

SPECIAL ISSUE

# Indian Journal of GERONTOLOGY

*a quarterly journal devoted to research on ageing*

**Vol. 25 No. 4, 2011**

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**Indian Journal of Gerontology**  
*(A quarterly journal devoted to research on ageing)*

ISSN : 0971-4189

**SUBSCRIPTION RATES**

***Annual Subscription***

US \$ 70.00 (Postage Extra)

UK £ 40.00 (Postage Extra)

Rs. 500.00 Libraries in India

**Free for Members**

*Financial Assistance Received from :*  
**ICSSR, New Delhi**

***Printed in India at :***  
**Aalekh Publishers**  
M.I. Road, Jaipur

***Typeset by :***  
**Sharma Computers, Jaipur**  
Phone : 2621612

# Indian Journal of GERONTOLOGY

*A Quarterly Journal Devoted to Research on Ageing*

**Vol. 25 No. 4, 2011**

*Special Issue on*

*Gerontological*

**SOCIAL WORK**

**Part - 1**

**Guest Editors :**

**Barbara Berknan**

and

**Daniel B. Kaplan**

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Four numbers of the Journal are published every year, in January, April, July and October. The contributions for publication should be sent to the Editor.

Contributors are requested to be clear and concise. The length of the articles should not exceed 12 double spaced typed pages. The manuscript should be in all final form for the press. The introduction and review of literature should be restricted and closely pertinent.

The manuscript should be typewritten on the one side of the page only, with double spacing and wide margins including titles, foot notes, literature citation and legends. Symbols formulae and equations must be written clearly and with great care. Too many tables, graphs etc. should be avoided. Each table should be typed on a separate sheet with its proper position marked in the text in pencil.

Three type written copies of the article should be sent. We appreciate papers **by e-mail** or **by CD**.

Literature citation — All references to literature cited in the text should be presented together at the end of the paper on alphabetical order of author's names. Each reference should be given in standard form as follows :

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3. Titles of journals abbreviated according to World List to Scientific Periodicals 1934
4. Volume number and
5. Beginning and the last page.

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References to several papers by the same author (s) published in the one year should be distinguished as 1969a,1969b,1969c,etc.

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## FOR OUR READERS

### ATTENTION PLEASE

Those who are interested in becoming the member of **Indian Gerontological Association** (IGA) are requested to send their Life Membership fee is Rs. 2000/- (Rupees Two thousand) and for Annual Membership Rs. 500/- (Rupees Five hundred only). Membership fee accepted only by D.D. in favour of Secretary, Indian Gerontological Association or Editor, Indian Journal of Gerontology. Only Life members have right to vote for Association's executive committee. They will get the journal free of cost.

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### Books Received for Review

- Ageing in an Indian City**  
by T.K. Nair, Published by eeswaar books, Plot 26, 2<sup>nd</sup> Cross Street (Appar Street), Kamakodi Nagar, Valasarawakkam, Chennai 600 087. Price Rs. 200/-
- Belief and Ageing : Spiritual Pathways in Later Life**  
by Peter G. Coleman and Colleagues, University of Southampton, Published by The Policy Press, University of Bristol, Fourth Floor, Beacon House, Queens Road, Clifton, Bristol, BS81QU, U.K.

## EDITORIAL

### International Social Work in Health and Ageing: Lessons from a Global Perspective

It is our honour to serve as editors of the two special issues of the Indian Journal of Gerontology dedicated to international social work in health and ageing. The questions of gerontology are truly global in scope. While we often speak of honouring cultural distinctions in our work, we are possibly more alike than we are different. It is our similarities which allow us to learn from one another's successes — as well as from our failures. In light of alarming predictions of the difficulties we will face due to population ageing, and with experts across the globe highlighting the benefits of interdisciplinary practice and multidisciplinary considerations for health and ageing, the Journal's issues on gerontological social work are both timely and telling.

As any gerontological professional can attest, ageing is a multidimensional process of interactions among biological, psychological and social domains. Those who wish to support, heal, or celebrate our older citizens must appreciate this multidimensionality. We have learned long ago, for example, that it is folly to treat chronic illnesses without consideration for the social environment, or to mobilize essential services without first assessing and addressing the recipient's feelings about accepting such help. Whether enabling healthy and productive ageing or responding to the myriad challenges which may arise in late life, gerontological social workers are an integral part of the health and ageing services spectrum. In addition to positions on care teams throughout the service spectrum, social work's unique skill set, values and roles are well-suited for providing supportive, therapeutic, and educational services to older adults and their caregivers (Kaplan & Berkman, 2011). A compelling report offered the following essential characteristics of the profession:

Gerontological social work is particularly concerned with ameliorating those physical, psychosocial, familial, organizational, and societal factors which serve as barriers to physical and emotional well-being in later life. Gerontological social work interventions are directed at enhancing dignity, self-determination, personal fulfillment, a decent standard of living, optimum functioning, and the least restrictive living environment possible. In addition, the distinctive value social work places on the uniqueness of individuals within a systems perspective prepares social workers to play a key role in designing and implementing equitable and effective programs to meet the needs of increasingly diverse older populations. (Scharlach *et al.*, 1997).

This depiction of gerontological social work highlights the invaluable contributions of these providers within elder care systems and reminds us of the importance of including social work scholarship in our efforts to understand and respond to the needs of older adults. Social work has been described as having “both a critical and strategic role in ensuring that systems of care are responsive to the needs of a diverse ageing and older population” (Sullivan, 2011). This idea of providing both a critical examination role and a strategic planning role is the essence of applied research and is one of the defining characteristics of social work in the modern world. It is in this context that we offer these two special issues of the Indian Journal of Gerontology, with the hope of reporting on a variety of social perspectives on ageing that can inform and guide our geriatric health and social service practices. These two issues offer a snapshot of current concerns, concepts and programmes related to the bio-psycho-social lives of older adults throughout the world. The six articles in this first issue on gerontological social work explain some of the current challenges related to global ageing and discuss an array of programming models which address such challenges.

James Lubben and JoAnn Damron Rodriguez begin this issue with a review of social and health perspectives on global ageing. Using comprehensive data compiled by the United Nations, the article examines age demographics by geographic regions and countries grouped by level of economic development. With lower fertility rates and longer life expectancies, greater numbers and proportions of older persons are a reality in every nation. Our understanding of the variability in the speed of population ageing is enhanced by analyses of gender

differences, marital status, and workforce participation of the elderly. We also cannot ignore important changes in kinship networks related to ageing trends, urbanization, and cultural developments, which are having profound impacts on dependency and support ratios in both developing and developed countries. Lubben and Damron Rodriguez explore the dynamics of population ageing in terms of the potential to 'drive transformations' in social structures and health care across the globe.

The next two articles focus on the social work profession itself, and our work with older adults in different parts of the world. Angie Ash and Judith Phillips examine social work with older people in Europe. Despite geographic proximity, the numerous countries located in Europe each have distinct political contexts and definitions of social work services. This diversity poses intriguing questions about how different nation states will respond to population ageing. Ash and Phillips explore the boundaries of Europe and review the debates in European social policy about welfare typologies, the relationship of social work to the state, and the diversity of roles in social work with older people across Europe. They propose that the nature of social work is tied to the type of welfare state in which it is practiced. In looking to the future of social work in Europe, Ash and Phillips raise the question of whether the profession will remain diverse or seek a converged approach in order to better assure that the rights and needs of older adults will be met.

Elizabeth Ozanne's article reviews Australian policy and service developments in response to a steadily ageing population and summarizes the corresponding changes in the gerontological social work profession. Over the past few decades, Australia has worked to maintain a coherent national policy on the health care, income security and long term care needs of older adults. A primary emphasis of this policy approach has been to steadily increase the incentives and service options that will support older people to remain in their homes for as long as possible with an appropriate quality of life. Thus, a predominantly institutional care system has shifted toward a range of supportive community care options for seniors. Social work training programmes in Australia have responded to the realities of population ageing with academic courses and specialist policy and practice research units on ageing. This type of purposeful approach to building a care system and professional social services workforce to meet the needs of a growing older adult population

offers important lessons to other countries in considering how they will respond to predictions of demographic shifts and warnings of inadequate service systems.

As nations confront an ageing population with growing demands for appropriate social, health and mental health services, the broad national responses of each country can be examined by tracing the ever-changing landscape of regulatory policies that shape and govern service delivery systems. Hanae Kanno and Amy Ai follow such trends in Japan's policies designed to respond to a very serious problem—the escalating number of elder abuse cases. The authors examine the history of Japan's policy developments and then organize major findings from recent national studies into both micro and macro-level factors that have contributed to the increasing discovery of elder abuse cases. The most recent Japanese elder abuse prevention law, in 2006, has resulted in a surge of reported instances of abuse, which was to be expected after the law created new avenues for case detection and additional professional responsibilities for case reporting. The authors hope to see the creation of more effective social intervention programmes to adequately support family caregivers and respond to the needs of elders at risk for abuse and neglect. This article provides important lessons learned from Japan's elder abuse research and policy developments over the past thirty years, particularly for those nations with similar cultural contexts and emerging patterns of rapid economic growth.

In the article by Jinyu Liu and Mercedes Bern-Klug on elder's expectations of community health services in China, the authors describe how strong cultural expectations for filial piety are defied by recent changes in fertility, migration to urban areas, and rising life expectancies. Thus, today's Chinese families face unique challenges in caring for their elders, and professional providers are recognizing the need to create community services that will support the increasing older adult population. The study described by Liu and Bern-Klug documents older Chinese adults' perspectives on the availability of community-based services and their expectations for provision of those services. They found that there is a large discrepancy between what elders believe to be available and what they expect will actually be provided in terms of personal care services and home visits. These discrepancies were greatest among

those older adults without a pension and those living alone—a finding which suggests that the development of community based health services should be prioritized to areas with concentrations of these vulnerable elders.

Bolstering the capacity of formal elder care systems is an essential focus for countries around the world. However, family caregivers and other informal providers shoulder the vast majority of the burden in both developed and developing nations. In recognition of the potential human and economic costs of family caregiving, innovations in caregiver support programmes must keep pace with the anticipated increase in the numbers of older adults needing help because of chronic illness and disability. Rhonda Montgomery, Jung Kwak and Jeannine Rowe's article describes the significant challenges for social service professionals in connecting family caregivers to appropriate resources and supportive services. The authors define caregiving as a dynamic process for which effective support programs must be provided in sufficient quantities, and targeted to specific needs as they evolve over time. They suggest a framework for identifying effective service delivery strategies and resources for supporting caregivers. Care management is presented as a logical and effective mechanism for triaging services for caregivers and a compelling new evidenced-based protocol is described for improving care planning by practitioners and caregiver service utilization.

These six articles in this first of two special issues on international social work in health and ageing highlight research findings related to the development of social services programming, workforce development and policy. These articles teach us that the realities of population ageing offer a powerful warning about the need to transform social structures and health care. As we look at the differential state of readiness of countries around the world, we can see that nations may need to learn from each other and even collaborate to assure that diverse social service systems converge in their approaches to helping older adults in need. Appropriate service systems and sufficient workforce capacity must be complemented by appropriate policies that reflect the contemporary needs of the older adult population, as well as the distinct cultural contexts and economic developments in each nation. For countries facing rapid population ageing as well as major social, economic, or political shifts, it is prudent to use contemporary research findings to guide the

implementation of appropriate health and social services. As we consider the dynamics of population ageing and the different responses of social service systems in countries throughout the world, we can glean valuable insights on how we might better prepare for the rapidly growing proportions of older adults. In the subsequent special issue on gerontological social work, social perspectives on community development, employment, and health and illness in late life are presented.

