-term care for the aged (Kinoshita, 1994).

THE JAPANESE HEALTH SYSTEM OF ELDERLY CARE AND WELFARE

The decade of 1973 to 1982 was quite unique in the Japanese history of health and medical care for the aged. In 1973, the free medical program for the aged (*Rojin iryo muryoka*) was adopted as part of the National Health Insurance plan. This program entitled all individuals age 70 or over and the "bedridden" between the ages 65 and 69 to receive both ambulatory and hospital care services free of charge. Nevertheless, this program met with great opposition because of its effect on the Japanese health system; the major concern was reflected in the rapid increase of medical expenditures for the aged and in higher rates of their receiving medical care (Kinoshita, 1994).

Consequently, to counteract the rising costs of care for the elderly, the "free medical program for the aged" was discontinued and health policy was once again revised. Since February of 1983, a new system has developed in Japan, independent of the National Health Insurance System: the Health and Medical Service System for the Aged (HMSSA). This program was established independently of the existing health insurance to cover those over 70 years of age. The new stipulations of this program require that elderly patients co-pay set amounts of approximately Y400 ($3) at each physician visit per month and about Y300 per day in case of hospitalization (Kinoshita, 1994). According to Kinoshita (1994), while structurally more solid and comprehensive in scope, it remains to be seen whether or not the new system (HMSSA) is working in the way it was intended by the government: to reduce medical expenditures for the aged.

Also in 1983, the *Health Care Law for the Elderly* was enacted, foreshadowing the coming of an "aging society" (Anme, 1993). The aim of the new law was to establish a comprehensive system of caring for health from one's youth onwards and to further develop medical care for elderly persons. The law defines services covering community-based health care, prevention of disease and rehabilitation, and provides for health-check benefits for persons over 40 and medical benefits for persons over 70. According to Anme (1993), "the principle behind this law is that people should become aware of their own mental and physical changes as a result of the aging process and should recognize the importance of continuing self-reliance and self-help (p.158)."

Generally, in terms of health and social care, the Japanese are becoming convinced that the aged should be able to live at home, with the help of organized care services. As a result of this attitude, the HMSSA reimburses home health care visits by physicians, nurses, physical and occupational therapists, and the reimbursement rates for these services will be expanded in the near future (Kinoshita, 1994; Powell and Anesaki, 1990). Particularly noteworthy in this regard is a government proposal to establish a new system of home nursing within the HMSSA (OECD, 1992a; Kinoshita, 1994). Although not currently covered by the HMSSA, the numbers of home helpers has increased considerably over the years and the government has stated that it will increase the number of home helpers for the future (Phillips, 1992).

FAMILY AS A CARE-GIVING INSTITUTION

Japan is widely viewed as a society that values and honors its elders. Japanese modernization and Japan's traditional systems of filial (having to do with son or daughter) obligation and care have maintained some degree of stability and consistency for many years. Palmore's work, *The Honorable Elders* (1975), and Palmore and Maeda's, *The Honorable Elders Revisited* (1985), stresses the significance of family and strongly emphasizes that "familism" is a way of Japanese life, as it is in many other Asian family systems. By comparison with the "individualistic West", the Japanese family is far more integrative in relating the older generation to the young, which evolved from the centuries-old Confucian concept of filial piety or obligation.

According to this doctrine, the younger generation "owes" the older generation because since birth, everything has been done for the children by the parents. The expected way of repayment is to give care and assistance to their aging parents under the same roof until their death. It seems, many, if not all, aged Japanese expect to be looked after by their own children, preferably by the family of the eldest son (Palmore, 1975, Palmore and Maeda, 1985, Ogawa and Retherford, 1993).

Also, the unusually high incidence of co-residence (Rogers, Watkins, and Woodward, 1990) in Japan partly reflects the persistence of Confucian "moral prescriptions" about filial obligation to parents. Customarily this is the duty of the eldest son, if there is one, and usually the son's wife plays the role of principle caregiver. Reinforcing Confucian tradition are legal requirements of familial

support of the elderly that still exist in Japan, although they are rarely invoked. In this respect also, Japan is unusual, as such requirements have been abolished in most other industrial nations (Ogawa and Retherford, 1993).

Because women are the primary caregivers for elderly parents, or parents-in-law, changes in the status of Japanese women have had a great impact on care of the elderly. Educational attainment of women has been rising in Japan over the last few decades (OECD, 1992a; Statistics Bureau, Management and Coordination Agency, 1986). As a result, there has also been a major shift in female participation in the work force, away from farming and unpaid family work to paid employment outside the home; among married women aged 20 to 49, the proportion working as paid employees rose from 13 percent to 42 percent between 1963 and 1990 (Loscocco and Kalleberg, 1988; OECD, 1993b; Richman, 1990). During the same period, the proportion working as family workers decreased from 13 to 10 percent (Ogawa and Retherford, 1993).

These changes in women's education, work outside the home, increased public support for the aged in the form of pensions and medical coverage, and legal changes have collectively worked to weaken family obligations to elderly parents. Consequently, public and political support for community-based services within Japanese communities has recently increased and is continuing to rise (Powell and Anesaki, 1990; OECD, 1992a; United Nations, 1994; Kinoshita, 1994). Although it is more common in Japan for the elderly to live with other family members, family caregiving is on the decline which has augmented the substitution of family care services for formal services. If current trends in

family caregiving persist, as they are projected to, community-based support for the care of Japanese older adults is likely to continue.

UNITED STATES

THE U.S. HEALTH CARE SYSTEM

The United States is the only advanced industrial nation that has no single nationwide system of health insurance or universal coverage. In the U.S., employers voluntarily provide health insurance coverage to their employees and dependents; government programs are confined to the elderly, the disabled, and some to the poor. These private and public health insurance programs all differ with respect to benefits covered, sources of financing, and payments to medical care providers. There is little coordination between private and public programs. Some people have public, private or both public and private insurance while others have neither. Approximately 14 percent, or 35 million Americans have no health care insurance whatsoever (De Lew, Greenberg, and Kinchen, 1992; Friedman, 1992). Nevertheless, some of those without health insurance are not entirely without health care. Although they receive fewer and less coordinated services than those with insurance, many of the uninsured receive health care services through public clinics and hospitals, state and local health programs, or private providers and by shifting costs to other payers (Freeman et al, 1992).

In recent years, health care reform has been at the top of many public agendas however, little has been accomplished in the actual implementation of a universally accessible health care system. On the whole, health care reform in

the U.S. has focused on controlling rapidly increasing financial expenditures for health care at the federal, state and local levels. Despite these efforts, health care costs continue to escalate (Schneider and Guralnik, 1992; OECD, 1992a). The resulting pressure on public, private, and individual budgets keeps the issue of controlling health care costs high on the public agenda.

HEALTH CARE INSURANCE IN THE U.S.

Basically, there are three types of health care insurance that can be obtained: private, Medicare, and Medicaid. It is of the latter two that I want to briefly discuss. Medicare, *Title XVIII* of the *Social Security Act*, was enacted in 1965 and was designed to provide health insurance to all persons aged 65 and over. Administered by the federal government, it is the single largest health insurer in the country, covering about 13 percent (31 million) of the population, including virtually all of the elderly 65 years and older, and certain people with kidney failure (Torres-Gil and Douglass, 1991; Pearman and Starr, 1988).

Medicare's coverage of important components of the continuum of long-term and community services is limited. With few exceptions, Medicare does not cover home and community-based long-term care services. Medicare covers an extremely small percentage of nursing home and home health care costs (Kane and Kane, 1987; Rabin and Stockton, 1987; Achenbaum, 1986). Furthermore, because of the lack of funds put toward long-term care, "only the frail elderly aged 65 and over are even eligible for personal services; since Medicare does not cover custodial services alone, whether at home or in an institution, most

functionally older people are not served under the program (Olson, 1994b, p. 30)."

Unlike Medicare, Medicaid is a means-tested program that is limited to low income individuals. Medicaid, *Title XIX* of the *Social Security Act*, was also enacted in 1965. The original intent of the program was to serve as a third party insurance program to help pay for medical care for low-income persons. It covers preventive, acute, and long-term care services for about 10 percent (26 million) of the population (De Lew, Greenberg, and Kinchen, 1992). Nearly all public funding for long-term care is provided under the Medicaid program, which is designed and administered under general federal guidelines. The national government contributes between 50 and 80 percent of the costs (Pearman and Starr, 1988). The original intent of Medicaid was not to provide significant amounts of long-term care for the elderly. Yet, by 1990, the elderly represented nearly 20 percent of the 26 million Medicaid recipients and about 40 percent of the programs total expenditures of $70 billion (Pepper Commission, 1990, p. 30). It has been estimated that expenditures will continue to increase, the majority made up of nursing home costs. Unfortunately, to qualify for coverage under Medicaid, the elderly must meet restrictive income and asset eligibility standards, which for most people means exhausting all of their resources (Olson, 1994b). Also, pressure to contain growing government costs over the last two decades has led to a reduction in Medicaid and Medicare benefits and other programs serving the elderly, including more stringent eligibility requirements and caps on reimbursement rates (Binstock, 1993, Pearman and Starr, 1988, Olson, 1994b).

DEVELOPMENT OF COMMUNITY-BASED SERVICES

In an effort to curtail spiraling costs of institutional services in the late 1970s and early 1980s, national and state political leaders began to search for alternative, less costly ways of providing for publicly supported long-term care. Accordingly, policy makers turned their attention to in-home and community-based services. Limited federal funding became available primarily for home-care demonstration projects under several programs, including amendments to the Social Security Act (Title XX), Medicaid (Section 2176 Waivers), and the Older Americans Act (OAA) (Torres-Gil and Douglass, 1991; Olson , 1994b; Achenbaum, 1986). The overriding goal of these programs was to demonstrate whether the cost of providing community-based services would be less than that of nursing home care. "Given this perspective, policy makers have been interested in cost-based questions rather than in the quality and effectiveness of services (Olson, 1994b, p. 36)." According to the OECD and several other studies, community-based care services seem to be the cheapest alternative to institutional and other formal care services for the elderly. However, according to Benjamin (1985), home care services have not significantly replaced nursing homes in the U.S. primarily because it has not been proven, just supposed, that the former save costs.

Most importantly, community-based assistance, such as home care (social and health services), respite services, especially day care (adult day care did not even exist in the U.S. prior to 1970 -Olson, 1994b), has been inadequately funded (Jamieson, 1992; Furukawa and Shomaker, 1982; OECD, 1992a; Rabin

and Stockton, 1987). On the whole, the United States has extremely fragmented and limited publicly supported in-home or community-based services. At the same time, home care in the private sector has dramatically altered. Over the last decade, the U.S. has witnessed the growth of for-profit homemaking and home health agencies (including home nursing) in this previously nonprofit field. Furthermore, nonprofit agencies have been increasing charges, including co-payments, eliminating "free care" for those with limited income, and reducing or eliminating less "profitable" programs and services. Thus, the insufficient number of public services will be felt even more acutely in the next several decades by those who cannot afford to
buy them if this trend continues.

HEALTH AND LONG-TERM CARE FOR OLDER AMERICANS

Despite health care reform legislation initiated within the past ten years, the United States has yet to develop a comprehensive national policy for long-term care. One of the main reasons put forward to explain the lack of the initiative to develop such policy measures is that the issues and problems of old age are private problems requiring private solutions. According to Olson (1994b, p. 28), "The American ethos of individualism and self-reliance, and the policies based on these, presuppose that individuals and their families should and will provide for their own social, financial, and service needs."

In addition to family assistance, the preferred methods of self-support for the elderly, well or impaired, include the encouragement of personal savings, private

pension plans, and more recently programs such as private long-term care insurance and Home Equity Conversions. Policy makers argue that by expanding their capacity to pay, the aged will be able to purchase the services they need in the private sector (Kane, 1994). However, according to conclusions drawn from a major study conducted by Rivlin and Wiener (1988), at best only a small minority of older Americans will ever be capable of meeting their long-term care needs through their own efforts alone. Expanding inflation rates and inadequate pensions are rendering many people's retirement planning insufficient. The vast majority of the elderly will require some form of supplementary help or care.

Moreover, the combination of a reliance on individual resources and a welfare approach to public support (Medicare/Medicaid), as noted by Rivlin and Wiener (1988), has fostered a "two-class system of elder care." Formal in-home and community-based services, in particular, are concentrated among the economically privileged. Since there is a difference between real needs existing in the community (societal demand) and the ability to pay for appropriate services (market demand), a large percentage of older people with limited income are not able obtain community-based services. The Brookings Institution has estimated that long-term care costs will probably escalate faster than the cost-of-living. Therefore, the elderly will be even less able to afford community-based services in the future and community-based services appear to be the most cost-effective option in long-term care (OECD, 1992a; Jamieson, 1992; Olson, 1994b; Furukawa and Shomaker, 1982). Unfortunately, the availability of

care in the U.S. is largely dependent mostly on costs, who pays for them, profitability, and other factors unrelated to the actual service needs of the elderly.

FAMILY CARE AND OBLIGATION IN THE U.S.

Studies show that families in the United States provide around 80 percent of all long-term care. Most of the burden of care is provided by a family member who is traditionally a female; women represent over 70 percent of all caregivers (Brody, 1990, p. 35). One difference in the United States with family caregiving is that many older adults, whether they prefer care by family members or not, have little or no choice for care alternatives because public resources are scarce and private options are costly.

Family members, in general, and women in particular, are not only the major caregivers in the U.S., but also studies show that the vast majority prefer to provide such care rather than to institutionalize their relatives. Both older people and their families strongly resist nursing home or other institutional placement, viewing it only as a last resort after other alternatives have been tried.

The question is whether American women can continue to provide nearly all the long-term care in the future. "Paradoxically, the family is expected to provide even more caregiving in 1990s and beyond, when it is least able to do so (Olson, 1994b, p. 43)." There are several unique features of contemporary society that contribute to the unfeasibility of greater amounts of elder care by adult children, especially daughters, or even spouses. One of these features is the consistent rising rate of female participation in the work or labor force. In the United States,

the percentage of women in the work force has steadily climbed from 38 percent in 1950 to over 70 percent in 1994 (OECD, 1993a). Another feature is that lower fertility rates and childbearing at later ages have meant a decrease in family size, with fewer children available to share caregiving responsibilities. Also, more elderly parents are surviving for longer periods and to older ages. Caregiving children as well as spouses are also increasingly in advanced age themselves. As society continues to change in structure and size, family caregiving situations are likely to become further complicated.

In general, American older adults value their personal independence and autonomy. Most individuals strive to maintain their own residence for as long as possible. At the same time, they do not want to become a burden to their adult children. Older people move in with their children, primarily daughters, only when it is no longer possible to live alone (Brody, 1990). American elderly tend to prefer "intimacy at a distance" (Rosenmayr and Kockeis, 1963).

Overall, due to the high costs of community-based and in-home services, many caregivers in the U.S. do not have a choice about whether or not to assume full responsibility for elderly relatives. Caregiver burdens and excess stress can also lead to antagonism in the relationship between the older person and family members which can also lead to elder abuse. It is very possible that an increase in the availability, accessibility, and use of formal community-based services could actually enhance the relationship between caregivers and care recipients as well as contribute to the latter's dignity (Olson, 1994b; Heumann and Boldy, 1993b).

SUMMARY OF KEY POINTS IN CHAPTER ONE

DEMOGRAPHIC SIMILARITIES

A "gerontological explosion" in the proportion of the elderly in the populations of the industrial countries will likely have an effect on social, economic, and health care policies well into the next century. Comparative figures for population aging, together with their recent and foreseeable evolution, show that the 60 and over age group has grown from 11 percent to 17 percent in 40 years and is expected to increase by another eight percent in the next 30 years, attaining a proportion higher than that of the steadily diminishing under age-15 group (Chasteland, 1990). This change in demographic structure is projected to occur relatively faster in Japan and in Germany (Masson, 1990; United Nations, 1994). More importantly, the majority of the growing elderly population is most likely to consist of a high proportion of those 80 and older, or the "oldest old." Since older adults need and use a disproportionately higher amount of care services, this increasing subgroup is likely to place great demands on the availability and provision of care services.

SOCIAL WELFARE POLICY FOR THE ELDERLY: COMPARATIVE ASPECTS

Not surprisingly, one of the primary differences among nations is where the locus of responsibility for care resides. Therefore, although in the 1990s all of the countries that I have focused on have become seriously concerned with the rising costs of supportive services for the elderly, they diverge on the question of who should (or will) bear the costs and who should bear the primary

responsibility for care. They also vary on the issue of who, if anyone, will profit from the service division.

The American cultural emphasis on individualism and self-reliance, which lies on one end of the spectrum, fosters privately provided support, whether by the family or paid caregivers. Public spending to heal social ills, including elder care, tends to be severely constrained. Moreover, state-supported programs often become stigmatized due to such factors as restrictive income eligibility tests.

At the same time, the privatization of human services brings the profit motive to the forefront. Therefore, access to services in the U.S. is often based on the ability to pay, resulting in large imbalances between need and availability of care (Olson, 1994a). Where the public sector funds "proprietary care", accountability and the quality of services may be negatively affected as well.

Societies with more "collectivist" approaches assume that increased need for assistance, medical or social, among the aged is a social problem engendering social solutions, not solely medical solutions. For example, Sundstrom,Thorslund, and Johannson note that in Sweden, the public sector is responsible for its dependent older population. Health care in Sweden is presumed to be a "right." The individual or the family is not expected to shoulder the entire burden of care. In addition, although medical and social welfare services are available to all sectors of society, the elderly tend to be one of the more important target groups.

In the U.K., despite collectivist social security norms and an entitlement approach to health care, the state plays a relatively minor role in the direct

provision of long-term care. For these services, the national government relies on "residualist social welfare models (Hunter, 1993)." The family is the preferred caregiver, programs are developed only to fill gaps when family and kin are not available.

Walker and Warren (1994) indicate that until recently the public sector in Britain dominated for-profit and nonprofit organizations in the delivery of formal services. Since 1979, and the emergence of the Thatcher and Major governments, the for-profit sector has grown at the expense of publicly supported care. According to these authors, the promotion of greater privatization ensued and further engenders challenges to basic values underlying the British welfare state.

The German welfare system utilizes the "subsidiary principle": the public sector intervenes only when individuals and their families are incapable of providing for themselves; however, the dividing line for when the state is supposed to intervene is unclear. Although the entire German population is now covered under health insurance, there is no similar provision for long-term care. In fact, the voluntary sector is primarily responsible for the organization and delivery of formal services, with the economically needy subsidized by the state.

The Japanese style of welfare avoids both self-reliance and individual dependence on privately contracted services. Although the nation acknowledges social obligations to older people, based on Japanese communal values, it places primary responsibility for their care on the family institution.

Recent efforts to initiate public policy supported assistance entail a unique blend between the state and the private economic sector.

MEDICAL CARE, SUPPORTIVE SERVICES AND THE SOCIAL CONTEXT OF CARE: COMPARATIVE ASPECTS

Objectives for long-term care services vary considerably among nations. Aid can focus on the caregiver, the care recipient, or both. As addressed by most of the literature on care for the elderly, especially Kane and Kane and Rabin and Stockton, successful long-term care entails a continuum of interrelated health and social services as well as a supportive environment.

Social welfare policy in Sweden appears to reflect the importance of these interconnections more than in any other nation. Both medical and social services are highly subsidized by the state and utilized by a significant percentage of older people. On the other hand, Sweden's health and support benefits are funded and administered separately.

Japan is also attempting to develop additional and improved linkages between medical treatment in hospitals and clinics and supportive services, including preventive health measures, for its elderly population.

Many nations, including the U.S., Britain, and Germany focus primarily on medical treatment for those individuals experiencing a diminishing capacity for self-care. Moreover, the evidence suggests that there is a relatively rigid separation in these countries between social services and health care. Heinemann-Knoch (1994) points out that this separation of health care and

caregiving in Germany, for example, has generated greater dependency among older people than their conditions would warrant.

Public funding for the elderly in the U.S. is mostly provided for the medical aspects of long-term care needs, and even these are both narrowly defined and severely constricted. In Britain, the costly NHS is state-run and state-funded; the more modest social services are a local responsibility financed through a mix of national and local sources.

HOME AND COMMUNITY-BASED SERVICES: COMPARATIVE FEATURES

Countries differ considerably in their commitment to provide in-home and community services for the elderly. In the U.S., recent efforts to maintain older people at home have been motivated primarily by financial considerations, and have been accompanied by few public sector dollars. In many other nations, monetary inducements similarly have motivated a strong interest in non-institutional forms of care. However, an underlying goal similar in the U.S., Sweden, Germany, Japan, and the U.K., is the growing determination to avoid premature or unnecessary institutionalization and to allow the elderly to remain in their own communities for as long as possible.

Swedish health and social welfare services originally had been geared toward institutional care. Sundstrom and Thorslund (1994) advise that the priority placed on community and home services over the last decades is due both to economic and humanitarian factors. Significantly, frail older people in need of services are eligible for them regardless of whether or not they have relatives

capable of caring for them. Approximately one-fifth of the aged in Sweden receive some home assistance (Johansson, 1991; Olson, 1994a; Tornstam, 1991; Thorslund, Norstrom, Wemberg, 1991) for which they pay only a fraction or none of the cost.