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*Guest Editors*  
**Barbara Berkman**  
 and  
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Indian Journal of Gerontology  
2011, Vol. 25, No. 4, pp.453-473

## Social and Health Perspectives on Global Ageing

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### ABSTRACT

*The article compares key demographic trends by geographic region and by clusters of countries grouped according to level of economic development. These analyses identify variations of rates of population ageing and potential consequences. The article concludes with an overall discussion of ramifications of population ageing to a selected array of social and health issues.*

**Key Words:** Global ageing, Economic development, Potential consequences, Social and health issues

### Dynamics of Population Ageing

For centuries, cultures around the globe have celebrated the prospect of longer lives for their citizens. Until recently only select segments of the world population, most often members of privileged classes in more affluent societies could realize this dream. However, due in part to improved public health and economic conditions, human lifespan began to dramatically increase in most countries around the world. Increased longevity, along with other trends such as declining fertility rates, fostered major demographic shifts whereby persons 60 years of age and older now account for a larger share of the world population. These phenomena are referred to as *global ageing* when speaking about worldwide data, or *population ageing* when considering specific regions of the world.

Comparison between India and the United States illustrates these trends. In 1950, the life expectancy of a female child born in India was only half that of her counterpart in the United States; 36 years compared to 72 years (United Nations Department of Economic and Social Affairs, 2007). By 2008, the life expectancy of a female child born in India had doubled to 72 years. Although this remains lower than in the United States where life expectancy at birth is 81 years for women, the reduction from 32 years down to 9 years of cross-national disparity in life expectancy is illustrative of improved social justice embodied within the dynamics of global ageing.

The United Nations Department of Economic and Social Affairs, Population Division (2002, 2010) has compiled a wide array of data documenting population ageing. Although data are available at the individual country level, the present analyses will generally examine these data at larger geographical levels (e.g., continents) and by level of economic development (viz., more developed, less developed and least developed). Identification of which countries are included in each of the geographic and economic development categories are reported in appendices of two UN reports (Ibid.). The article first identifies key trends noted in these data by region and then examines gender differences in population ageing. These analyses are followed by a presentation of data that identifies potential formal and informal social support consequences of population ageing. The article concludes with an overall discussion of ramifications of population ageing for a selected array of social and health issues.

### Key Trends in Population Ageing by Region

#### Numbers and Proportion of Older Persons

Table 1 reports data from the United Nations (2002, 2010) documenting the phenomenon of world population ageing. The number of persons 60 years of age or older in the world will almost triple by the year 2050, growing from 737 million to over 2 billion persons 60 years of age and older. Some regions of the world will experience especially rapid population ageing. For example, Africa's 60 plus population will quadruple over the next 40 years while Asia and Latin America will see their 60 plus population triple during that same time period. What is even more remarkable is that the less and least developed nations are

ageing the fastest. Whereas most of the developed countries of the world had the luxury of first accomplishing economic development and then dealt with the consequences of population ageing, the less and least developed nations will have to simultaneously face the dual social transformation challenges of accommodating a rapidly ageing population while also dealing with issues of large economic development.

**Key Trends in Population Ageing by Region**

The first set of columns in Table 1 illustrates that the number of older persons is growing throughout the world. The second set of columns shows that the proportions of the population that is 60 years of age or older are also rapidly expanding throughout the world. Presently approximately 11 per cent of the world’s population is 60 plus years of age, but that will double to 22 per cent by 2050. In the more developed nations of the world, persons 60 years of age or older will account for one third of the total population by 2050.

These dynamics beg the question of which region and countries will experience the most challenging social transformation. For example, will it be harder for Asian countries to transform their societies in order to accommodate a shift from one tenth to one fourth older persons or will European countries be more challenged in 2050 when over one third of its total population will be 60 years of age and older. The answer to this question is partially provided by an examination of the aged population itself.

**Ageing of the Older Population**

As shown in the third set of columns in Table 1, the aged population is itself ageing. People 80 years of age or older presently account for 14 per cent of the world’s older population (those 60 years of age or older). However, by 2050, the proportion of 80 plus persons in the world will grow to 20 per cent of the total older population. This phenomena is especially evident in more developed countries where almost 30 per cent of the older population will be in their eighties or older in 2050.

The fourth set of columns in Table 1 documents the survival rates to age 80 by region. These data show that throughout the world the proportion of a given birth cohort reaching 80 years of age is significantly

**Table 1: Key Trends in Population Ageing by Region**

Region	Number of persons 60 years or over (in thousands)		% Population 60 or over		% of 60+ 80 or over as		Survival Rates to 80 years or over <sup>1</sup>		Total Fertility Rate per woman <sup>2</sup>		Ageing Index <sup>3</sup>	
	2009	2050	2009	2050	2009	2050	1990	2010	1950	2000	2000	2050
World	737,275	2,008,244	11	22	14	20	34	52	5.0	2.7	33	100
Africa	53,770	212,763	5	11	8	10	17	40	6.7	5.0	12	37
Asia	399,881	1,236,103	10	24	11	18	33	52	5.9	2.5	29	116
Europe	158,503	236,426	22	34	19	28	42	60	2.7	1.3	116	263
Latin America & Caribbean	57,039	186,036	10	26	15	22	40	56	5.9	2.5	25	112
North America	62,744	124,671	18	28	21	29	52	66	3.5	1.9	76	148
Oceania	5,338	12,246	15	24	19	27	49	52	3.9	2.4	53	120
More developed Nations	263,905	416,055	21	33	20	29	47	64	2.8	1.5	106	215
Less Developed Nations	473,370	1,592,188	8	20	11	17	30	50	6.2	2.9	23	87
Least Developed Nations	42,922	185,129	5	11	8	10	16	39	6.6	5.2	11	32

Sources: UN Department of Economic and Social Affairs, Population Division (2010). World Population Ageing 2009.  
 UN Department of Economic and Social Affairs, Population Division (2002). World Population Ageing 1950-2050.  
 NOTES: 1. The survival rate to 80 years or over is the proportion of newborns in a given year who would be expected to survive to at least 80 years of age if mortality trends at the time of their birth were to continue.  
 2. The total fertility rate is the average number of children a woman would bear over the course of her lifetime.  
 3. The ageing index is calculated as the number of persons 60 years old or over per hundred persons under age 15.



increasing. Looking at data for the whole world, those born in 1990 have a 34 per cent chance of becoming an octogenarian whereas the chances go up to 52 per cent for those born in 2010. In more developed nations, almost two thirds of a given birth cohort can now expect to reach 80 years of age. Given that this segment of the older population requires more extensive health and social services, these data suggest that the ageing of the older population might prove to be a more important marker of population ageing than merely the percent of persons 60 years of age and older.

#### Lower Fertility Rates Accelerating Population Ageing

Another dynamic aspect of population ageing concerns fertility rates which are dropping throughout the world. The world total fertility rate per woman in 2000 was only about half of what it was in 1950. Total fertility rates indicate the average number of children a woman would give birth to in her lifetime. These rates have dropped significantly in all regions but there remains considerable regional variation as shown in Table 1.

In order to maintain a stable population in modern industrial societies, the total fertility rate should approximate 2.1. With less than this replacement amount, the population of that society would begin to shrink. It is noteworthy that Europe and the more economically developed nations have rates that are considerably less than 2.1. As a result these regions are ageing even faster than other regions. Whereas their younger cohorts are shrinking because of lower fertility rates, these are also the same regions with higher survival rates for people 80 years of age and older. Both exceptionally low fertility rates and greatly increased life spans are driving population ageing of Europe and the more economically developed countries.

The final set of columns in Table 1 provides a composite measure that incorporates both the accelerated growth in older populations and the decelerated growth in the younger population. Already there are some regions of the world where there are more people 60 years of age or older than there are children. To quantify this aspect of the dynamics of population ageing, the United Nations has developed an *Ageing Index* measure. The Ageing Index is a ratio of the number of people 60 years of age or older to one hundred children 15 years of age or younger in

that same population. Thus, a number less than 100 implies that there are more children than older people in that region whereas ratios above 100 imply that older people are more numerous than children. In 2000 there were approximately three children 15 years of age or younger for every older person in the world. For the first time ever in human history, world population data for 2050 are expected to report these two age cohorts as being of equal size. Already older persons are more numerous in Europe than children. By 2050 this will be the case in most regions of the world. The only regional exception is Africa which has been especially hard hit by the AIDS epidemic. Differences on the Ageing Index are also noteworthy by level of economic development. The less and least developed nations will continue to have more children than older persons. By way of contrast, in 2050 it is projected that there will be two older persons for every child in the more economically developed countries.

#### Gender Differences in Late Life

##### Life Expectancy

As shown in Table 2 (UN, 2010) gender is a major factor in the dynamics of ageing. In Table 2, gender differences in longevity are shown in years of life expected for those who reach age 60. Worldwide men who have reached 60 years of age are expected to have 18 more years of life and reach age 78 whereas women who have reached 60 years of age can expect to live 21 more years and reach age 81. The advantage that women have over men in life expectancy at age 60 is consistent throughout all regions of the world as well as when comparing levels of economic development. However the gender differential is smaller in the less developed nations.

The complex biopsychosocial nature of the phenomena of female life expectancy advantage defies any one explanation. The shorter life expectancy for adult males may be attributed to a combination of factors, including increased homicide and accident rates, war fatalities, excessive alcohol consumption, poor diet, and environmental/ workplace degradation (Kinsella and Phillips, 2005). It has also been noted that throughout the life cycle women generally have lower mortality for most of the common causes of death (Kinsella and He, 2009). However in some Sub-Saharan Africa countries the gender advantage may even

**Table 2: Gender Differences in Characteristics of Older Population by Region**

Region	Life Expectancy at age 60		Sex Ratios <sup>1</sup>			% Currently Married <sup>2</sup>		% in Labor Force <sup>2</sup>	
	Men	Women	60+	80+	Men	Women	Men	Women	
World	18	21	83	59	80	48	40	20	
Africa	15	17	85	68	85	39	61	34	
Asia	18	20	90	68	81	52	44	23	
Europe	18	23	70	46	77	44	18	10	
Latin America & Caribbean	20	22	82	65	76	43	47	21	
North America	21	25	80	57	75	47	32	22	
Oceania	21	25	88	62	73	50	30	18	
More Developed Nations	20	24	74	49	78	46	24	14	
Less Developed Nations	17	20	89	70	81	49	47	24	
Least Developed Nations	15	17	85	74	84	41	67	41	

Source: UN Department of Economic and Social Affairs, Population Division (2010). World Population Ageing 2009. NOTES: 1. Number of men per 100 women. 2. Percent of those 60 or over

be reversed due to cultural factors of strong male preference, low status of women and HIV/AIDS (Ibid.). As women increase their educational attainment in developing countries, this may increase their survival as well as further widening the gender gap in longevity (Ibid). It is noteworthy that female life expectancy at birth has shown great progress since 1950 whereas male life expectancy has not improved as rapidly (United Nations, 2004).

**Sex Ratios**

The gender differential in life expectancy contributes to the second set of columns in Table 2 which reports sex ratios at age categories of 60 plus and 80 plus. These data report the number of men per 100 women in those age categories. Globally the marked increase in the number of older women is reflected in the sex ratio. The gender differential grows with chronological age. Among those 60 years of age or older there are 3 men for every four women. However among those 80 years or over, women are almost twice as numerous as men, Further, among centenarians women are between four and five times as numerous as men (United Nations Department of Economic and Social Affairs, 2007). The size of sex ratios also differs among the regions of the world, and it is more pronounced in economically developed nations than in less developed nations.

**Marital Status**

Worldwide fewer older women are married than older men. In Table 2 this trend is also shown by region and for developed, less and least developed countries, with almost half as many women married as compared to men. Worldwide 80 per cent of older men and 48 per cent of the older women are currently married. Africa is exceptionally disparate with proportionately the least women married (39%) in comparison to men (85%).