While community care also has been favored by successive postwar governments in Great Britain, in actuality these services have been subordinate to institutional interests, particularly in funding levels. Walker and Warren (1994) argue that the policies of the Thatcher era finally succeeded in promoting community care, however, the primary goals have been to control costs rather than to improve the quality of care.

In Germany, social service units, *Sozialstationen*, which developed during the 1970s, deliver in-home services for all needy individuals, regardless of age. Such assistance ranges from nursing care to neighborhood activities, and is funded through a combination of state and local subsidies, health insurance, social assistance, voluntary agencies, and client fees. However, according to Heinemann-Knoch (1994), despite their extensive network and growth in actual services, these programs are not yet able to fully meet the need of growing numbers of older people, especially the frail elderly and the poor.

FAMILY CAREGIVERS: INCREASING BURDENS ON WOMEN

Although the barrier between the formal (public) and informal (individual/family) sectors of society is the most clearly defined and rigid in the United States, "it is slowly becoming more demarcated in some of the social

welfare states; elder care is increasingly relegated to the discrete domestic domain (Olson, 1994a, p. 13)." Furthermore, support for community care and greater demands placed on women may be inextricably linked (Olson, 1994a; Tornstam, 1989; Ogawa and Retherford, 1993).

The majority of this chapter has indicated that many nations confronting rising social welfare costs are placing increased obligations on family members, primarily women, for caregiving tasks. One of the common features of the five countries is the gender-based accompaniments of growing elderly populations: each nation, though to a varying extent, has relied on and increasingly expects women to provide such services to older family members. "Family care is usually a euphemism for female care (Kane and Kane, 1990, p. 341)." Moreover, not only have more females added care of the elderly in addition to their reproductive and productive (paid work outside the home) work, but these efforts have been undervalued and taken for granted. However, the actual concepts of dependency and caring tend to be perceived diversely in different societies. Due to recent demographic, economic and structural changes within the family, family caregiving, in particular with respect to female carers, is increasingly being viewed by policy makers as being in crisis. There is serious pressure mounting to address this issue as concerns continue "about how much of a service burden these women can maintain in addition to their other commitments as mothers, wives, and workers (Kane and Kane, 1990, p. 341)."

Independent living, especially among the chronically ill, is highest in Sweden where decent public pensions, quality housing provision, and increases in home

and community-based services have increasingly allowed elderly people to cope on their own. Nevertheless, interdependence between the generations and the growth of independent living among the generations can occur simultaneously. According to Johansson and Thorslund (1991a), Sundstrom and Thorslund (1994b) and Tornstam (1989), family ties have strengthened in Sweden; in many respects, the immediate family plays a more important role in the life of elderly family members than in the past.

In Japan, household structure has changed in the direction of relatively fewer stem households and relatively more nuclear households. Between 1960 and 1990, the proportion of the elderly aged 65 and over living with children fell from 87 to 50 percent, a level still much higher than in the other industrial countries (Ogawa and Retherford, 1993, p. 587). According to one international comparative survey conducted in 1990, the proportion of the elderly aged 60 and over living in three generation households (elderly parents live with children and grandchildren) was less than one percent in England, slightly more than one percent in the U.S., three percent in Germany, but 32 percent in Japan (Management and Coordination Agency, 1991). Furthermore, only about 10 percent of the Japanese elderly live alone. These comparative data indicate that changes in co-residence patterns in Japan have lagged behind changes in underlying and demographic conditions.

An additional feature in the dominance of family caregiving that is receiving more attention is the issue of caregiver burden and ensuing "elder abuse". Due to the stress and pressures, financial and emotional, often placed on family

caregivers, there has been a growing emphasis to avoid or prevent these burdens from growing into antagonistic relationships between caregivers and recipients. According to several authors, it seems that one of the most advantageous solutions is to promote the substitution of some family care services for paid care services, such as community-based and home-based care (Olson, 1994a, Ogawa and Retherford, 1993; Johansson and Thorslund, 1991a). According to these authors, some substitution is already occurring, to varying extents, in Sweden, Japan, and Great Britain and Germany.

Changing population demographics and the decreasing availability of women as caregivers, coupled with the recent trend to allow the elderly to remain in their homes and to "age in place", are likely to continue placing a demand for increased services, especially community-based services, that allow the elderly to remain independent in their own communities even in extreme old age.

CHAPTER TWO
COMMUNITY HEALTH SCIENCE PERSPECTIVE

INNOVATIVE COMMUNITY-BASED AGING PROGRAMS AND STRATEGIES

Countries differ considerably, especially in the last two decades, in their commitment to in-home and community-based health care services for their elderly populations. Many of these differences arise from the motivations of the individual country's health care delivery system regarding elder care and who or what sector is given the responsibility for care of the aging. Differences also arise when comparing the cultures of the medical profession in each country, especially how health care is viewed as either a right, a privilege or a commodity. In addition, the rise of community-based services for the elderly has been driven by the recent inability to assume that primary reliance for care can be provided by family caregivers. Due to economic and social changes, this presupposition that families "ought" to provide the bulk of care for the elderly, while it may remain true in some instances, simply cannot be assumed.

This chapter will focus on particular health care programs for older adults in Sweden, Germany, Japan, and Great Britain that are both innovative and community-based. More specifically, I will concentrate on programs that have been successful in their respective country and provide a brief description of how the programs function. My examination will include a breakdown of community-

based health care services including in-home assistance, such as home health care, and more formal services, such as primary health care services.

The programs selected for examination were classified according to the model illustrated in Figure 11. The model represents the interrelationships among various factors influencing the provision of community care programs with

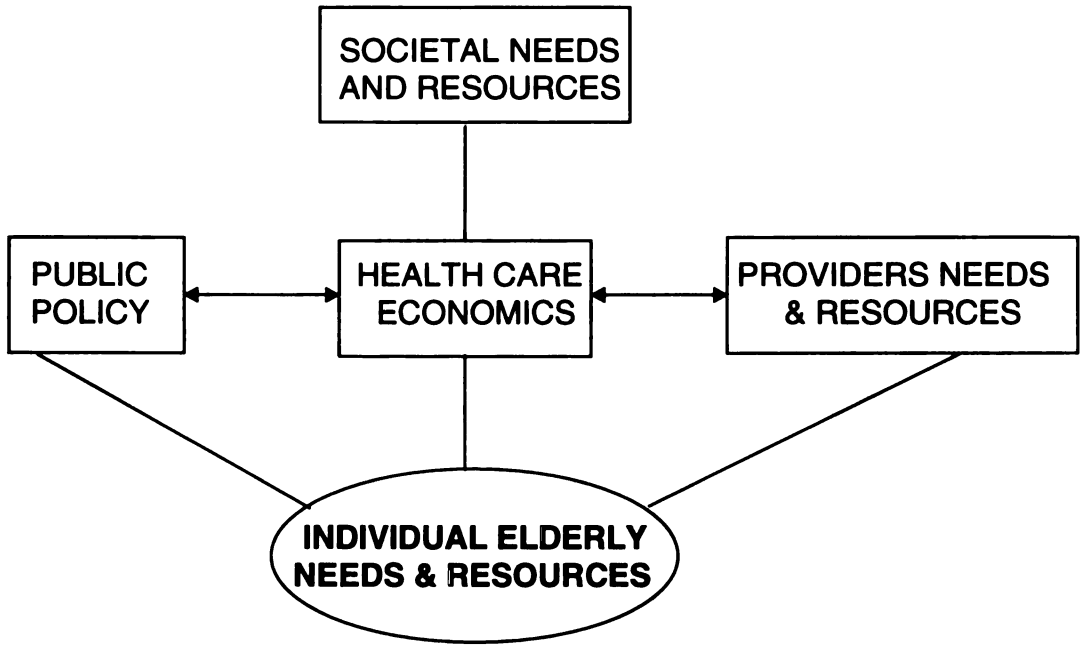

Figure 11 - A model of relationships among factors influencing the provision of community-based care for the elderly.

societal needs and resources at the top level. The health care economics of each country is an intermediary between public policy and provider needs; these factors interact with the individual needs and resources of the older adult to influence the provision of community-based care. These factors, in

combination, can work in a positive direction to increase the availability of services and access to health care programs. At the same time however, these factors can work against each other and prove to be obstacles to overcome in the development of successful community care services. Nevertheless, all of these factors relate mutually to each other and must invariably be taken into consideration when analyzing the success of community care programs. All of these factors were taken

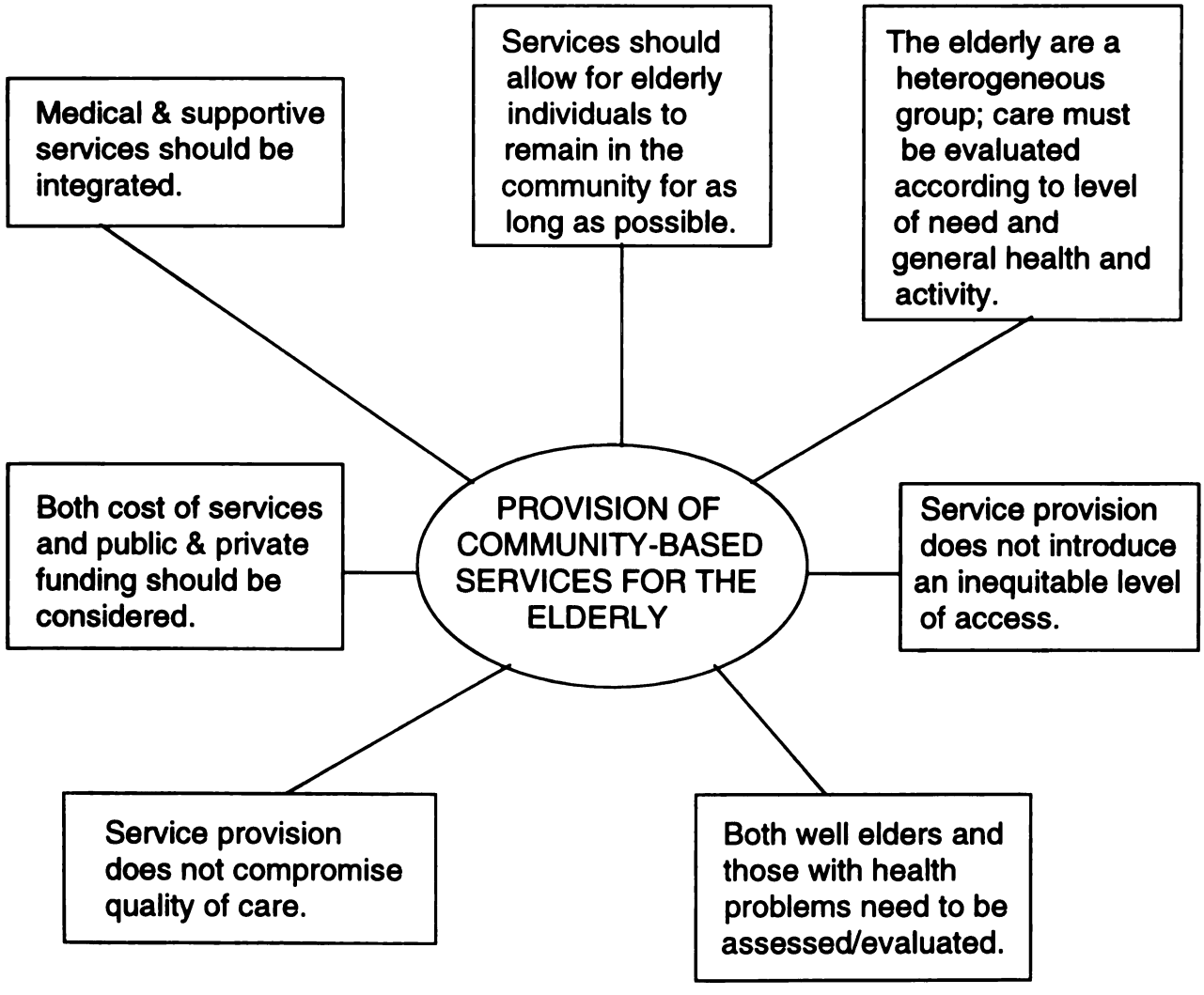

Figure 12 - Quality and value constraints on providers of community care to the elderly.