As a broad generalization it might be stated that older men are married whereas older women are not. Indeed there are more widows than widowers in part because older men have much higher rates of remarriage. Adding to the increased risk of widowhood is, of course, women’s longer life and also the tendency for women to marry older men. The sex ratio at older ages has many consequences for population and individual ageing. Certainly, the imbalance in the number of men

and women who are married in late life significantly impacts living arrangements and health.

Workforce Participation by Gender

As shown in Table 2, women are only half as likely as their male counterparts to still be working after age 60. Throughout every region of the world, older men are more likely to remain in the workforce than older women. It is also noteworthy that labour force participation varies considerably across the world for both genders. For example, men in Africa are three times more likely than their male counterparts in Europe to be in the labour force after age 60. A much higher percentage of both men and women work in old age in the least developed countries.

Gender differences in labour force patterns among older populations are likely to be the consequence of life course factors. For example, women are the traditional caregivers within families and thus may have had lower labour force participation throughout their lives. Women also experience a decline in income as widows (Kinsella and Phillips, 2005). Even those women who did participate in the labour market may have experienced role strain due to limited availability for child and elder care, leading to early departure from the labour market.

Changing Dependency and Support Ratios

Dependency Ratios:

The *Total Dependency Ratio (TDR)* attempts to capture at a macro economic level the capacity of a society to provide for its dependents. Thus the TDR adds together the number of younger persons (those under 15 years of age) and older persons (those 65 years of age or older) and compares that total with the number of persons 15 to 65 years of age. These data for 2000 and 2050 are presented in the first set of columns in Table 3. What is especially noteworthy in this set of columns is that the worldwide total dependency ratio is stable. The ratios for 2000 and 2050 are the same. However there is considerable regional variation with some regions experiencing a dramatic drop in their TDR (e.g., Africa) whereas other regions are experiencing a significant increase (e.g., Europe, more developed nations).

This difference in regional trends is explained in the second set of columns in Table 3 that report the portion of the TDR that is attributable

Table 3: Changing Dependency and Support Ratios by Region

Region	Total Dependency Ratios <sup>1</sup>		Old-age Dependency Ratios <sup>2</sup>		Potential Support Ratios <sup>3</sup>		Aged Parent Support Ratios <sup>4</sup>	
	2000	2050	2000	2050	2000	2050	2000	2050
World	58	58	11	25	9	4	4	11
Africa	85	54	6	11	17	10	2	4
Asia	57	57	9	26	11	4	3	10
Europe	47	76	22	51	5	2	9	27
Latin America & Caribbean	59	59	9	27	12	4	4	11
North America	51	66	19	35	5	3	10	25
Oceania	55	60	15	29	7	3	7	18
More Developed Nations	48	73	21	47	5	2	9	28
Less Developed Nations	61	56	8	22	12	5	2	8
Least Developed Nations	86	55	6	10	17	10	1	3

Source: UN Department of Economic and Social Affairs, Population Division (2002). *World Population Ageing 1950-2050*.  
 Notes : 1. The total dependency ratio is the number of persons under age 15 plus persons aged 65 or older per one hundred persons 15 to 64.  
 2. The old-age dependency ratio is the number of persons 65 years and over per one hundred persons 15 to 64 years.  
 3. The potential support ratio is the number of persons aged 15 to 64 per every person aged 65 or older.  
 4. The aged parent support ratio is the number of persons 85 years old and over per one hundred persons 50 to 64 years.

to the older population in a society. The *Old-Age Dependency Ratio (OADR)* is the number of persons 65 years of age or older per one hundred persons aged 15 to 64 years of age. The World OADR more than doubles between the years 2000 and 2050. The reason that the World TDR did not change is because the increase in the portion of the total dependency ratio attributable to older persons compensated for the decrease that was attributable to younger persons. The policy and programmatic implications of these shifts are quite significant for dependent care. Obviously the care systems designed for older persons are quite different and may prove more expensive than those for juvenile dependents.

The old-age dependency ratios are growing very rapidly in some regions of the world. They will triple in Asia, Latin America and the Caribbean. The economically less developed nations may be especially challenged by the rapid growth of their older populations. The decreased size of their juvenile dependent populations is not likely to bring sufficient savings to compensate for the expansion of services that will be required to care for their older populations.

#### Potential Support Ratios

The *Potential Support Ratio* flips the old-age dependency ratio so as to provide a means to quantify the number of potential caretakers for older persons. This measure counts how many people 15 to 64 years of age are in a society for every older person 65 years of age and older. The major theme demonstrated by this social indicator is that throughout the world there will be fewer people available to care for the older population in the future than has been the case in the past. In Europe and the more economically developed nations, there will only be two persons available for every older person in 2050. These data further suggest a need for a major paradigm shift to accommodate a world with many more older persons potentially in need of care at the same time that there are fewer within our societies that can informally provide such care.

#### Parent support ratios

A final measure that captures these phenomena is the *Aged Parent Support Ratio*. This indicator creates a ratio of the population aged 85 or over to that aged 50 to 64. This measure provides an indication of

the level of support families may be able to provide to their oldest members. In Table 2, globally, there were about 4 persons aged 85 or over for every 100 persons aged 50 to 64 in 2000. However this ratio is projected to reach 11 per 100 by 2050, suggesting a potential for the elderly parent support burden that is three times greater than it was in 2000. These challenges will be especially great in Europe and North America where the *Aged Parent Support Ratios* will be equal to or greater than 25. Similarly the more economically developed nations are expected to face greater challenges of caring for the very old than less developed nations. It has also been noted that intergenerational transfers of wealth decrease as persons live into very advanced old age (Lubben and Damron-Rodriguez, 2003).

Although the various social indicators in Table 3 provide valuable insight into the potential expansion of support needs, the indicators should be viewed as only gross estimates of those needs. For example, the dependency ratios generally imply that all people over age 64 are in some sense dependent on the population of working age. However, as shown in Table 2, many older persons continue to participate in the labour force and thereby contribute to economic growth and well being through their taxes, income, and wealth (Kinessel and Phillips, 2005). Alternative dependency ratios have been devised that recognize the variations related to productivity within these major age groupings. The alternative dependency ratios exclude younger disabled and persons outside the workforce and include productive older adults (Kinsella and He, 2009). However these alternative measures are not available for all countries and regions and so could not be used for the types of comparisons explored in the present article.

#### Implications for Families and Social Support

Despite the limitations of some of the measures, the various measures of population ageing presented in the previous sections have major ramifications for families and social support systems. Indeed, longevity presents an “unprecedented opportunity for intergenerational interaction and an unprecedented level of familial responsibility for elder care” (Damron-Rodriguez and Lubben, 2007). Demographic ageing and accompanying societal changes impact the family in major ways (Putney and Bengston, 2003).

### Kin Networks

Increasingly families will enjoy as many as five living generations (Bengtson *et al.*, 1996). Though including more generations, each generation tends to have fewer members. Families in developed countries are also smaller than in the past. This is referred to as the verticalization of the family structure. The network of kin relationships in ageing societies creates ties with persons within a generation and between generations (Bengtson *et al.*, 1996; Putney and Bengtson, 2003). As an example, in the USA in 1900, only 21 per cent of persons had a living grandparent, but by 2000, it was 76 per cent. Over this same period, the odds of a person over 60 having a parent alive more than doubled from 18 per cent to 44 per cent (Quadagno, 2008). This contrasts with the former more intense horizontal linkage with multiple members of a single generation. Today, throughout the world in ageing societies many families have multiple elders, parents, parents-in-law, stepparents, aunts and uncles for whom they may have intergenerational exchanges and may have some level of responsibility.

Many older people live with family in developing countries and alone in developed countries, though solitary living is increasing worldwide with 1 in 7 older people living alone (United Nations Department of Economic and Social Affairs, 2007). Multigenerational households have been declining in more developed countries, but two- and three-generation households are still the norm in many less developed countries. Continued verticalization of family structure is offset, however, by the trends of delayed marriage and rising ages at childbearing (Kinsella and He, 2009). Other social changes, particularly in developed countries, impact family networks. There is increasingly a wide variety of family forms and lifestyles, with rising rates of divorce and remarriage (United Nations Department of Economic and Social Affairs, 2007), delayed marriage, single parent households, same sex couples and increasing numbers of never-married and childless adults. These dynamics and the global trend toward fewer children which is manifested in both developed and developing countries translates to fewer potential caregivers for older parents.

### Urbanization and Family Caregiving

Urbanization almost always accompanies development and is progressing rapidly in many developing countries. China is a well known

example. In 1975 just over one third of the world population was urban. In 2000 the world reached a milestone with half of the population living in urban areas (United Nations Economic and Social Council, 2007). The migration to cities predominantly involves a younger population, leaving more elderly family members in rural areas, though there may be a stabilization of the age differential in cities overtime and marked exceptions (Kinsella and He, 2009). This urban movement of younger family members to cities disrupts caregiving patterns and adds to poverty among rural elders.

In previous sections, increased longevity and smaller family size have been described. These dynamics result in potential gaps in an older person's traditional social support network. In some extreme cases, older persons may face the prospect of ageing without having a son or daughter on whom they may depend for care. For example, Gironda *et al.* (1998) state that currently one fifth of Americans 65 years of age and older do not have any living children and that in the next cohort to reach 65 almost one third will be without living children.

While many older people receive financial and other support from adult children, support is often reciprocal. A recent European study revealed that transfers from older parents to children were much more frequent and substantial than those in the opposite direction, and the difference remained positive even though it declined with age (Albertini *et al.*, 2007). In countries with well-established pension programmes, many older adults give support and care to their children and grandchildren. Grandparenting is a primary role for older persons. Almost half of coresiding grandparents had primary care-giving responsibility for their co-resident grandchildren younger than 18 (Kinsella and He, 2009).

Older people in less developed countries are less likely to provide financial help to younger people, but often contribute significantly to family well-being in many ways, ranging from socialization to housekeeping to child care (Kinsella and Phillips, 2005). Older people provide care for a variety of people (spouses, older parents, siblings, children, grandchildren, and nonfamily members). They do so for many reasons, including illness of a spouse or sibling and to assist single-parent families, working mothers, and orphaned grandchildren. Often

the care provided by older family members is essential to the wellbeing of a family (Kinsella and He, 2009).

### Implications for World Health

The demographic transition described as population ageing is in parallel with the epidemiological transition. The latter is the transition of morbidity and mortality in ageing societies from infectious disease to non-communicable chronic disease as the cause of disability and death. This trend can be seen over time within a country. For example, in the USA in 1900, pneumonia, tuberculosis, and diarrheal diseases were the leading causes of death and in 2009 the chronic conditions of heart disease, cancer, and cerebrovascular disease replaced the former acute conditions (National Center for Health Statistics, 2007).

Developed countries have experienced the progress of medicine in this century including the introduction of antibiotics that allow persons to survive infectious diseases. Malnutrition and infectious diseases remain high in developing countries with high mortality, but, surprisingly, in these countries chronic conditions are among the leading causes of death as well. According to a comprehensive 2002 report for developed countries the leading causes of death were heart disease, cerebrovascular disease and respiratory cancers, and for developing countries with high mortality the leading killers were respiratory infections, HIV/AIDS and heart disease (Kinsella and He, 2009). In 2000 HIV/AIDS accounted for 6 per cent of deaths in developing countries (Kinsella and Phillips, 2005). The obesity epidemic in developed countries may significantly impact life expectancies in these countries (Kinsella and He, 2009). Overall cancer incidence and rate declined in 2007 for the first time over all years of recording (World Health Organization, 2009), although there are exceptions (i.e., lung cancer for women is increasing).

In the International Classification of Impairments, Disabilities and Handicaps (ICIDH), WHO proposes three possible outcomes of disease: impairment, disability, and handicap (Kinsella and Phillips, 2005). By any measure, however, ADL and Instrumental Activities of Daily Living (IADL) problems increase with age. Even if rates of disability can be reduced or the onset postponed, demographic trends will almost inevitably increase the numbers of disabled older people in less developed countries, especially when the numbers with dementia are included.