into account to determine the relative fruition of the individual programs; this model was very useful in comparatively examining aging programs according to each country. Moreover, the community care programs were evaluated on how well they adhered to particular quality and value constraints on provider needs as indicated in Figure 12. These elements were crucial in the identification of the innovating aging programs and in the determination of the relative success of each program based on the model in Figure 11.

IN-HOME ASSISTANCE

Home-help assistance is without a doubt the core community-based service enabling older people to remain at home and is one of the most widely used in all industrialized countries. According to Jamieson (1992), the "essence of home care is that it provides help with all the activities of daily living that people are unable to perform, whether through illness or, as more common in older people, through general frailty (p. 883)." There are, however, two categories of in-home assistance: *social home care* and *home health care. Social home care* deals with chore or homemaking services such as laundry, cleaning, cooking, and other aid for home maintenance, personal care, and meal deliveries (Meals-on-Wheels). Conversely, *home health care* involves the provision of medical or health care services such as medical treatment, physiotherapy, and nursing, usually by a nurse, physician or other allied health professional, to those elderly who find it difficult, due to frailty, physical disability, or other logistic reasons, to receive care in a facility-based setting. However, not all home health aides

would fall under the heading of a "professional health care worker;" in some areas, home health aides are empowered to perform tasks that elsewhere would fall within the jurisdiction of practical nurses. Although my primary focus is on home health care, I will also include some social home care services , for example, nutrition services, that overlap with those under the main rubric of "community-health care."

Home Health Care:

Since a 1988 governmental proposal in Sweden with the basic idea that services and care for the elderly should be "moved" to the patient and not vice-versa, there has been an extensive support system set up to provide home care services (Johansson and Thorslund, 1991a, p. 38). Approximately 15 percent of the Swedish elderly use home care services (home health and social home care combined) at some point in their lives (Johansson and Thorslund, 1991a).

Together with home help services and the work carried out by relatives, home nursing is seen as the most important element of home health care. In Sweden, it is unusual for general practitioners to make home visits, so district nurses are the main providers of home health services (Thorslund, Norstrom, and Wernberg, 1991). The remarkable aspect about the district nursing program, and home health care in general, is that any elderly person, who expresses need or is referred by a physician, has access to home health care, whether by a district nurse or nurse's aide. Irrespective of where the elderly person lives or to which social class or age group belonged to, the entire elderly population may demand

and receive the same qualified resources and treatment; economic obstacles to an individual's use of the health services are virtually removed.

Other changes in the home help role include giving home health aides the responsibility for performing "simple" home nursing functions, for which the home help service is reimbursed by the health service (county medical authority). This is more cost-effective than sending out a district nurse to fill every health related need (Johannson, 1991; Nusberg, 1984). In addition, home help aides are being taught to help clients help themselves (self-care) in order to maintain maximum independence (OECD, 1992a; Thorslund, Norstrom, and Wernberg, 1991).

Unique to Germany, social service units known as *Sozialstationen* have been created through the initiative of the private sector which solely used to organize the provision of home care services. As a result of the reorganization of the 1970s aimed at providing more effective professional home care, "catchment areas" were defined; this meant that one organizational unit, or *Sozialstationen*, administered by a social welfare organization, delivered in-home services to the elderly, sick and well (Heinemann-Knoch, 1994; Nusberg, 1984; Jamieson, 1992). The available services include family welfare, nursing, care and treatment of elderly and ill persons, homemaking, Meals-on-Wheels, neighborhood activities, and several social services. Funding is now from an admixture of private, public and voluntary sources. Given the federal nature of the German governmental structure, there is no one model for a *Sozialstationen*. Each state has its own concept of what coordinated service delivery should

involve. Although services are available to clients of all ages, in practice, the elderly constitute 70 to 90 percent of the clientele (Heinemann-Knoch, 1994).

The advantage of the *Sozialstationen* service stations is that they facilitate the coordination of in-home health and social assistance services all under one roof. In general, these agencies consist of offices with telephones, where administrative work is done, clients call in, and a mobile staff of trained nurses, caregivers for older people, Home Helpers[1], social workers, semi-skilled helpers, and volunteers are at hand to be sent out at all hours of the day. German researcher Dieter Grunow believes that about two-thirds of the people served by *Sozialstationen* would have to move to an institutional setting if the home care they received were stopped (Grunow, 1984).

In recent years, there has been a slight decline in the ratios of German family help to formal aid: home care services appear to be replacing family care to a limited extent (Presse-und Informationsamt, 1990). Care by in-home services has been increasing since about 1985; in 1990 there were about 4000 "social service stations" (*Sozialstationens*) in the FRG, plus about 400 in the new states of the FRG (Heinemann-Knoch, 1994). Although home care services are increasing in Germany, there is a growing shortage of personnel and issues need to be confronted concerning low-wages for professionals and "burn-out" effects. Measures aimed at better recruitment and improved training are currently underway, yet efforts to increase pay rates and standardize professional training for the non-medical staff have been slow going.

As explained in chapter one, Japan places a great deal of responsibility for the care of elderly individuals in the hands of the family and relatives, not only for care but for housing as well. For many years past up to the present, the Japanese government has offered tax deductions, housing allowances, and other attractive benefits to children and relatives for taking care of elderly family members. Nevertheless, according to a study by Ogawa and Retherford (1993), "in contrast to norms of care for elderly parents, expectations of old-age support from children have steadily declined over time, adapting to changes in underlying socioeconomic and demographic conditions (p. 585)." Consequently, the Japanese government has changed from placing the burden of care to the families and has instituted a major effort to take responsibility for some of this care through governmental strategies and programs for the aging. The government is trying to transform the Japanese care system of the 1990s as one identified as a "community-based care system, open to the family institution, to the state bureaucracy, and to entrepreneurial efforts (p. 254)."

As part of a ten year welfare strategy, Japanese policy is aimed at increasing the number of professional helpers[2] and home care services[3], for both health and social care, available to accommodate elderly people in the future. The "home care service ten year plan" provides for the increase of about 31,000 jobs to 100,000 for Home Helpers (Anme, 1993). Ten thousand day service centers and 10,000 Home Care Support Centers will be built in the near future to aid the elderly and their caretakers (Nishio, 1994). Currently, Japan has over 400 *Home Care Assistance Centers* which dispatch professional home assistance

personnel for medical treatment, nursing care, or other assistance needed within the home. The Japanese *Home Assistance Centers* combine both social and medical (health care) services in one "service center" to avoid overlap among caregiving duties.

According to hospital and health expenditures provided by the OECD, institutional care in hospitals, nursing and residential homes has never been an important part of the British way of caring for elderly people. In particular, the U.K. does not use hospitals and medical facilities to care for the aged to the same extent as some other industrialized countries[4]. This comparatively low use of hospital facilities is partly an indication that the U.K. has a well developed system of public home care services. Although not all home care services are extremely well organized and accessible, home nursing seems to be one of the more successful home health care services provided by the local health authority (Baldock, 1991a; Robinson, 1993). Elderly people living at home are most likely to receive home health care from a "district nurse." These are qualified nurses who often work in teams together with support from junior nurses and auxiliaries. Most district nurses are attached to general practitioner (GP) practices and approximately 70 percent of the visits follow a referral from a GP; home nursing is a service provided free of charge upon a physician's recommendation. In some local districts, physicians and home nurses share a common clientele in order to facilitate the exchange of information between the two. For the most part, home health care services in the U.K. remain largely based on means tests,

income eligibility, and demonstration of need (referral). This means that not all British elderly have access to district nurses.

Consequently, there is increasing evidence of the setting up of private, for-profit care agencies, often by former nurses and social workers. Since the late 1980s, private agencies have opened up offering a wide variety of health and social services. It is argued by Baldock (1991a) that this trend will develop as "more of the British elderly retire on generous pensions, as the reservoir of informal carers shrinks for demographic and employment reasons, and as the public home care services target their resources more selectively (p. 55)."

Perhaps the most sophisticated form of community home health care is probably the "hospital-at-home" (Warner, 1993; Nusberg, 1984) which is currently being tested in the U.K. Practically all forms of hospital care, except for surgery, can be made mobile and brought to the elderly patient's home if needed. According to the OECD (1992a) and Warner (1993), "hospitals-at-home" cost less than full hospitalization and may often be considered desirable over hospitalization in certain circumstances, for example, where older spouses have been taking care of each other and hospitalization of one may precipitate a sudden deterioration of the other who has been left at home.

The best known of these "hospital-at-home" schemes is the *Peterborough at Home Scheme.* With an introduction of what was effectively a system of case management, whereby a district nurse takes overall responsibility for coordinating care and can, when necessary, call any extra help needed, the scheme demonstrated that non-emergency patients can be offered care of

hospital quality and at a slightly lower cost. The psychological benefits to the patients and families have so far been considerable. The average age of the people helped by the scheme was 71 and the average length of care was less than 17 days (Baldock, 1991b).

OTHER EXTENDED FORMS OF COMMUNITY-BASED HEALTH CARE ASSISTANCE

Sweden and the U.K. have made considerable use of a program of "alternating care" for elderly persons who have difficulties living independently. This type of care has been successful in sustaining frail persons in their homes who would otherwise be institutionalized (OECD, 1992a). These persons spend short periods of time in health care institutions receiving therapy and care, alternating with longer periods in their own homes receiving community care. The successive periods of intensive care and regular supportive care are designed to ensure that the elderly person can continue to remain in his or her own home as long as possible. On-going coordination is necessary between housing, health and social service funding and administration for the duration of alternating care (Davies, Bebbington, and Charnley, 1990). Housing allowances are paid to the elderly person to maintain the home during the institutional visits. Regular assessments are made of the individual's needs at the health care institution; the recommendations for support services are carried out by community care agencies (OECD, 1992a).