Another important health measurement is the level of burden caused by a chronic condition and disability, or the global burden of disease (GBD). Leading causes of burden in developed countries are heart disease, depression and stroke. For developing, high mortality countries burden is substantially caused by: HIV/AIDS, respiratory infections, and perinatal conditions. In 2020 GBD is projected to shift worldwide to be increasingly related to heart disease, depression and road traffic accidents (Kinsella and Phillips, 2005).

Older adults in developed countries experience “very good” to “excellent” health; 44 per cent of those 65-74 in the US and 35 per cent of those over 75. Disability rates for older people in some countries are falling (Institute of Medicine, 2008). These factors weigh on the side of the compression of morbidity. However, in any compression of morbidity, with health improving in tandem with mortality, health and social welfare costs will only decline if disability rates fall. The “social pathologies” must also be considered. These include: cirrhosis, substance abuse, obesity, suicide, homicide, HIV/AIDS, and resurgent diseases such as drug-resistant tuberculosis and other strains of infectious diseases (Kinsella and Phillips, 2005). The obesity epidemic, for example, may significantly impact life expectancies in developed countries (Kinsella and He, 2009).

World Bank, World Health Organization and Harvard School of Public Health have produced global measures of active life expectancy and years of disability (Mathers *et al.*, 2002). This research attempts to refine simple measures of life expectancy to adjust for years of life lost from premature death and years of life lived with disabilities. This refined analysis demonstrates considerable variation in active life expectancy across regions of the world. Worldwide the overall healthy active life expectancy is 7.5 years lower than total life expectancy at birth. It is also noteworthy that the male-female gap is lower for healthy active life expectancy than for total life expectancy (Mathers *et al.*, 2004). Research on healthy life expectancy focuses on the challenge of adding healthy years to life in contrast to extending life expectancy itself.

### Implications for Health Care Services

Older adults disproportionately utilize health care services. In the US, though older persons represent 12 per cent of the population, they

account for 26 per cent of physician visits and 35 per cent of hospital stays (Institute of Medicine, 2008). In 1999, costs per US citizen for health care services for those under 65 years of age was \$2,793 and for those over 65 years of age was \$11,089—and was a staggering \$44,520 for persons in a nursing home (Institute of Medicine, 2008). Additionally, older persons use high cost emergency room services at a higher rate than younger populations and are more likely to have repeated hospitalizations shortly after discharge.

Late-life disability attributed to people aged 65 and over, though higher than for the younger population, is on the decline even as chronic illness increases (Kinsella and He, 2009). Eighty-two percent of older adults in the US have at least one chronic condition. This suggests a need for rehabilitative and chronic disease management programs and the potential to increase the ability for self care.

Older adults are particularly vulnerable between transitions in care as examined in the Institute of Medicine Report (2001) *Crossing the Chasm of Care*. On average, about 6 per cent of older people in the more developed world live in residential care communities and nursing homes at any point in time. In 2000, approximately 4 per cent of the older population in the US was in Skilled Nursing or similar facilities. The number of persons 85 and older in institutional care was much higher than the numbers of the younger old (age 65-84), who were more likely to have short stays in these facilities for rehabilitation purposes. Thus, for older adults who require assistance with ADLs over time, or long-term care including medical and social assistance, coordination of care is a pivotal issue. Older adults in the US prefer to live in the community with a range of services than to live in a residential care facility.

The community health care model was originally developed as a commissioned paper by the World Health Organization's (WHO) Kobe Centre for Health Development (Lubben and Damron-Rodriguez, 2003) to provide a framework for international dialogue on community health care. Home and Community-Based Services (HCBS) is an evolving paradigm that integrates social health care for the provision of long term care with medical models of health care delivery. This model recognizes the need for health promotion and disease prevention for older persons in order to promote self-care. It also respects the continued

contribution of family caregivers, though such contributions are challenged by the changes in family structure as noted previously. Honouring the preferences of older persons and reducing costs are two strong rationales for focusing on non-institutional care. Just over 60 per cent of disabled persons in the US receive some form of HCBS (Institute of Medicine, 2008).

A recent report in the United States by the Institute of Medicine (2008) describes many innovative and evidence-based models of HCBS that demonstrate improvement in both the quality of care and many that also reduce costs. However the diffusion of these models has been minimal, often because the current financing systems do not provide reimbursement mechanisms. This requires policy changes to include such features as patient education, care coordination, caregiver support, team collaboration, geriatric physician reimbursement differential, as well as support for the development of technological advancements for the home. Additionally, the report recognizes the critical need to increase the formal geriatric labor force in order to meet the needs of new delivery systems and support the challenges of family support for growing numbers of older persons.

## Conclusion

Global and population ageing will drive transformation of social structures and health care delivery throughout the world. No country will escape the consequences of population ageing. Indeed, the UN proclaims global ageing is unprecedented, unparalleled, pervasive, profound and enduring (United Nations Department of Economic and Social Affairs, 2007). The Population Reference Bureau declares population ageing a human success story and asserts that policies on ageing must address the entire society (Kinsella and He, 2009).

The Madrid International Plan of Action on Ageing and the Political Declaration adopted at the Second World Assembly on Ageing in April 2002 marked a turning point in how the world addresses the key challenges of building a society for all ages. The Plan focuses on three priority areas: older persons and development; advancing health and well-being into old age; and ensuring enabling and supportive environments (United Nations Department of Economic and Social Affairs, 2007).

Structural gaps in the potential for kinship care will require more attention by policymakers and community health and welfare service providers. It has been acknowledged that the nations of the developed world first experienced economic development and then the ageing of their societies and that developing nations are ageing while still experiencing high levels of poverty. Community health care approaches may also become attractive models for more economically developed nations that are fast discovering that expensive institution-based programming is not sustainable within the context of rapidly ageing populations. However, the growing share of the GNP devoted to publicly financed long-term care is projected to increase so dramatically in developed countries that other collaborative activities in many domains of human activity are required (Lubben and Damron-Rodriguez, 2006). A policy commitment for integrated community health and social welfare systems that support family caregiving and promote older adult self care is needed.

Although the dynamics of population ageing will challenge all societies, it must be remembered that, for centuries, cultures around the globe have sought longer lives for their citizens. In the past, most societies only afforded the opportunity of a long life for a select group of citizens. Now a long life has become a realistic dream for many more people around the world. Thus population ageing should be celebrated as a major achievement of social justice. The challenges it presents may be unprecedented but they are not insurmountable.

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**Indian Journal of Gerontology**  
2011, Vol. 25, No. 4, pp.474-493

## **Social Work with Older People in Europe: Diversity and Change**

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### **ABSTRACT**

*Any account of social work with older people in Europe has to grapple with a number of definitional and conceptual challenges. These include delineating and describing 'Europe' and the typology and histories of its welfare states; defining social work, social care and social services (terms that share no common European definition); and recognising the differing meanings of 'old age' across Europe. This article reviews these definitional and conceptual differences, and gives an overview of social work with older people in Europe. It describes social work's diversity in its engagement with older people in Europe, suggesting this arises out of the type of welfare regime in which social work with older people is practised. A distinct European identity for social work with older people is not yet apparent. Economic pressures on welfare states, and the political decisions they take to deal with these, may lead to convergence across Europe particularly in the type of welfare provision to older people. If this occurs, it would impact the nature of social work with older people in Europe.*

**Key Words** : Social work; Europe; Older people; Welfare regime

As the population of Europe ages, older people increasingly encounter health and social care services. This may involve contact with a social worker, mostly it will not. An earlier review of social work with older adults in Europe described its diversity, and noted the definitional and conceptual challenges this presented (Phillips, 2006).

This article revisits the subject of social work with older people in Europe. First some terms under discussion – social work (and, relatedly, social care), and what constitutes ‘Europe’ – are defined and delineated and some features of demographic change in Europe are considered. Second, the social policy context and debate in European social policy about welfare typologies or regimes is reviewed. Third, the diversity of social work with older people across Europe, and the relationship of social work to the state are considered. Finally, current and future directions for social work with older people in Europe are discussed, and it is suggested that the nature of social work across Europe is rooted in the type of welfare state in which it is practised. There are still few comparative accounts of social work with older adults in Europe, and social policy commentary is largely concerned with the European Union (EU), particularly pre-enlargement Europe (pre-2004), although this is beginning to change (e.g., Fernández, *et al.*, 2009; Velladics *et al.*, 2006).

### Defining terms

Terms such as ‘Europe’, ‘social work’, ‘social care’, ‘welfare state’ are variously defined across Europe, and are used interchangeably across different social policy arenas (Manthorpe and Livsey, 2009). So, too, is ‘old’ differently defined. In most states, receipt of a state pension marks the move to ‘old age’; ‘pension age’ varies across Europe, and it is generally rising. At 2010, the most common pension age was 65 (Austria, Belgium, Denmark, Greece, Sweden and Spain); or 67 (in Germany, and France for full entitlement).

The international definition of social work is: "The social work profession promotes social change, problem solving in human relationships and the empowerment and liberation of people to enhance well-being. Utilising theories of human behaviour and social systems, social work intervenes at the points where people interact with their environments. Principles of human rights and social justice are fundamental to social work" (International Federation of Social Workers, 2000).

This definition underlines social work’s professional status and captures the more emancipatory aspects of the social work role, such as promotion of human rights. ‘Social work’ is a protected title in most

of the EU; only registered and qualified social workers can use this title.

‘Social care’, on the other hand, has no international definition. The term can include social work practice in residential, day and other group care. It can be used, as in the UK, as a replacement term for ‘social services’, differentiating such provision from health care. Or, it can describe practice, and training for practice, in care-providing services, distinct from therapeutic social work designed to enhance personal functioning (Payne, 2009).

‘Personal social services’ is a term most used in the UK. It refers to services like residential or home care, delivered to the older person in need, by the state, charities or not-for-profit organizations, (for-profit) businesses, or paid for by the person in a private arrangement. Across Europe, these services may be staffed by professionally qualified social workers, or by social care workers who may be variously called social assistants, animateurs or residential care workers. Some of these services may also be provided by unpaid volunteers. Further, the familiar term ‘welfare state’ has no universally agreed definition: “[a]s an entity it does not exist – it is a collection of services and policies and ideas and taxes, including tax reliefs, whose boundaries expand and contract over time” (Timmins, 2001).

‘Social assistance’ commonly describes provision in central and Eastern Europe, referring to means-tested cash benefits and personal social services combined (Munday, 2003). ‘Informal care’ refers to care provided by families, typically women. Cash-for-care schemes, where the state provides cash payments to older people to purchase their own care, blur boundaries between formal and informal care. In the Netherlands, relatives can be paid for care-giving; in Austria, Italy and Greece, cash payments can be used to pay grey labour care workers (Pavolini and Ranci, 2008; Ungerson, 2004).

These are not the only terms where boundaries are flexible, permeable and difficult to define; the same challenge arises in relation to geographical boundarying of what is termed ‘Europe’. How Europe is delineated is subject to change and flux (Shardlow and Wallis, 2003). As a geographical entity it includes the westernmost peninsula of Eurasia, surrounded by sea to the north, west and south; and bounded

on the east by the Ural mountains and Caspian Sea, and Caucasus mountains and Black Sea, although these boundaries have shifted over centuries. Sometimes 'Europe' is used to denote Europe before enlargement and the accession of several Eastern Europe states to the EU (Kuus, 2004).

In 2010, the European Union (EU) was made up of 27 states<sup>1</sup>. Ten states joined in 2004, of which eight (Poland, Lithuania, Estonia, Latvia, Slovakia, Slovenia, Hungary, Czech Republic) had been part of the former communist bloc. Romania, and Bulgaria acceded to the EU in 2007. To add further ambiguity, the European countries of Switzerland, Iceland and Norway are not EU members; and the Council of Europe, whose primary aim is to create a common democratic and legal area throughout the European continent was, in 2010, made up of 47 member countries.

While the boundaries and identity of 'Europe' have shifted historically, European social policy has developed a more distinct form, sometimes called the European Social Model (ESM) (Lyons and Lawrence, 2006). The EU has developed trans-European social rights programmes alongside economic policies to secure a 'single market'. Social rights confer protection from risks of market economics, such as loss of income in older age. Nonetheless, it would be misleading to suggest EU members shared a common social policy (Ginsberg and Lawrence, 2006). The welfare regimes of Europe (which are discussed below) are diverse, and these shape the social policy of the individual states, as well as the nature and practice of social work with older people in them.

### Demographic change in Europe

The population structure of Europe is changing; all EU countries have ageing populations. The proportion of people aged 65 and over is projected to rise from 17 to 30 per cent by 2060; the proportion of people of working age is shrinking; birth rates are low; and life

<sup>1</sup> At 2010, EU member states are: Austria, Belgium, Bulgaria, Cyprus, Czech Republic, Denmark, Estonia, Finland, France, Germany, Greece, Hungary, Ireland, Italy, Latvia, Lithuania, Luxembourg, Malta, Netherlands, Poland, Portugal, Romania, Slovakia, Slovenia, Spain, Sweden, UK 521 million people in 2035 and to fall to 506m by 2060 (Eurostat, 2010b). The proportion of people aged 80 and over is on course to be 12 per cent in Europe by 2060 (Eurostat, 2010b).

expectancy at age 65 is increasing (Eurostat, 2010a). The population of the 27 EU states was 495 million in 2007, and is projected to peak at 521 million people in 2035 and to fall to 506m by 2060 (Eurostat, 2010b). The proportion of people aged 80 and over is on course to be 12 per cent in Europe by 2060 (Ibid.).

In every EU state people are living longer and in better health. Feminization of the general population is occurring, as the numbers of women exceed those of men. In the UK, women form half the 25-64 age group; this rises to 72 per cent of those aged 85 and over (Walker and Naegele, 2009). The majority of frail and vulnerable old people are women, who make up two-thirds of those aged 80 and over. More than a third suffer with dementia, increasing the risk of abuse, as frailty and vulnerability increases with age and are factors associated with the risk of elder abuse (Age Platform-Europe, 2010; O'Keefe *et al.*, 2007).

Consequently, long term care expenditure is expected to rise significantly as a proportion of GDP in many countries (Fernández *et al.*, 2009). At the EU level, responses to the ageing of European states include moving from institutional care to home-based, community care, the integration of health and social care, and the development of multi-disciplinary teams of health care workers and social workers. Providing care for Europe's older people is challenging for a number of reasons, including, funding welfare services through taxation; balancing work and informal (unpaid) care-giving with employment; and ensuring the supply of appropriately qualified and skilled care workers to meet workforce demands for care in the home (Cameron and Moss, 2007). In recognition of this, the European Parliament agreed on a resolution in 2010 on the long term care of older people, aimed at developing an EU-wide code of conduct for long term care for older people, and exchanging best practices across the Union (European Parliament, 2010).

### European welfare states

Social work practice is rooted in the welfare regime from which it emanates. Esping-Andersen's (1990) early welfare regimes typology paid little attention to personal social services or the role of unpaid female labour in the production of care; the focus was on the state and the market, not the state and the family (O'Connor, 1993). Anttonen and

Sipilä (1996) included personal social services in Esping-Andersen's typology, delineating four types of welfare regime. First, the Scandinavian (Nordic) type is characterized by a universal right to services, funded through taxation. Local government is central in the planning and delivery of services, with a limited role for non-state organizations. Social work in these states would promote equality and security, and assist citizens in accessing their entitlements to meet their needs.

Second, the 'family care model' is characteristic of many southern European states, e.g. Portugal, Spain, Italy, Greece, Cyprus, and Malta. Here, social care provision is limited, and the state role is modest. Charities, religious and some for-profit organizations are significant care providers, along with women and families. The rights of users of services as citizens are less established than in other welfare regimes. Social work in these states may involve giving support, information or advice to families caring for an older person.

Third, in liberal and residual Beveridgean welfare states (e.g., the UK), the state assesses needs for means-tested social care services, which are mostly provided by the private sector. Health and social services are organised differently across the four UK nations – Wales, Scotland, Northern Ireland and England. Of the four, England has most rigorously pursued the model of state withdrawal from social service provision, and the substitution of cash-for-care through self-directed care (Department of Health, 2007). This shift has had implications for social work, which originally developed in the UK as a casework response to the needs of older people. Since the 1990s, the social work role has become that of care management, where social workers assess an older person's needs and financial resources against strict eligibility criteria, and then cost and arrange services.

Fourth, the central European corporatist and conservative subsidiarity model characterizes the welfare states of Germany, Austria and the Netherlands, and to a lesser extent France and Belgium. Services to older people are funded through health or social insurance and provided by a small number of large and well-established NGOs (non-governmental organisations) and families (in Germany), and by church-based NGOs in the Netherlands (Munday, 2003). The social work role is one of assistance to enable people to organize different kinds of help to maintain social integration.

Most pre-2004 accession states in Europe can be accommodated within an increasingly hybrid amalgam of the third and fourth types of welfare regime, i.e., liberal, residual and rooted in subsidiarity (Munday, 2003). This four-fold typology, however, takes no account (without development of a fifth type) of central and eastern European states, with their historical legacy of limited, state-provided, institutional care for older people and an emphasis on family care. That said, the nature and scope of social work with older people in Europe has sprung from the historical, social and economic features of the varying welfare regimes (Harris, 2008). Ney (2005) used the conceptual division of 'path dependency' and 'path departure' to analyze active ageing policy in Europe. 'Path dependent' change in the present arises from past political, economic and social policy – it is dependent upon it. In England, self-directed support and personal budgets are consistent with the means-tested residual history of its welfare state. 'Path departure' change is radical divergence from the past and its political and social paradigms, e.g. the re-construction of welfare in Germany following reunification in 1990. It is suggested that responses to challenges facing European social welfare are largely path dependent, and this is considered next.

### **Challenges and directions in European social welfare**

While the particular histories, drivers of change and policy responses to population ageing have varied across Europe, all countries face similar demographic and economic influences on provision for older adults in Europe (Tarricone and Tsouros, 2008). The main challenges to European welfare states are social, economic and ideological; they include population ageing, reduced informal family support (as women increase their labour market participation, decreasing the amount of unpaid care and domestic work they provide); increasing costs of care; raised expectations of the quality, intensity, and flexibility of services; and policy and political preference for a reduced state role and greater personal 'responsibility' to provide social care in old age.

Anderson (2003) observed that "[t]he family is the cornerstone for care in Europe" (p4). A key issue for older people is whether any legal obligation falls upon family members to support them economically. In conservative, corporatist welfare states, (e.g. Austria, Germany, Greece and Luxembourg) subsidiarity requires action to be taken at the

level of the individual and family before the state will intervene. Families thus are obliged to pay for the care of their older members. Daatland and Herlofson (2003) found a north-south divide in Europe when it came to filial support of older people in urban populations of five countries: it was highest in Spain and Israel, and lower (although still substantial) in Norway, England and Germany. These filial obligations did not mean that the family was regarded as the 'natural' care provider; the welfare state was still the main form of provision even where filial support to older people was high. There were calls in each country for greater state support.

The collapse of the global economy in 2008 and its aftershocks on levels of employment, economic growth and tax revenues amplified calls in Europe for a reduction of expenditure on welfare. Some countries, e.g. the UK, were early adopters of a mixed economy of welfare, where the state, business and the third sector [charities, NGOs and not-for-profit organisations] share – but not equally – the provision of welfare support with families. Most European countries are pursuing this model in one way or other in an effort to reduce state expenditure on care for older people. Economic pressures are severe on welfare provision that is state-provided and funded through taxation, as in Denmark and Sweden. Cash benefits made to older people (as in Austria) may fluctuate or fail to maintain their value when economic conditions are difficult. Generally, social care services are more vulnerable to cutbacks than health care; governments typically favour greater protection of health expenditure when cutting back on public expenditure (e.g., as in the UK in 2010).

The historical legacy of care services in Europe means provision is increasingly unfit to meet the needs of older people, as they grow older. For example, Sweden and Italy have little institutional care provision, contrasted to Hungary which is over-provisioned (a legacy of institutionalised care in this former communist state). The shift to community care from residential provision has been marked in UK social care planning since the 1980s, as it is now in Romania. Denmark historically has preferred community-based provision over institutional; no new nursing homes have been built there since 1987 (Schultz, 2010). Re-provisioning social care services in many former communist states (e.g. Hungary, Poland, Romania) has been hampered by a lack of

information on provision and needs of older people, although the European Commission-funded ANCIEN (Assessing Needs of Care in European Nations) research programme has begun to generate data on long term care in 20 EU states (ANCIEN, 2010).

Supply and demand problems beset provision of long term care services to older people, and ensuring supply of sufficiently and appropriately qualified care workers is a workforce challenge for most European states. There are insufficient numbers of trained nurses and doctors in Sweden, Poland and Finland. Demand for services is increasing. Reliance on unpaid female care-giving is common; in Slovenia 90 per cent of long term care to older people is unremunerated female labour (Ripel and Ogorevc, 2010).

Permeating all this are the impacts of economic globalisation, and increased individualization of care provision in older age. In general, economic globalization refers to the increasing speed and reach of global flows of money, technology, goods and services (Ginsberg, 2001), creating dense global connections, especially in trade, financial and labour markets. Alongside this, what Beck (1992) called a "social surge of individualization" tasks people with "choosing and planning one's own life course" (Ibid., p.93). Such individualization emphasizes personal enterprise, action and responsibility; it pays little heed to the needs of older people who may be frail, highly dependent, living with dementia or otherwise unable to demonstrate the requisite 'enterprise' in old age. This is typified in England, where the policy emphasis is on self-directed support and personal budgets to buy care. For some older people, the exigencies of individual budgets have been unwelcome (Glendinning *et al.*, 2008). In any case, cash-for-care ignores the impacts of structural inequality, poverty, gender, ageism (Ferguson, 2007): all aspects of disadvantage that professional social work is uniquely equipped to understand. The role of social workers in delivery of these personalisation policies is uncertain; they may spend less time on assessment and more on support brokerage, an ambiguous role for a state employee (Leece and Leece, 2010).

### **Social work with older people in Europe**

While social work is primarily tied to the state (e.g., Scandinavia, UK and Ireland) it is not exclusively a state activity. The social work

role and tasks are distributed across the third sector in most European countries (for example, the Netherlands, Greece, Spain and Portugal), as (most commonly) activities of the local state, social service configurations, functions and programmes differ among countries. 'Ageing' itself is also characterised by diversity. Across Europe, social work is called upon to address the values, norms and traditions of diverse groups of older people (Guttmann and Lowenstein, 1991). This includes older people with dementia, learning disabilities and mentally ill-health, as well as people from minority ethnic groups, who may face extreme ageism, racism and social exclusion in old age, and be at increased risk of abuse because of their vulnerability.

The European Commission has competence in areas of good practice in care for older people. This has mainly focused on transfer of knowledge through research and training programmes. There has been little critical comparison of social work with older people across Europe. The social work role with older people varies, from maintenance to behavioural change (e.g. Germany, with its concentration on functional assessment); social intervention (e.g. France, where the four components of intervention consist of help, animation, education and home care), to the management of care (e.g. the UK). In the UK, the social work role with older people was radically recast in the 1990s as previously outlined. It moved from a relationship-based model of social work to one of care-coordination and risk management, driven by cost and application of strict locally-set eligibility criteria, within a national single assessment process. As a result, UK social workers undertake limited face-to-face work with older people; formal care-giving is provided by care workers, who may not have the requisite vocational care qualification. Advocacy, counselling and crisis management can offer significant support to older people going through transitions in later life, but these services are now rarely a distinct feature of UK social work with older people.