Additionally, the Japanese government has introduced several measures to address problems in long-term care for the elderly. One community-based step was to introduce a new type of intermediate care facility for the aged, called *rojin hoken shisetsu* or the *Health and Medical Care Facility for the Aged* (Phillips, 1992). With an emphasis on rehabilitation programs and community-based health care assistance, these facilities are expected to facilitate smooth transition from general hospitals to living at home.

Furthermore, the United Kingdom has pioneered in "day hospitals" for the elderly in an attempt to separate the social (custodial) from the medical aspects of care (Robinson, 1993). Day hospitals provide medical care and rehabilitation while permitting patients to return home in the evening. They are used by people recently released from hospitals or by persons seeking to avoid hospitalization. Day hospitals can be free-standing but are typically situated in a hospital or nursing home. This program also provides opportunities for socializing, and sometimes the line separating day hospitals from other forms of day care becomes quite thin.

PAID FAMILY CAREGIVING: HOME HEALTH AND SOCIAL CARE

Another unique aspect of in-home assistance in Sweden is that family care for elderly relatives is often state-supported. If health care needs (according to a physician's statement of need for care) for the elderly individual or individuals can be adequately met by a family member or relative, the family member has the option of claiming economic support from the county or municipality.

Furthermore, in special cases, for example when the older person needs more or less constant care due to an acute or chronic illness, the family member can be employed by the municipality or county as a "personal carer" (Johansson, 1991). To be employed as a family carer does mean, however, that you have to leave your regular job, with no guarantees about getting it back. The "personal carer" policy, includes paying caregiving salaries to family members when caregiving is a regular job, providing labor market training to salaried caregivers when their personal caregiving experience ends, and service support policies that call for more community-based outreach programs to provide services to caregivers and help alleviate their burdens. The Swedish Red Cross has taken the initiative in providing short training courses in care of the elderly to family members and other interested individuals (OECD, 1992a; Nusberg, 1984.) The caregiver salaries are available to relatives who provide at least 20 hours of care per week. These salaries are equivalent to those paid by home health care agencies and are provided by the Swedish government as taxable income with benefits including vacations and pensions (Gerald, 1993). Hokenstad and Johannson (1990b) found that there were more than 10,000 salaried family caregivers in Sweden.

Sweden also encourages home health support from family members as implemented by a "paid care leave" policy through the *1990 Care for the Elderly Bill;* this policy reflects Sweden's commitment to family caregiving. The "care leave policy," recently enacted in 1992, in contrast with the long-term "personal carer policy," entitles family members to take time off from work and be paid an

insurance allowance for up to 30 days to care for an elderly relative (Gerald, 1993). Since the paid leave is limited to 30 days in the lifetime of the individual receiving care, this is not meant to be used for ongoing caregiving situations but for more acute illnesses.

Generally, the availability of services and home care for the elderly, free or heavily subsidized, is being extended in Sweden. For example, the numbers of home help provided for the elderly and handicapped has increased from 35 million in 1969 to over 93 million in 1988. Furthermore, the number of home help recipients has more than tripled since 1964 (Cates, 1993; Tornstam, 1989). Due to these types of services, Sweden has achieved a 34 percent overall reduction in institutionalization from 1970 to 1985 (Cates, 1993).

Another program, which is not as comprehensive as home health care policies in Sweden and Germany, is one found in Great Britain. Referred to as the "Invalid Care Allowance (ICA)," the U.K. program takes the form of a regular allowance to an elderly person, who is separately entitled to an Attendance Allowance. The Attendance Allowance is a universal entitlement program to which any qualified elderly person (must show need for assistance) has a right, regardless of income. This allowance is paid directly to the care receiver who may or may not choose to use it to purchase care. But if a care receiver does get this allowance, their caregiver can apply for a separate ICA. This benefit is paid to those who give up full-time work in order to care for an ill elderly family member (Baldock, 1991a; Gerald, 1993).

NUTRITION PROGRAMS

One of the most essential programs, although not directly a "health care" or "medical" service, for the health maintenance of older adults is the delivery of or provision of meals or other nutrition services. Proper nutrition is one of the best preventatives of poor health regardless of age, but becomes increasingly important as a person ages. Furthermore, good nutrition is a major determinant of both good health and recovery from illness and surgery (Furukawa and Shomaker, 1982; Chernoff and Lipschitz, 1986). Therefore, it is important when looking at community health care services for the elderly that nutrition services be addressed since they are so crucial in health prevention and promotion in the elderly.

Lunch clubs or meals in a congregate setting (gathered together) and Meals-on-Wheels are considered important "social care" programs as opposed to "health care" programs, although they do have vital roles in good health care maintenance. Meals-on-Wheels programs are more common than meals in a congregate setting in most countries (the reverse is true, however, for the United States). The one similarity that was found was that the U.S., Germany, Sweden, U.K., and Japan all have a type of home-delivered nutrition program identified as "Meals-on-Wheels." This program seems to have a universal label for home-delivered meal services regardless of the diverse cultural differences. Volunteers are widely employed in meal delivery in the U.S. and Germany.

An interesting variation on the U.S. congregate meal setting can be found in Stockholm, Sweden where meals are offered at midday in school cafeterias; the

meals are printed everyday in local newspapers so that the participants can exercise some choice. In addition, the locations of the meals in the schools also holds promise for intergenerational contacts (Johansson and Thorslund, 1991b).

Studies also show (Nusberg, 1984) that in the U.K., especially in England, Meal-on-Wheels recipients are not notably impaired as far as food preparation abilities are concerned (Johnson, di Gregorio, and Harrison, 1992; Baldock, 1991b). Many could probably benefit more from assistance with shopping or delivery of raw food ingredients rather than fully prepared meals. In response to this, the Catering Research Unit in Leeds, England has experimented with providing other meal options to clients, including the delivery of long-life food and cooking on the part of the recipient. The consumer reaction to these experiments has been good according to Baldock (1991) and Walker and Warren (1994); users are happy to be able to prepare their food at a time of their choice and to their own tastes. According to British researcher Malcolm Dean, such meal options "proved to be a highly effective adaptation of the desired compromise between prepared food and the flexibility of timing and sense of achievement (Johnson, di Gregorio, and Harrison, 1992, p. 124)"

Germany, where over 10 percent of the elderly receive Meals-on Wheels (Heinemann-Knoch, 1994), was one of the first nations to experiment with the delivery of frozen meals that had to be warmed up by the recipient. It was found that frozen meal delivery not only cost one-quarter of hot meal delivery, but it permitted the delivery of meals on weekends as well, when hot meal systems usually shut down (OECD, 1992a). In addressing the objection that frozen meal

delivery cuts down on personal contacts with the recipients, the response is made that friendly visiting can compensate for whatever loss in socializing that might result. Agencies delivering meals at home in Germany seem to be moving towards the frozen meal alternative, even providing recipients with a small freezer if they do not have one.

PRIMARY HEALTH CARE/AMBULATORY COMMUNITY-BASED PROGRAMS

In recent years, a growing emphasis has been placed on the medical and health establishments to increase the availability of and access to a diverse array of primary health care services, including health prevention and promotion, for the entire population, especially the elderly. Meeting the health needs of an expanding elderly population will require attention to the overall structure of primary health care services and how these services are delivered at the community level. Overall, according to several sources, four principles of "good" primary care for the elderly have been identified:

1. To help elderly people prevent unnecessary loss of function.
2. To help elderly people prevent and treat health problems which adversely affect quality of life in old age.
3. To supplement the care given by neighbors and friends and try to prevent the breakdown of informal support systems.
4. To help elderly people have a good death as well as a good life (1-4 adapted from Freer and Williams, 1988; Almind, Freer, Gray, and Warshaw, 1983).

This section illustrates a few specific programs, representing these principles, that deal successfully with community-based care primary health care services for the elderly. Obviously, it would be quite a large task to identify all of the

successful programs in the chosen countries due to the broad nature of the field of primary care, so certain programs have been recognized that seem to be promising and may be of use for elder care in the United States.

In Japan, the main programs of community-based primary health care that are currently in place were implemented by the Japanese municipal governments according to the *Health Care Law for the Elderly of 1983.* This law set up an overall system of community-based measures encompassed in one program for health prevention and care as follows (adapted from Anme, 1993):

- *Provision of a health handbook.* The handbook functions as a recipient card for medical services received by persons over the age of forty.[5] It records results of medical check-ups, medical care, health counseling, and visiting guidance. In addition to its record-keeping function, the health handbook also contains information on good health practices.
- *Health education.* Lectures and classes on diet, health promotion, and prevention of geriatric illnesses are offered for persons over the age of forty.
- *Health consultation.* Again, for persons over the age of forty, doctors and public health nurses are available to counsel individuals on health-related subjects.
- *Medical check-up.* Medical check-ups are available to screen patients suffering from circulatory diseases and those at high risk of becoming ill. Check-ups cover medical interviews, physical-therapeutic checks, and tests of other areas. As necessary, home visiting check-ups are conducted for the bedridden or infirm elderly. Early detection checks are of a particular priority, especially for cancer.
- *Medical care.* For persons over the age of forty and those with disabilities, a community rehabilitation program is available in the event of adverse after-effects being suffered following a stroke or other attack.
- *Provision of medical treatment fees.* Where an elderly person is admitted to a health care institution, then the local municipality has the responsibility of meeting the cost of medical treatment.
- *Home-visit advice.* Nurses visit the homes of elderly persons who have functional disabilities or need assistance and provide advice about care to both the elderly person and caregivers.

The cost for the various community-based health care provisions for the Health Care Law for the Elderly program is shared between the national and municipal governments, with some of the medical check-up expenses being met by the recipients.

Another extremely innovative element that seems to be crucial to "good" geriatric primary care is the use of multidisciplinary comprehensive geriatric assessments in the primary care setting (Nelson and Berwick, 1989; Solomon, 1988). Basically, a comprehensive geriatric assessment culminates in the generation of an all-inclusive list or evaluation of the patient's health status, needs, strengths, and disabilities. Many different domains are evaluated such as functional status, health status, physical impairment, and mental and psychological state.

In Sweden and the U.K., geriatric assessment teams have been established to improve the quality of primary health care delivery to older adults, not only in the hospital setting but also in community-based clinics and, when necessary, home-visits (Nusberg, 1984; OECD, 1992a). Particularly, geriatric assessment teams have been extensively used in Sweden to rule upon all applications for institutional care to avoid unnecessary institutionalization. These interdisciplinary teams have been effective in diverting many older people from institutional forms of care, allowing them to stay in their homes with appropriate community services.

THE USE OF NONTRADITIONAL PERSONNEL AND VOLUNTEERS

In addition to home help services, the U.K. is well known for its volunteer organizations that play a significant role in the provision of personal care services to the elderly. There is a long tradition of volunteering in Britain; particularly among certain sections of the middle classes, contributing some of one's time to participation in a voluntary organization is almost a cultural norm (Davies, Bebbington and Charnley, 1990; Baldock; 1991a). The U.K., in fact, has emphasized "good neighbor schemes" in recent years, through which neighbors are encouraged to provide "unobtrusive" services such as watching over older people living alone in their block. This, in turn, sometime leads to the provision of more direct services, such as friendly visiting. More importantly, such schemes provide a "safety net of information and contact for those who have fallen through the web of social and health care services provided by statutory and voluntary services (Nusberg, 1984, p. 124)." It seems that these types of programs are more likely found in neighborhoods where many women do not work full-time outside of the home (OECD, 1992a; Nusberg, 1984). The hope is that good neighbor schemes will take some pressure off the public social services and provide needed early warning systems.

In addition, Japan has been one of the few countries that has been able to develop a reliable and successful volunteer network for elderly caregiving services. To supplement professional Home Helpers, many individual volunteers and groups of volunteers offer services to assist the elderly who express a need for assistance at home. In fact, there has been a sharp increase in both the

number of volunteer groups as well as in the number of volunteers since 1988 (Nishimura, 1993). These volunteers are without a doubt significantly reducing the need for personnel for care of the elderly (Ando and Searight, 1993).

Rural areas in Sweden also make extensive use of postmen to "reach out" to isolated older persons. The postmen are trained by health and social services departments in the variety of benefits available to older people. They are then in a position to communicate this information to their clients while delivering the mail and at the same time check on their well-being. If something seems wrong, they can then report back to the appropriate authorities. Postmen may also be used to deliver medications and food and help in snow removal. This innovative use of public servants in duties beyond their traditional roles is now being emulated in Germany. The U.K. also utilizes milkmen, who still deliver dairy products on practically a daily basis, to perform similar early warning functions.

Although much of the success of these individual programs is due to their basic adherence to the factors and elements listed in Figures 11 and 12, the levels of accessibility, funding, and cost effectiveness vary by country. Figures 13 and 14 provide a short summary of the community care programs introduced in this chapter as well as a brief description of the function of each particular program.

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[1] The title of "Home helper", aside from home health care professionals and aides, is considered a profession in Germany. Many Germans, especially women, choose this option as viable lifetime career, either full or part-time.

[2] In Japan, professional home helpers are given equivalent status to Japanese nurses. As Japanese nurses, almost 100 percent women, are not yet recognized as an established profession, they are regarded as assistants to physicians and are treated as such.

[3] Initially in Japan, home help had been available only to low-income elderly households. In 1982, however, the scope of the home-based care program was enlarged to cover all elderly persons in need of such services, with the recipient either paying according to income or covered by the National Health Insurance System.

[4] The industrialized countries with the highest rates of institutionalization include: Canada, 8.7%, Finland and Ireland, 8.0%, Netherlands, 10.9%; Norway, 8.9%; Sweden, 8.7-10.5% (OECD, 1992a). The U.K. has a rate of less than 4%. These rates include institutionalization of the elderly in medical and non-medical facilities. One reason for such high rates in Sweden is that this range includes those elderly living in service apartments which are independent living units supplemented by community care services.

[5] The Japanese government believes in an early health promotion approach to geriatric illnesses.

	Sweden	Germany (unified)	Japan	Great Britain
Type of Health Service Delivery System	Insurance/Social Security; Health care under compulsory social-ized health insurance; guaranteed consumer good or service. Backed by public financing.	Universal national health insurance - Health care as a state mandated public service grounded in a social contract and sickness fund. Supported by public/priv.contribution	Insurance/Social Security; Health care under mandatory health insurance; guaranteed consumer good or service. Supported by public/private contribution	National Health Service - Health care as a state supported consumer good or service. Physicians are state employees. Supported by public taxation.
INNOVATIVE AGING PROGRAMS **Home Health Care**	District nursing provided for any older adult in need of services.	Sozialstationen social service units coordinate and provide home health and social services to well and sick elderly persons.	Home Care Assistance Centers combine both social and medical services in one dispatch "service center"; Successful volunteer network.	District nursing available to elderly individuals with a physician referral or to those who meet eligibility requirements; Hospital-at-Home;
Other Forms of Community-Based Extended Health Care Assistance	"Alternating care" programs; Use of rural postmen to reach out to isolated older adults.		"Intermediate Care Facility for the Aged" provides rehabilitation and community-based services.	Good neighbor schemes; "Alternating care" programs; Day hospitals provide medical care and rehabilitation.
Paid Family Caregiving	Personal carer program for long-term caregiving; Paid care leave for short periods.			Invalid Care Allowance (ICA) for full-time caregivers.
Nutrition Programs	Meals-on-Wheels; Congregate meals in a school setting.	Meals-on-Wheels delivery of frozen foods.	Meals-on-Wheels.	Meals-on-Wheels delivery of raw/long-life foods.
Primary Community-Based Health Care Services	Use of comprehensive geriatric assessment teams in home & hospital settings.		Health prevention and care program set up by Health Care Law for the Elderly of 1983.	

Figure 13 - Summary of innovative aging programs in selected countries

Sweden	**District Nursing**: Main providers of home health services administered to any elderly individual who expresses need or is referred by a physician. **Alternating Care Programs**: Elderly patients readjust to independent living after a hospital stay by spending short periods of time in health care institutions receiving therapy and care, alternating with longer periods in their own homes receiving community care. **Use of Postmen**: Rural areas make use of postmen to reach out to isolated older persons. **Paid Family Caregiving**: A family member has the option of claiming economic support from the county or municipality if they can meet the needs of an ill or disabled elderly relative. **Midday Lunch Club**: Meals served in a group setting are offered in school cafeterias and menus are printed in local newspapers. **Comprehensive Geriatric Assessment & Teams**: Conducted usually by a team of health care professionals; an evaluation of an elderly patient's health status, needs, strengths, and disabilities to aid in the development of a plan of care.
Germany	**Sozialstationen**: Service units that coordinate and provide home health and social services to well, sick, and disabled elderly within specified catchment areas in the community. **Meals-On-Wheels**: In addition to regular meal service delivery, an option is provided to those who wish to receive frozen meals.
Japan	**Home Care Assistance Centers**: Coordinate both medical and social services in one dispatch service center to elderly in the community who express need for medical treatment, nursing care, or other assistance. **Volunteer Network**: Individuals and groups of volunteer networks offer services to assist older adults and supplement professional home helpers. **Health Prevention & Care Program**: A series of community-based primary health care measures in one program for health prevention and care for those individuals aged 40 and over.

Figure 14 - Description of community-based aging programs according to individual country.

Figure 14 (cont'd).

Great Britain

District Nursing: A home health service provided by the local health authority free of charge to elderly individuals with a physician's referral; administered by qualified nurses who often work in conjunction with a general practitioner's practice.

Hospital-At-Home: Hospital services and care, except for surgical procedures, are made mobile and administered in the elderly patient's home.

Good Neighbor Scheme: In residential areas, neighbors are encouraged to provide unobtrusive service such as watching over older adults living alone on their block; schemes often lead to friendly visiting and telephone reassurance.

Alternating Care Programs: Elderly patients readjust to independent living after a hospital stay by spending short periods of time in health care institutions receiving therapy and care, alternating with longer periods in their own homes receiving community care.

Day Hospitals: Provide medical care and rehabilitative services to elderly patients recently released from hospitals or by persons seeking to avoid hospitalization while permitting them to return home in the evening.

Invalid Care Allowance (ICA): A family caregiver can apply for a separate monetary allowance to receive benefits if he/she gave up full-time work to care for an ill elderly family member.

Meals-On-Wheels: In addition to regular meal service delivery, an option is provided to those who wish to receive raw food ingredients to prepare their own meals.

CHAPTER THREE
INNOVATIVE COMMUNITY-BASED STRATEGIES: POLICY IMPLICATIONS AND APPLICATIONS FOR THE UNITED STATES

The United States government has often been criticized for its lack of commitment to the needs of elderly residents, especially with the recent controversies of possible means testing for Medicare and implementation of managed care systems. "It is one of the ironies of U.S. public policy that, in promoting individualism and self-reliance, the structural arrangements tend to foster dependency (Olson, 1994b, p. 50)." Although statistics from the Department of Health and Human Services show that the U.S. does make available an "adequate" amount of community-based services such as home nursing, Meals-on-Wheels, and other home health care assistance, a great majority of these are for-profit or restricted eligibility services, meaning that most American elders do not have access to them.

This chapter will focus on what implications or applications that the specific community-based programs, identified in chapter two, or principles of care, illustrated in Figures 11 and 12, could have for the United States in the near future. In other words, by looking at the historical development of health care, in the U.S. and in the other selected industrialized countries, can the U.S. learn anything from looking at other community-based models or paradigms of health care and social policies?

My goal, however, is not to provide a critique of the inadequacies or shortcomings of American health care and social welfare policy and services, but to examine if the various community-based programs developed in other economies might work if transferred to or implemented in the United States. It is important also to recognize that, while financial considerations will always be a hindrance to any policy decision, it is almost impossible to provide a complete analysis addressing both cost factors and implementation; my main focus is on the latter. By exploring what other industrialized countries are doing for the care of their elderly populations, it is more than possible that the dialogue about creative policy alternatives open to Americans in dealing with their own elders could be enhanced.

THE PROVISION OF HOME HEALTH CARE

In Great Britain and Sweden, district nursing is seen as one of the most critical functions for elder care in the community. Realistically, it is not possible for the United States to provide such services to *all* older adults in need unless a universal plan of health care is implemented. As stated earlier, while there are some nursing agencies that provide health care to older residents within their own homes, most are for-profit agencies or have strict eligibility requirements, thereby making the services inaccessible to most elderly individuals.

Again if funding is obtainable, the idea of sending a district nurse, health visitor, or nurse's aide to an older person's home upon request seems very advantageous in coordinating and providing needed services to older adults or

even to supplement informal caregivers. Although in Great Britain, *every* elderly person is assigned a district nurse or health visitor regardless of need, it seems that the U.S. could use multidisciplinary assessment to determine if home nursing is needed for that particular patient. Although this would make the service accessible only to a select group, perhaps the target group could be those at highest risk for institutional care.

Conceivably the single best strategy that the U.S. can learn from the home health care experience in Sweden and the U.K., in addition to the continuity of care, is the remarkable interaction between the main primary care providers and ancillary home health professionals. In fact, district nurses and health visitors often work in the same primary care setting as the general practitioner and both health care providers share the same patients. Of significance in the U.S. is the lack of communication between home health care providers and the elderly individual's general practitioner or main physician. Often, the interaction between the medical establishment and community care providers ends with a referral for need of services. The quality of care received and attention to specific problems of the older person most likely would greatly improve if there were a common link and greater interchange between home care providers and physicians.