The more residual the state support to the older person, the more severe the eligibility criteria for services. State support for long term care of an older person in England, for example, is restricted to those with limited income and financial assets. In Denmark, older people are eligible for long term care irrespective of their income or the availability of family care. Cash allowances are paid to older people in Austria with

agreed needs for care, without means-test. In Germany, statutory social care insurance covers the cost of long term care needs of older people. Who assesses the care needs of an older person also varies. In Germany a single needs assessment is carried out by a physician for the health care insurance fund (whether public or private). In France, domiciliary care assessment is carried out by one of a team of medical or social care staff. In England, social workers assess need and develop a care plan; eligibility criteria are set locally (Fernández *et al.*, 2009).

The consequences of such changes of professional role have been the de-professionalization and lowering of the status of social workers in many European countries (Chopart, 2000). In Spain, for example, the status of social work remains high; in Germany and France, the confidence in and strength of the profession is low despite common attempts to professionalize social work (Lyons, 2007). Elsewhere, a reconstruction of social work has occurred, to meet demands to modernize welfare (e.g., Romania and the Czech Republic). Notwithstanding these challenges to the profession, social work has been seen as a valuable contribution and an investment in the future welfare of Europe. The Committee of Ministers of the Council of Europe recognized in 2001 that "social work has made and continues to make a significant contribution to the response of economic and social changes and to the support of vulnerable people and communities during periods of change" (Council of Europe, 2001).

### **Social work education**

Social work academic discourses differ across Europe. In some countries (e.g., Germany, France, Italy Lithuania, Poland and Spain) the notion of lifelong learning and 'social pedagogy' guide the curriculum. Social pedagogy, a long-established epistemological paradigm, is distinguished from social work by its embrace of a 'normal state of society', where the institutional and individual need for learning and adjustment throughout life is nurtured to enable people, communities and societies to deal with social problems (Lorenz, 2006). In the UK social work education, individualist casework (with its focus on personal responsibility and individual adaptation to circumstances) predominates the curriculum, with community-based approaches (that recognise the impacts of poverty, inequality and social exclusion on individual functioning) at best marginal. This contrasts with social democratic

welfare regimes where individual casework and community-based approaches are regarded as complementary, receiving equal emphasis in social work education (Ibid.).

The academicization of social work education in Europe has accelerated since the 1980s, when Finland, Iceland and Ireland were the only countries requiring graduate-level professional social work training. By 2006, professional social work qualification had been established at graduate or postgraduate levels in Estonia, Italy, Latvia, Lithuania and the UK, and (depending on the definition used of social work) Germany (Lorenz, 2006). Social work incorporates knowledge from a wide variety of disciplines, such as sociology, psychology and criminology. Nordic countries and liberal regimes like the UK, include social policy. In Finland, research and social policy analysis are regarded as central to competent practice, and are core elements of social work education curricula. To date, there has been little attempt to infuse social work with critical gerontology (to expose the political, economic and social influences on ageing), or to include geriatrics and gerontology in the professional social work curriculum (Ray Bernard and Phillips, 2009).

### **Human rights**

Human rights of older people are a focal point of social work education in Europe, although statements of rights of older people were slow to develop, compared to charters on the rights of children (e.g., the UN adopted the Convention on the Rights of the Child in 1990). As noted earlier, the statement “principles of human rights and social justice are fundamental to social work” is part of the international definition of social work. The Madrid International Plan of Action on Ageing (MIPAA) was adopted in Madrid in 2002 by 151 countries. This was founded on the original International Plan of Action on Ageing of 1982 (Vienna) and the 1991 UN Principles for Older Persons, which contained guidance on interdependence, participation, care, self-fulfilment and dignity. MIPAA identified priorities for policymakers, including advancing health and well-being into old age, areas where social work can offer a great deal in advocating, enabling and providing care that centres on the older person’s goals, needs, and strengths.

Tang and Lee (2006) identified the particular role social workers have in enabling older people realize their human rights, through social work’s critical professional awareness of the nature of oppression and discrimination. However social work is rooted in the welfare system in which it is practised. Lyons (2007) argued that although there was a shared acknowledgement within the profession of the role of social workers in promoting equality and human rights, the way in which this was pursued in practice was contingent on national circumstances, social and economic policies, as well as public attitudes. Human rights may be a core part of the social work curriculum in much of Europe, and social work is potentially in prime position to promote these. However, welfare regimes that emphasize individualism and personal responsibility for dependency (such as the UK) mitigate the emancipatory potential of social work to ensure the human rights of older people (Ellis, 2004).

### **Environments of practice and care**

In most European states, community care and enabling older people to stay in their own homes has been a policy direction since the 1990s. In general, a greater proportion of people age 55 and older live in Europe’s countryside than in urban areas. Older people often live in poor quality housing, which they may have found hard to maintain as they have aged (Giarchi, 2006). Retirement migration into relatively isolated rural settlements can lead to requests for formal care, particularly if family support is not available nearby. Increasing numbers of migrants moving from Scandinavia, Britain and Germany (e.g., to Spain and Portugal), can be isolated if they experience health and social care problems, because of geography and limited second language fluency. Social workers may not be trained to understand different cultures; consequently older people may be isolated geographically and linguistically (King *et al.*, 2000). Some states, such as the more recent members of the EU (e.g. Romania) have little, if any, care provision for older people outside major urban centres. Social isolation, social exclusion of older people from particular ethnic groups, rural poverty and lack of accessible sources of informal or paid care in remote communities are all problems where social work can provide advocacy, practical support and care services.

### Partnership and multi-disciplinary work

At the policy and organisational level, the EU heavily promotes 'partnership' as the means to organise and deliver services (Munday, 2007). Partnership is central to the mixed economy of care, with its emphasis on involvement of non-state organizations, especially the private sector, in the provision of care. Consequently, the boundaries of social work are increasingly blurred as more social workers practice in multi-disciplinary settings with, for example, doctors, psychiatrists, psychologists, nurses and other health workers. How far moves towards integration are delivering better outcomes for older people is uncertain. Multi-agency working may be more effective in delivering services where there is little division between health and social care, such as in France (Munday, 1996). In England however, a single assessment process was introduced in 2004 to promote a multi-disciplinary model of service delivery, yet evidence of its effectiveness for older people with complex needs is lacking (Challis *et al.*, 2010).

### Futures for social work with older people in Europe

We have suggested that the diversity of social work practice with older people in Europe is rooted in the type of welfare regime in which it is practised. Welfare regimes still matter in how states respond to ageing and the social risks arising from deindustrialisation (Tepe and Vanhussye, 2010). If this is the case, how should social work in Europe respond to the care of older people? Should the profession remain diverse, or aim for a converged approach to work with older people across Europe, not only to lift its own status but, crucially, to ensure that the rights and needs of Europe's older citizens are met?

Across Europe, the backcloth to social work with older people in the early 21<sup>st</sup> century is state withdrawal from provision of welfare, and fiscal austerity. Although profit-making businesses are increasingly involved in care provision, the private sector has not embraced social work. Social work with older people remains low status and attached to the state. It is transacted in a globalised world, where ageing populations face common challenges. New social problems emerge, such as transnational care and support of older people: these require global responses that social workers are called upon to deliver. The effects of globalization, individualization and cash-for-care services are ambiguous:

social work is uniquely equipped to understand and work with these ambiguities and their impact on older people (Lorenz, 2005). This may lead to a stronger European identity for social work. Similarly, if convergence of European social and economic policies accelerates, this too may drive development of a European social work identity.

Nonetheless, there is no definitive, unifying interpretation of social work with older people in Europe, particularly from a 'top down' policy perspective, that is, one deriving from central social policy (Lorenz, 1994; Frost, 2008). Lorenz (1994) argued social work's professional strength and value lay in its identification with promoting human rights, citizenship and self determination. Thus any unification of the social work identity would come from a 'bottom up' approach, one based on common values, ethical and moral codes and intellectual frameworks of the actors: what social workers believe in.

The diversity of social work with older people is not a professional weakness, but reflects its role in bridging society and the individual, mediating the impacts of social problems on the needs and interests of users of social services. Whether or not social work with older people in Europe converges, the 'collective hopes, dreams and affiliations' Lorenz speaks of offer a unifying identity for social work with older people that transcends national boundaries.

### Acknowledgement

**Acknowledgement of research support: Economic and Social Research Council Research Fellowship award PTA-026-27-2617.**

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**Indian Journal of Gerontology**  
2011, Vol. 25, No. 4, pp.494-515

## **Australia's Response to Population Ageing and the Development of Gerontological Social Work**

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### **ABSTRACT**

*Australia's population is steadily ageing, which has allowed time for the government to develop appropriate anticipatory strategies. Compared to Asia, the actual size and pace of population ageing has been relatively modest with approximately 2.9m 65+ out of a total population of 22m (13%). Since the mid 1980's Australia has had a coherent national aged policy in place in relation to health care, income security and long term care and has steadily increased the incentives and range of services that maintain older people at home for as long as possible with an appropriate quality of life. Over the same period, there has been a major shift in the balance of care from largely institutional to a range of community care options. The development of gerontological social work in Australia has paralleled government policy leadership and service development and most social work programmes in the country now offer mainstream or elective courses on ageing with some having specialist policy and practice research units. This paper reviews Australian policy development in relation to population ageing and outlines the parallel development of gerontological social work.*

**Key Words:** Australia, Population Ageing, Gerontological Social Work

Under the Howard Conservative government from 1996-2007 a National Strategy for an Ageing Australia (Commonwealth of Australia 2001) articulated the overall direction of policy and service development. Under the Rudd/Gillard Labor Social Democratic Government that was first elected to office in 2007, policy in relation to ageing has primarily

been articulated by new health (Commonwealth of Australia, 2009) and tax reform initiatives (AFTS Secretariat, 2010) and a social inclusion agenda (Prime Minister of Australia, 2008). The former has emphasized greater attention to health promotion strategies and self management of chronic health conditions, the latter has focused more on eradicating inequities in service provision related either to disability, ethnicity or socioeconomic status. As Australia's population profile becomes older, the better articulation of hospital and health service reform (Commonwealth of Australia, 2009) with post acute care, supported housing (Jones *et al.*, 2010) and community care is becoming increasingly important, as are ongoing innovation and interventions to maintain older people in the community for as long as possible. Long term care expenditure represented 1.1 per cent of GDP in 1997 and is projected to rise to 1.38 by 2031.