Furthermore, home nursing, as in the case of Sweden and the U.K., also provides for a vital contribution to the link between primary care and informal carers. In the U.S. however, less attention has been paid to improving connections between the formal and informal networks, including informal carers

in the "macro/mega geriatric team approach". No doubt, in many individual situations relatives are able to communicate freely and appropriately with nurse or general practitioners, but there is a need in the U.S. to provide for a systematic approach to refine this connection. Not only does better communication make sense, but also the burden of responsibility cannot always lie with the home care providers and nurses or the health care team. Self-care also has made a significant contribution in this and other age groups, and informed self-reporting would help to shift the doctor-patient relationship from the traditional and often paternalistic model to one in which the elderly patient and relatives have a more equal partnership.

PRIMARY HEALTH CARE/AMBULATORY COMMUNITY-BASED PROGRAMS: CASE MANAGEMENT

Along the lines of care coordination and case management, the U.K. and Sweden's use of geriatric assessment teams is a model that some American medical facilities are trying to emulate. Recently, it has been acknowledged that primary health care teams, as opposed to uncoordinated individual health care professionals who have little or no interchange, are very advantageous when dealing with elderly patients. As Nelson and Berwick (1989) have pointed out, comprehensive geriatric assessments which measure different functional levels are increasingly being considered an essential measurement tool for needs assessments for older adults; this is especially true in the primary care setting.

A simple "macro-team" might involve a general practitioner, a nurse or nurse practitioner, and possibly a social worker or case worker. Beyond these individuals, a wider network might include various specialists, pharmacists, physiotherapists, and many others. It seems that primary health care and hospital settings in the U.S., although very busy sites, could make use of these types of assessments on a routine basis. Although many insurance companies do not currently reimburse health care providers for time taken to perform written or oral geriatric assessment tests, the assessment seems, at least in Sweden, to play an essential role in the evaluation of a patient's health and daily assistance needs, the development of a plan of care, and the actual implementation of a plan that is best suited to the individual needs of both the patient and family. The way primary health care teams operate needs to reflect a more complex yet realistic approach to the day-to-day conditions and demands of primary care than earlier more simple models. It is also noted by Papsidero (1994), Berwick and Nelson (1989) and Freer and Williams (1988), that the use of geriatric assessment and team evaluations is crucial in monitoring change over time, thereby improving the identification of those at risk for institutionalization or other assistance needs.

For the United States, to succeed in keeping elderly people in their own homes as long as possible may require not simply an increase in resources, but also changes in the way existing and possibly new resources are used. Also sometimes called the *augmented home care* model, team approaches and evaluations have received surprisingly little publicity and attention. The essential

features of this model, as used in the U.K. and Sweden, is that older people who have an acute problem or crisis and would probably be admitted for institutional care are seen quickly for a multidisciplinary assessment, and whatever resources are required to maintain the individual in his/her home are provided without delay. This may not require additional resources, but may require existing health and social service staff to be involved in a way that is different from their usual practice.

EXTENDED FORMS OF COMMUNITY CARE ASSISTANCE: COORDINATION OF SERVICES AND INTERMEDIATE FORMS OF CARE

Germany and Japan have both found a solution to coordination problems that commonly occur between health care service and social care service providers. The use of social service units, or *sozialstationens*, in Germany and *Home Care Assistance Centers* in Japan, have greatly reduced the confusion among service providers, families of the care recipients, and the care recipients themselves. With the coordination of both in-home health and social care services, these agencies arrange and provide services to elderly residents within their target community. This way, services can cater to the particular and individual needs of older community residents. Also, when nominal fees are involved, they can be based on the financial constraints of each area.

The lack of coordination of and the fragmentation of the American health care delivery systems seems to be one of its most extensive problems. The U.S. has no single unit that is responsible for the provision and delivery of community-

based care services. From the successful response from policy makers regarding the use of integrated coordinating centers, it would seem that the United States could make use of Japan and Germany's continuum of care models. If funding, federal or local, is obtainable, then it seems feasible to develop "one-stop" service centers which offer a wide range of services at one site. While there may be multiple points of entry into the system, elderly clients could be served by one case coordinator, responsible for assessing needs, coordinating a program of care, and organizing the delivery of services using whatever local resources are available, from family and friends to volunteers and trained service providers. The ultimate goal would be to "minimize dependence and to foster the maximum degree of independent functioning (Kahn and Kamerman, 1976)."

American elders can utilize to some degree the *Area Agency on Aging*; these agencies are community organized centers, located in various counties in the U.S., which coordinate services however, access is limited to those who are referred by a health care professional and pass the "needs evaluation" screening. Therefore access to services is confined to a small quantity of the total population. Furthermore, the *Area Agency on Aging* does not provide the services themselves; they "purchase" the services from other nonprofit service agencies. But as many nonprofit agencies have recently enforced stricter eligibility requirements and means tests or have turned into for-profit agencies, the availability of services has become increasingly restricted.

While cost effectiveness and efficiency are sure to be primary motives in the development of such coordination agencies thereby making eligibility restrictions unavoidable, it seems that it would be possible, through proper geriatric assessment, to target the provision of community care for those elderly individuals at high-risk for institutionalization. Also, the use of sliding-fee-scales could also help reduce some of the financial backlash created by the implementation of such programs.

If such service coordination centers were developed in the U.S., dissemination of information about available services and entitlement regulation would have to be a top priority. A systematic attempt to develop guidelines and educational material would allow older individuals and their relatives to have more a detailed idea of services available, and how and when to request them. Unless information is made available and accessible, not only to older adults, but also to their families who are involved in decision-making, members of the community, physicians, nurses, and other health care providers, the services would not reach those who truly were in need of them.

Programs which provide services that allow an elderly individual with either an acute or chronic illness to spend part of their treatment in an institutional or formal setting and an alternating period receiving home-delivered community care services seem to hold much promise for the U.S. These programs, often called *alternating care* programs, offer a wide range of services and help to minimize dependence among older patients even when they are suffering from multiple ailments. Sweden and Great Britain have both successfully

implemented these schemes and studies have shown that they have helped to reduce the rate of institutionalization in both countries (Cates, 1993). Japan has also recently introduced *intermediate care facilities for the aged*, similar to American assisted living complexes, which provide both medical, rehabilitative, and community care to those elderly recently released from an inpatient stay at the hospital. Similar to the programs in Sweden and U.K., these services facilitate the transition from hospital stays to independent living again in the patient's own home. In addition, British *day hospitals* provide similar services of medical care and rehabilitation during the day while allowing elderly residents to return home in the evening; *day hospitals* are analogous to a "medical and rehabilitative day care."

Often, in the U.S., patients upon leaving a long or short-term stay in a hospital have difficulty returning to independent life, so these types of alternating care programs could equally be successful as in Great Britain and Sweden. It seems feasible that intermediate facilities could be established within the hospital itself or as another institutional structure, where patients could receive therapy and care, alternating with longer periods in their own homes receiving community care. In Great Britain and Sweden, housing allowances allow the elderly person to be away from their homes for short periods of time. Again, for the U.S., if those at highest risk for institutionalization are targeted, the elderly person can continue to remain in his/her own home as long as possible.

The *hospital-at-home*, which is currently being tested in Great Britain, is probably the most complicated and least feasible of all of the identified programs.

Logistically, it seems that the provision of hospital procedures, aside from surgery, within an elderly person's home would cost more than going to the hospital site. The OECD (1992a) and Warner (1993), however, indicate the contrary; *hospitals-at-home* cost less than full hospitalization. Also, historically, "house calls" are routinely made by British general and family practitioners and nurses which is the reverse in the case of the United States; physicians rarely make house calls in urban areas, although they are more prevalent in rural parts. Partly due to this reason, the implementation of the *hospital-at-home* scheme does not seem practicable in the U.S. Also, American elders, it seems, tend to feel more "safe" and reassured if hospital procedures requiring a physician's presence, even for simple procedures, were performed in the hospital itself and not in the patient's home.

PAID FAMILY CAREGIVING

Paid family caregiving is a difficult concept to grasp within the historical context of America's health care system and its general themes of individualism and self-reliance. The family is, for the most part, expected to shoulder the burden of informal care for their elderly family members, while at the same time take care of all other regular life activities such as child-rearing, home maintenance, and employment. As indicated earlier, the burden of care usually falls hardest on female caregivers.

Great Britain and Sweden have made extensive use of paid family caregiving as a means of supplementing informal carers. Sweden especially has

implemented paid leave programs that are both efficient, convenient, and extremely well organized: the *personal carer program* for long-term caregiving, and *paid care leave programs* for short care periods. If funding were attainable, it seems that these types of programs would greatly reduce not only the financial burdens that many family caregivers suffer, but would also reduce emotional stress as well. If the U.S. allocated adequate amounts of money to full-time family carers, these individuals, as in Sweden and Britain, would be more comfortable in their decisions of how to divide their time between caring for an older family member and other life activities. Furthermore, taking off time from work to care for an ill elderly relative for a short period of time would be made much easier if the carer was monetarily reimbursed for his/her time. Additionally, paid family caregiving would provide incentives for family members to care for an elderly family member within the home rather than to look for a more convenient or formal alternative, such as institutionalization. Although the literature on paid family caregiving in Sweden and Britain does not indicate if there is any abuse of this liberal program, it is likely to be of concern for the United States.

NUTRITION SERVICES IN THE COMMUNITY

Along with Sweden, Great Britain, Germany, and Japan, the United States has a *Meals-on-Wheels* program in virtually every community. The delivery of food service in the U.S., however, differs from most other industrialized countries in that the staff is composed primarily of volunteers. More importantly,

congregate meals are much more prevalent in the U.S., while home delivery of meals is more popular in other countries.

Sweden's implementation of congregate meals in school cafeterias is an exceptional idea not only to provide a change of scenery for participants but also to encourage and preserve intergenerational contacts. Congregate meals in the U.S. are usually served in senior centers or other recreation centers. If space in school cafeterias were available and it did not interfere with the daily routine/schedule of the school, it seems that this program could be implemented without much difficulty.

It also stands to reason, following the example of Britain, Sweden, and Germany, that the delivery of long-life and raw food materials and frozen foods would be extremely efficient and convenient for those who are able and prefer to prepare their own meals. These types of food services are only likely to become prevalent in the U.S. after a thorough cost-analysis study which documents that these alternatives are more cost-efficient and effective compared to the standard *Meals-on-Wheels* services.