Since the mid 1980's Australia has undertaken regular planning reviews of its aged care policy (Commonwealth of Australia, Treasury 2007). In May 2010, the Australian Federal Government established a new *Caring for Older People Inquiry* (Commonwealth of Australia, Productivity Commission 2010) to explore Australia's long term care needs to 2050. The mandate of the Inquiry is to

- Examine the **social, clinical and institutional aspects of aged care** in Australia, building on the substantial base of existing reviews into this sector
- Address the interests of **special needs groups** e.g. indigenous aged, dementia sufferers etc.
- Develop **regulatory and funding options** for **residential and community aged care** (HACC) (AFTS Secretariat 2010)
- Examine the **future workforce requirements** of the aged care sector
- Recommend a **path for transitioning** from the current regulatory arrangements to a new system that ensures continuity of care and allows the sector time to adjust
- Examine whether the **regulation of retirement specific living options** should be aligned more closely with the rest of the aged care sector

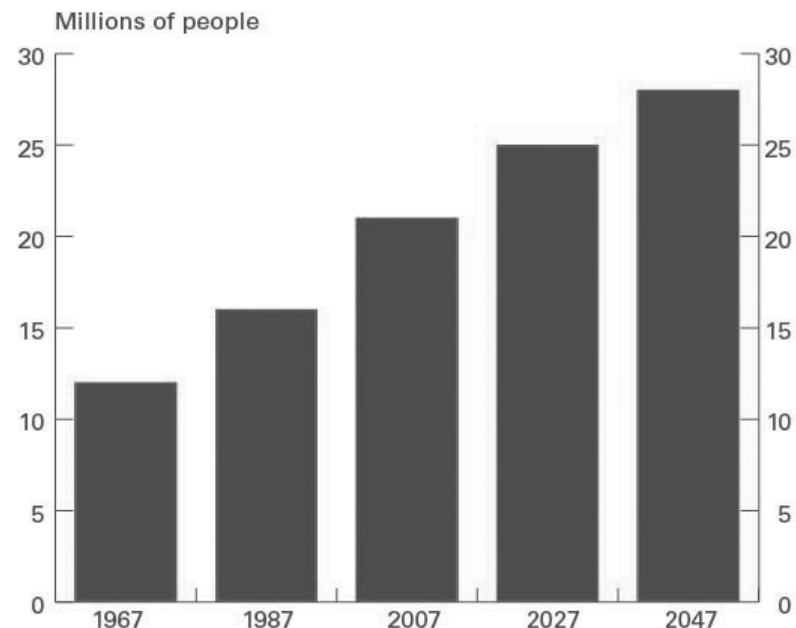
- Assess the **fiscal implications** of any **change in aged care roles** and responsibilities

This paper will explore Australia's response to population ageing by first examining the countries specific demographic profile and the historical development of policy and services in relation to an older Australia. It will then examine how social work has responded to population ageing, what are some specific development priorities in this regard and some of the challenges in relation to an older Australia going forward.

### The Demography of Ageing in Australia

Australia's total population is 22m and by 2047 it is projected to rise to 28.5m.

**Figure 1: Historic and Projected Australian Population**

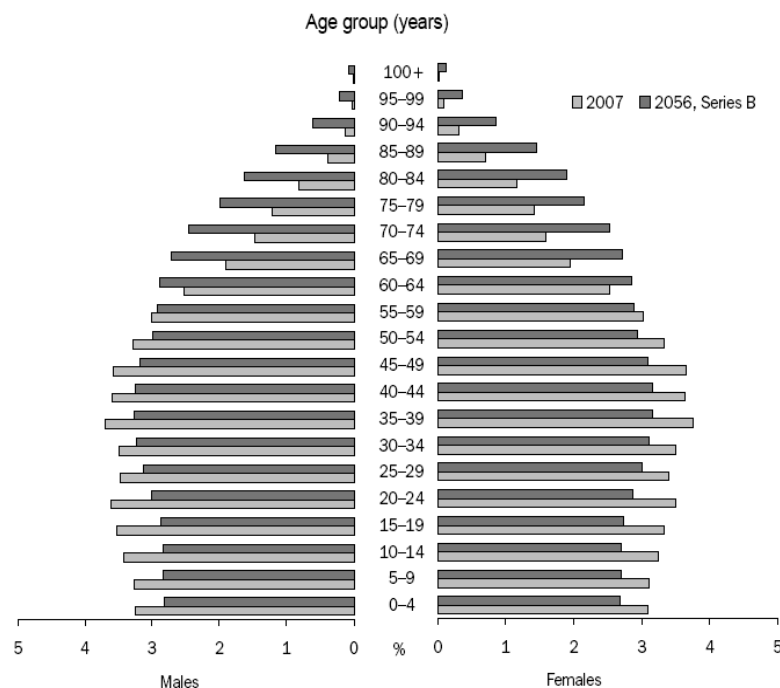


Source: Australian Bureau of Statistics data and Treasury projections

There are 2.9m people over 65 in Australia representing 13.2 per cent of the total population. In the last decade, the growth rate of the 65+ population has been fairly constant at about 2 per cent per annum.

Life expectancy in Australia has been increasing almost continually throughout the last century and into this one, including for those in older age groups (AIHW 2007). At age 65, Australian men can expect to live for a further 18.5 years (83.5) and women for another 21.8 years (86.6). This is between 7 and 9 years more than their counterparts at the beginning of the 20<sup>th</sup> century (ABS 2008) and has resulted in growing numbers of older people who may need aged care services and financial support during retirement. Among the population who are most likely to need and use aged care services, those 85 years and over, the rate of growth has been considerably higher (between 3% and 7% per annum). Between 1998-2008, the number of people in this age group increased by 61 per cent. Growth in the very old population will be a major influence on government spending on aged care in the future, with the number of people aged 85 years and over projected to increase in the next 50 years to 1.8m people, or 5 per cent of the total population (ABS 2008).

**Figure 2 Population Pyramid Australia 2007-2056**



Australia's older population comes from diverse social and cultural backgrounds given the country's substantial post war migration programme. Over one-third of older people were born overseas. Numbering close to 1 m, overseas-born people accounted for 25 per cent of Australian residents aged 65 years and over on 30<sup>th</sup> June 2007. The birthplace with the largest numbers of older overseas-born Australians is the United Kingdom (over 300,000). However, almost two thirds (62%) of older overseas-born Australians come from non-English speaking countries. In all 22 per cent of older Australians were born in a non-English speaking country. Italy is the major country of birth of older immigrants from non-English speaking countries (117,000 people, or 4 per cent of all people aged 65 years and over) followed by Greece (63,000 people, or 2%), the Netherlands, China, Croatia and Poland (all 1%) (ABS, 2008). There has been a major shift in post war migration from the old countries of Europe to increasing numbers from the Asia/Pacific region and Africa.

The number of older Aboriginal and Torres Strait Islander people is small but growing, representing currently approximately 2 per cent of the population. By and large Australia's indigenous population has not participated in the revolution in longevity achieved by the rest of the population, largely due to the cumulative disadvantages of early dispossession from their tribal lands and a history of colonization and marginalization (AIHW, 2007).

While the number of people of traditional working age (15-64) is projected to slightly increase, their proportion in the population is expected to fall. In 2007 there were 5 people in the workforce to support every person aged 65 and over. By 2047, there will only be 2.4 per cent people of working age supporting each person 65+.

### The Australian Aged Care System

One hundred years ago (1909) Australia recognised older people's need for support and assistance by introducing the Aged Pension (FaHCSIA 2008). At that time the pension was paid to men and women of 'good character' when they reached age 65, at a time when men had a life expectancy of 55 and women 59. The Age Pension (along with pensions for war veterans and their spouses and widows) continue to be a major pillar of the Australian retirement income system.

Aged care services have a more recent history in Australia, mostly being developed after World War II in response to the housing needs of low-income older people and the nursing care needs of the frail aged.

Ten years ago (1999) the International Year of Older Persons highlighted the need for an appropriate caregiving mix for frail older persons, encompassing family, community and institutional care systems (United Nations 1999). In its policy response to the International Year of Older Persons (The National Strategy for an Ageing Australia), the Australian Government articulated its goal to develop a world-class, high-quality aged care system (Commonwealth of Australia 2001).

In 2008 the Ministerial Conference on Ageing was established to provide a forum for all levels of government to work together and respond to such issues as housing for older people, the need for 'active ageing' and more cohesive and efficient aged care services across Australia (DoHA, 2008).

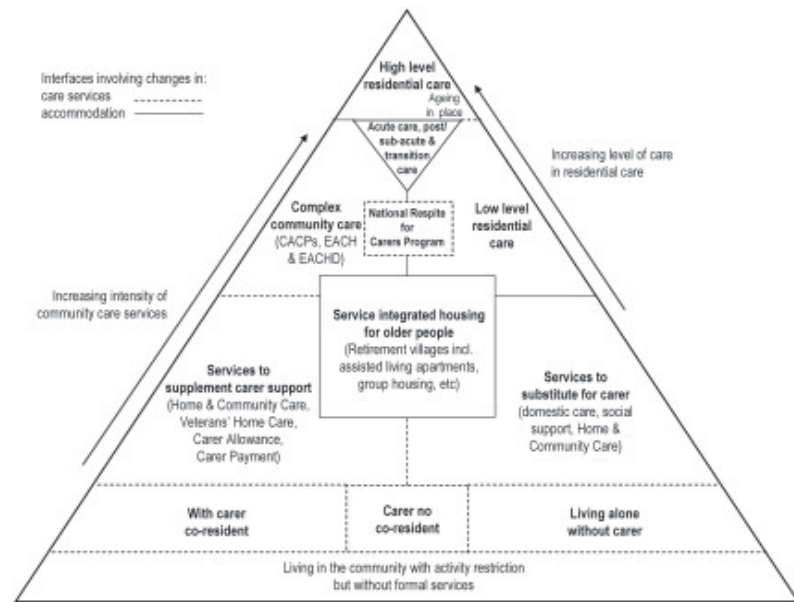
The Australian long term care system covers a range of services provided to older people who have diminished capacity to care for themselves because of physical/mental disability or frailty. It can include one or more of the following

- Assistance with everyday living activities – such as cleaning, laundry, shopping, meals and social participation
- Help with personal care – such as help with dressing, eating and toileting
- Health care – such as medical, nursing, physiotherapy, dietetics and dentistry
- Accommodation – provision of high and low care

The intensity and type of aged care services required to meet the needs of older people increase with frailty and aged-related illnesses. About 54 per cent of Australians aged 70 years and over report needing assistance with personal and everyday activities compared with 85 per cent of those 85 years and over (ABS, 2004).

The aged service continuum in Australia is summarised in Figure 3. The closer the service is to the top of the triangle, the greater the level of care required and the more resource intensive the service tends to be (Commonwealth of Australia, Productivity Commission 2010; Howe, 1996).

**Figure 3 : Models of care in the aged care system**



Source: Commonwealth of Australia, Productivity Commission (2010)

Australia has a federal system of government in which the central government deals with national concerns such as foreign policy, social security and major forms of taxation, and State/Territory governments cover areas such as education, public housing and hospitals. The provision of aged care involves all tiers of government, including local government, with care being provided by a range of public and private (profit and non-profit) providers.

Following extensive review and discussion at the Council of Australian Governments in April 2010, the Rudd Federal Government announced, that responsibility for Aged Care would transition to the Commonwealth and that the General Services Tax (GST) would be reclaimed from the states to finance this. Though two states, Victoria and Western Australia, initially resisted this takeover, on the grounds in the case of Victoria that they already had a well functioning system, and in the case of Western Australia, that they did not wish to give up the GST, there is a general view in favour of one national system.

The aims of the Australian long term care system are to ensure that all frail older Australians have timely access to appropriate care and support services as they age through a safe and secure age care system (DoHA, 2009).

Key themes running through the Aged Care Act 1997 (the foundation Act of the current system), the accompanying Aged Care Principles and the Home and Community Care Act 1985 are the need to

- Guarantee an acceptable standard of care
- Provide accountability and transparency
- Facilitate access to care regardless of economic and other circumstances
- Target services and funding to those with the greatest need
- Encourage diverse, flexible, efficient and responsive services that facilitate independence and choice.

A further long-term objective of government is to realise greater integration in the provision of care for older Australians. The National Healthcare Agreement states that "older Australians (should) receive high quality, affordable health and aged care services that are appropriate to their needs and enable choice and seamless, timely transitions within and across sectors (COAG 2009)."

### **The Response of Social Work Education to Population Ageing**

Work with the elderly has long been a traditional area of social work practice in Australia, particularly when the aged were identified as a major population in poverty (Rosenman 1988). Access to universal health care, a public pension and post war affluence have however lifted the present generation of elderly largely out of poverty and it is the issue of population rather than individual ageing that is presently preoccupying governments and the professions as income security and health expenditures rise and more and more of the population achieve a substantial extension of life into their 80<sup>th</sup> year and beyond.