THE USE OF NONTRADITIONAL PERSONNEL AND VOLUNTEERS

Both Japan and Britain have benefited greatly from extensive networks of group and individual volunteers. This is one potential source of personnel for care of the elderly that the U.S. seems to be lacking in. Aside from the need for increased resources, the U.S. should look to Japan as a model for mobilizing volunteers to perform simple tasks, tasks that do not need to be performed by a

nurse or home health care professional, thereby increasing cost-efficiency. Moreover, the use of *good neighbor schemes* in Britain are not difficult to implement, although they do require a sense of "being neighborly", a trait that that many might argue is not reflective of Americans (Weaver, 1976). Nevertheless, it is possible that *good neighbor schemes* are already in place in the U.S., although not as extensive as in Great Britain, through the church or in close knit neighborhoods where everyone is familiar with each other and aware that elderly people live among them who might need assistance or a friendly visit periodically.

Over the last century, informal care has frequently developed into more formal volunteer services and some of these, for example, Meals-on-Wheels, have been absorbed into health and social services. There is renewed interest, however, in the potential of volunteers, and the elderly are an obvious target group. At the same time, with a growing retired elderly population, the many fit elderly could be an important source of volunteers. Hopefully the volunteer sector will continue to expand at the grassroots level, but it is important to appreciate that no services are ever totally free of cost. Training and administration are as important to volunteer activities as to formal services, and these costs can be substantial.

In addition, the U.S. might consider experimenting more widely with the use of non-traditional personnel, such as postmen, in reaching out to the elderly. Although this idea does not seem very feasible given the immense numbers of people that individual postmen serve and that they rarely approach individual

homes, it is possible that in more rural areas, where postmen are familiar with the individuals on their routes, they could "reach out" to isolated older persons and check on their well-being from time to time. Volunteer networks also need to be increasingly established and mobilized. Neighborhoods could be mobilized successfully, as has been the case in the U.K., to watch over vulnerable elderly or those living alone and provide a needed early warning system.

Policy makers need to invest resources in new forms of community-based care that maximize the potential of older Americans. As pointed out by Kayser-Jones (1981), care must be provided in such a way as to show elderly residents that "we value them as human beings." A profit-making environment is unsuitable for the development of such facilities. Those elderly who need assistance cannot age with dignity unless they receive respect and public support as a right. This would allow older adults to have maximum choice in their living arrangements. "A sense of control over one's life is essential for maintaining personal integrity, and should be supported by public policy to the fullest extent possible (Olson, 1994b, p. 51).

Over 90 percent of public Medicare and Medicaid funds put aside for long-term care still accrues to nursing homes in the U.S. (Olson, 1994b). While institutional care may be necessary and even beneficial in some cases, it must be seen as an alternative to community supports, not as a primary means of care.

In the absence of a comprehensive and affordable health care system for younger generations, a large majority of Americans enter middle and old age vulnerable. At the same time, the lack of affordable, quality supportive services for the elderly has engendered greater expectations of and burdens on the family. Public policy must recognize the social, economic, and health needs of the entire society and realize that the reality is that improved care for elderly individuals will have important implications for other generations as well.

SUMMARY AND CONCLUSIONS

Despite problems that the selected countries have experienced, they have made some remarkable achievements in the care of their elderly populations. Most already have 16% or more of their population in the 65 and over age group, a situation the U.S. will be approaching *very* soon, and are coping with the situation in a rational and benevolent manner. Sharp discontent, among the elderly for lack of resources is rarely found. The universal availability of benefits in the cases of Germany, Japan, the U.K., and Sweden, permits needs to be met on the basis of functional criteria, and the fact that such benefits are usually available to all age groups regardless of income level increases the political support available for health and social services. Perhaps a reason that community health programs, and universal health care services in general, have never obtained adequate political support in the United States is that they have never been perceived as services required by potentially everyone at some point in their lives.

The implementation of community care, and health care policy in general, is difficult and expensive, and the health care systems of other countries are, in many ways, as fraught with problems as the United States. Escalating costs, inadequacies in coverage, and personnel shortages are common throughout the

industrial world. Nevertheless, the experience of other countries still holds important lessons for the U.S.

Perhaps the most significant is that it is possible to shape a health care system which provides *almost* everyone access to quality care regardless of income level at a total systems cost no larger than the present U.S. expenditure for health care. And, by and large, the countries discussed already have considerably larger proportions of older people in their populations than does the United States.

How is this accomplished? In the U.K., an underlying social philosophy created the base for the "welfare" state. In Sweden, Germany and Japan, the "welfare" state emerged more gradually as a result of many pragmatic considerations. It just seemed simpler and more cost-effective to provide for the needs of everyone through one bureaucratic structure, the government, than to create numerous bureaucracies, public and private catering to clients eligible for benefits on the basis of differing criteria. In Sweden, the private, for-profit sector is hardly at all involved in the health and social care system, for both historical and ideological reasons. This notion is one that is likely to change as for-profit service agencies expand along with the aging population and the need for services, and as pensions continue to remain generous. Aside from Germany, a main theme reflected by the U.K., Sweden, and Japan's policies and programs is that profit motives are not thought to mix well with social care needs (Nusberg, 1984).

There is little question that other countries have been more willing to fund health and social care services at a more generous level than has been the case so far in the United States. This is reflected, for example, in the much higher availability elsewhere of home help and other community-based services. A higher value set on public responsibility for fellow citizens, especially the elderly, explain much in the greater willingness to be taxed in other industrialized countries. All of the countries discussed, aside from the U.S., give a significant role for the public sector in providing or insuring care and a negligible role for the for-profit sector, especially in providing long-term care. However, at the same or smaller cost (calculated as a percentage of GNP) (OECD, 1993a), other countries have been able to provide a broader range of services and higher quality institutional care than the U.S. Such services include home nursing, health visitors, chiropodists, the loan of special aids and equipment, day hospitals and specially trained staff to deal with the long-term care needs of elderly people. While examples of many of these services can be found in the U.S., many only exist ad hoc, experimental, or on a demonstration basis. In some countries, such services are commonly available to everyone in need and at little, if any, out-of-pocket expense to the client. Need, rather than financial means, is the major criterion for service eligibility. People are not required to become bankrupt or spend their children's inheritance to have their long-term care needs met, whether in a community or in an institution. Fees, where they are charged, are based on an "ability to pay" basis. Such policies reflect a recognition that chronic illness afflicts rich and poor alike. To be sure, countries

may be able to provide such services only at the expense of other kinds of health provisions.

These differences are highlighted by the fact that cost effectiveness and efficiency has not been at the forefront of European and Japanese policy discussions regarding the extensions of community-based services, as they have been in the U.S. The possibility that home care *might* end up costing more (or less) than institutional care was considered a risk worth taking in favor of permitting elderly individuals to stay in their own homes and preserve age-integrated societies. It is only relatively recently, as other countries have begun to experience hard times economically, that serious research into the cost-effectiveness of community-based ("open") and institutional ("closed") forms of care have been undertaken.

While American taxpayers may not wish to fund health and social care services to the same extent that they are supported in some other countries, there is still much this country can do to streamline existing efforts. The fragmentation in the service delivery system and lack of coordination in the provision of services so common in the United States does not exist to the same degree in most other industrialized countries. Systems have been put in place in Japan, the U.K., Sweden, and Germany which can provide a readily accessible continuum of care. This has been achieved in almost all cases by the public sector's taking the lead in both providing services itself and coordinating the efforts of voluntary agencies along with its own, to assure that a full range of services is provided to its elderly residents. Responsibility for the provision of

services usually rests with local government. The national governments set policy guidelines, provide much needed financial aid, and monitor program implementation. Japan and the U.K. especially have an interest in preserving a strong voluntary sector; non-profit agencies obtain large public subsidies to perform functions the government would otherwise have to provide.

Various institutional mechanisms have been developed to assure easy access to health and social care systems, such as unified or collaborative medical and social services departments like in the U.K. Many of these institutional mechanisms developed in the selected focus countries provide simple access in one location to a fairly comprehensive range of services. At the same time, as in Sweden and Japan, there are multiple entry points into the system.

Income tests are widely used to help defray the costs of health care services in the U.S. however, they are also used to a limited extent in other industrialized societies. While services may be "free" to the very poor, others pay according to their ability. Fees are nominal in most countries, but they certainly hold the potential for providing a fair way of sharing costs between consumers of services and taxpayers. In many areas of the U.S., where older persons cannot obtain services and even though they can pay or contribute towards them, it seems that more consideration could be given to providing publicly-supported community services on a sliding-fee-scale basis, which can be adjusted according to a community's financial circumstances.

If cost factors remain a primary consideration, another approach might be to limit eligibility for the range of community-based services to those at risk of institutionalization. It seems that, along with the use of multidisciplinary and comprehensive geriatric team assessments among primary care patients, that such individuals could be identified with reasonable precision. This would also be beneficial if home health care and other community services are found to be less costly than institutional alternatives. On-going case management assures that community care functions are appropriately allocated and coordinated among family and neighbors (if available) and volunteers and the public health and social care services.

While hard evidence is sparse regarding the effectiveness of community services in preventing unnecessary institutionalization, they certainly are widely believed to be effective, and countries continue to place high priority on their expansion. An eye to economy is leading some to consider utilizing existing long-term care facilities to deliver services to the community dwelling elderly to maximize the capital investment made in these institutions (OECD, 1992a; Nusberg, 1984). Certainly, the experience of multidisciplinary geriatric assessment teams, where they have been created to determine the actual need of applicants for institutional care, has been that many applicants do not need this intensive level of care and can continue to manage in the community with appropriate supports. The effectiveness of such teams is, of course, predicated on the availability of adequate community services if alternatives are recommended.

The availability of "at risk" registers on which all older persons who are vulnerable for health reasons are inscribed, annual visits to persons over 65 or 70 years of age by health visitors, and the mobilization of youth, neighbors, postmen, and volunteers are, in addition, relatively inexpensive ways of monitoring the well-being of frail older persons and serve as valuable early warning systems for appropriate intervention to prevent further deterioration in health.

The availability of geriatric medical specialties and geriatric departments in general hospitals seems to be an efficient and cost-effective way of concentrating a variety of expertise and resources on older persons suffering from a complex interaction of health and social problems. Geriatric consultants do not replace general practitioners, but serve in a complementary role. Where geriatric medicine is practiced, the quality of both care and after-care following discharge seems to be higher because of the team approach that is followed and the close coordination with the social services, a skill that the medical profession is not really noted for. This service, too, helps minimize the cases of unnecessary institutionalization.

Finally, stress is being placed everywhere on preventative measures that may slow down pathological aging processes. Areas of promise lie in nutrition, exercise, and education regarding "self-care".

The United States has been accused by some as "throwing money at the problems." Others feel that not enough money is being thrown at problems concerning care for the elderly or the most critical issues are not given high

priority. Perhaps a more systematically thought through use of the money spent might take us a major step forward toward a comprehensive health and social community care system.

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