There are currently 27 Schools of Social Work in Australia that graduate approximately 1,500 students annually (Ozanne and Agbim,

2007). The majority of these schools deal with ageing as a significant lifecourse issue and offer either electives or specialist units on intervention with the elderly. Several schools also have substantial post graduate research units on ageing and graduate a steady stream of Ph.D students on ageing related topics. The integration of ageing material across the curriculum is however by no means systematic or universal and ageing is not yet a mandated field of practice required for accreditation (as is child protection, indigenous practice, and practice with culturally and linguistically diverse populations (McCormack, 2008; Ozanne, 1989).

The primary fields in which social workers work with older adults in Australia are health, mental health, community care, and family support services. The majority of social workers tend to be involved in direct service delivery as caseworkers or care managers, with approximately one third in program. The management or more senior policy and planning roles (Hughes and Heycox, 2010).

Individual counselling, family and intergenerational casework and groupwork occurs primarily in family support services, community health and mental health centres, local government services, postacute rehabilitation services and nongovernment aged and disability services and in private practice (Naughtin and Schofield, 2009).

There has been a major expansion of community care services in Australia since the mid 1980's, from a small and fairly basic set of home support type services to the development of a broad mix of service types and a range of more and less intensive home support packages requiring active brokering and care coordination (Howe, 1996). Under new Extended Care at Home Packages (EACH), an older person can now be maintained at home even with very high levels of disability, including dementia. Local governments employ social workers as assessment officers, care managers, and directors of aged and disability services. Social workers are also part of core staff groups in not-for-profit intensive home care agencies as care managers and CEO's.

One of the largest areas of social work practice with older adults is acute and postacute care in hospitals and rehabilitation centres where social workers are employed as program coordinators, discharge planners, case managers, and direct care workers. Social workers are key members of Aged Care Assessment Teams, which serve as

gatekeepers to long-term care facilities and have a strategic role in relation to family support in interdisciplinary acute and postacute rehabilitation.

Social workers are also employed in psychogeriatric assessment teams and services, such as the Cognitive Dementia Assessment and Management Services (CADMS), which are focused on early diagnosis of dementia and appropriate referral of family members to various support services (Manthorpe and Iliffe, 2009). They are also active in Alzheimer's advocacy organizations across Australia and in running the very positively evaluated Living with Dementia groupwork program nationally.

Social work roles in long-term residential care are less well developed in Australia than in some other countries where social workers take more key roles in managing long-term care facilities. Managers of these facilities in Australia tend to be nurses (if they have qualifications at all), and social workers are employed primarily in direct care manager and service delivery roles in public high-level care facilities as caseworkers, family workers, group workers and discharge planners.

Social work has had a long-term commitment to end-of-life care across a range of settings from the acute hospital to hospice to coronial services. There has been a major review and restructuring of end-of-life services over recent decades to keep pace with the demands of population ageing and to ensure a timely, high, and equitable standard of response across all service types. Social workers in partnership with other professional groups, have taken a strategic role in several of these developments (Cartwright, 2008).

Case management has seen steady development as a mode of practice in Australia over the last couple of decades in health, mental health, child welfare, vocational rehabilitation, disability and gerontology (Ozanne *et al.*, 1990). The National Case Management Society, which was formed in Australia in 1998, holds an annual conference and produces a quarterly journal. Social workers have been active in this development both in broadening the approach to case management from a narrow health to a more psychosocially focused activity and in addressing the diversity of practice populations. Since late 1990's three major texts on case management practice in Australia have been published by social

workers in concert with others (Ozanne *et al.*, 1990; Gursansky *et al.*, 2003; Moore, 2009).

Australia has a universal health care system, Medicare, funded from taxation with a small population co-payment. Health care is thus still largely a public system, and Australia has so far not seen the development of large-scale managed care providers. New forms of public regional coordinated and integrated health care delivery systems are, however, being trialed (Commonwealth of Australia, 2009), and these schemes increasingly mandate some form of case or care management as the preferred mode of practice (Fine, 1999).

Increasingly, private practice social workers have encountered the impact of population ageing on individuals and families. Private practitioners are involved in intergenerational family counselling in nuclear and reconstituted families. In addition, social workers in private practice have encountered increased instances of having to assist families in a much longer-lived society with major life course transitions around divorce, widowhood, retrenchment and retirement.

In the last decade numerous new social work roles have been created in the aged and community care service system as existing services have expanded and new service types have been created. Social workers have taken up new roles on guardianship and administration tribunals, as members, investigators and guardians. They have assumed roles as complaints officers and ombudsmen in new quality assurance arrangements in health care. They have also become key players in aged care assessment teams, cognitive assessment and dementia management services, and care coordinators in rapidly expanding home care services, implementing a range of new flexible and innovative home care packages (Fine and Pross, 2009).

### ***Work with underserved and at-risk populations***

In the Australian context, older populations identified as at particular risk are Aboriginal and Torres Strait Islanders, culturally and linguistically diverse populations, dementia sufferers and their caretakers, low-income and homeless aged, and rural and remote dwellers (Ozanne, 2009). Social workers are active in the targeted delivery of services to these groups, which are explicitly recognized in current government policy



and programme initiatives. There are also several under-recognized and underserved populations, for instance, older gay lesbian intersex and transgender populations, the older disabled, older prisoners and older refugees. Individual social workers have highlighted the plight of these populations and advocated for more explicit attention to their needs (Hughes, 2009; Harrison, 1999; Bigby, 2002; Dawes, 2009; Lipmann 2009; McDermott *et al.*, 2009; Hugman *et al.*, 2004).

Social workers have taken a prominent role in heading up some of the major aged advocacy organizations and peak bodies in Australia in both CEO and policy officer positions. Through these activities several have also taken leadership positions in the International Federation of Ageing and regional Asia Pacific aged policy forums (George, 1997). Australia hosted the 2010 International Federation of Ageing Conference in Melbourne in May and will be hosting the 9<sup>th</sup> Asia/Oceania Regional Congress of Gerontology and Geriatrics in October 2011. Social Workers have been active in the establishment of various self-help and advocacy organizations, like Alzheimers' Australia and the Carers Association, and hold roles as CEO's policy officers and researchers in these organizations.

As government has taken a more proactive role in the last decade in restructuring the service system in relation to an older population, so also key aged advocacy bodies and national councils have formed new coalitions and engaged in partnering discussions and mergers to increase their power and influence on government. Social workers have been active in these negotiations and in many instances have taken a leading role in pressing both industry and consumer claims (Encel and Ozanne, 2007).

### **Increasing Publication and Research**

The last decade has seen a steady increase in the number, range and quality of social work publications on ageing from both a policy, research and practice perspective. In 2007 Borowski and colleagues published a major policy text on Longevity and Social Change in Australia. In 2009 a special issue of Australian Social Work was commissioned on Diversity and Ageing (Ozanne *et al.*, 2009). In 2009 Moore Elizabeth published Case Management for Community Practice and Hughes and Heycox (2010) published their text on Older People,

Ageing and Social Work utilizing Australian case study material and highlighting the needs of some non-traditional client groups. Several social work research centres around the country have done substantial work on financial abuse of older persons (Wilson *et al.*, 2009), social isolation and the elderly (Findlay, 2003), end-of-life care (Cartwright, 2008) the older intellectually disabled (Bigby and Knox, 2009), innovative service integrated housing models (Jones *et al.*, 2010) and psychosocial support in dementia care (Manthorpe and Iliffe, 2009).

### **Workforce Development**

In the last half decade there has been much greater recognition by government of the need to put more substantial resources into workforce development and capacity building in relation to population ageing (Commonwealth of Australia, 2009). Presently the social work workforce is small relative to other groups like nurses (Healy and Lonne, 2010), but there has been a substantial expansion of training positions for social workers in the last half decade and new government investment made in the expansion of clinical training places both in terms of absolute numbers and the development of new training settings e.g. general practice/primary care (Health Workforce Australia, 2010). These developments are utilizing both interdisciplinary and discipline specific programmes and new rotational learning models.

### **An Agenda for Future Action**

In reviewing the current development of gerontological social work in Australia in response to population ageing, the following areas would seem to have priority. In this regard the US Hartford Geriatric Social Work Initiative provides a ready model for emulation ( Berkman *et al.*, 2000; Hooyman, 2009).

#### ***More specifically defining the social work contribution to the quality of life of older persons***

There is perhaps a need in Australian social work circles and beyond to define more explicitly the social work contribution by ratifying a core national statement of knowledge, values, skills and competencies and articulating more explicitly to external publics what is unique about social work's focus in this area of practice in terms of skills in psychosocial assessment, systems analysis and ecological understanding.

***Mobilizing more effectively existing practitioner resources***

Frontline workers are presently mediating rising demands from ageing baby boomers, often without specific training in gerontology or any continuing and further education backup from their professional organization or social work schools. There needs to be a two-way process whereby their frontline experience is mined (Epstein, 2009) but also supported by appropriate developmental opportunities so practitioners might hone their skills in advanced practice and research with older persons.

***Development of innovative field practicum***

Service reform in response to population ageing has been an active part of government service restructuring in Australian aged services over the last decade and a half. In this period quite a lot of new service settings and practice models have been developed, pioneered by on the ground practitioners working collaboratively with other disciplines. These services are often also a part of larger regional service systems and networks. They represent the frontline of change and are valuable primary training sites for social work students. Designing, supporting and resourcing innovative field units in these settings is critical for the future training of students.

***National training institutes for faculty/postgraduate students***

Achieving funding support from some of the government ageing workforce initiatives or a philanthropic body to support national social work training institutes for faculty and/or post graduate students in gerontology would be one way to foster and develop teaching and research capacity in schools of social work. This might also be undertaken collaboratively with the Australian Association of Gerontology.

***Fostering joint appointments between Universities and major aged care providers***

A development which has taken off more recently in Australia is the initiation of several joint appointments between universities and major aged care providers in the public health, charitable, non government and private sectors. The aim of these appointments is to forward applied research into evidence based practice in these settings and consolidate

an ongoing research relationship with universities. Currently in the State of Victoria there are several such joint appointments with St. Vincents Health, Mercy Care, Uniting Church, Brotherhood of St. Laurence (major NGO) involving both The University of Melbourne and LaTrobe University. There are similar developments at The University of Queensland and Curtin University in Western Australia.

***Emerging researcher forums***

Given the relatively small critical mass of gerontologists and social workers around Australia, support for this type of development would appear essential to reinforce emergent research capacity. The Australian Association of Gerontology started an Early Researcher on Ageing Network in 2006 and this has since blossomed into a regular annual event just prior to the national Gerontology Conference.

***Funding for postgraduate scholarships***

There has virtually been no development of dedicated gerontological social work scholarships in Australia. The only scholarships presently available for master's doctoral and post doctoral studies rely on individual faculty building in such scholarships to their grant applications. Philanthropic and government funding of dedicated scholarships is an option that would be timely to explore. Current government reviews recognize this as a critical issue in development and training of the future workforce.

***Collaborating on joint research projects***

There has been a steady rise in the amount of gerontological research and publication in social work over the last decade. Though the Australian Research Council/National Health and Medical Research Council Ageing Well Research Network, whose remit was to stimulate gerontological research and capacity building, has come to an end – there are now several research centres around the country forwarding gerontological research efforts. In order to increase their successful strike rate, social workers probably need to take maximum advantage of the initiative to partner with colleagues from other disciplines on topics relevant to social work's core concerns. International collaborative research with Asia and Pacific Rim countries and gerontological centres in the United States, the United Kingdom and Europe would help further this agenda.

### ***Establishing a Visiting Scholar Exchange Program***

Social work should perhaps take more advantage than it presently does of the RM Gibson Travelling Scholarship in Gerontology sponsored by the Australian Association of Gerontology in bringing key overseas social work gerontologists to Australia. Australian faculty would also greatly benefit from the opportunity for exchange with some of the key gerontological centers in the Asia and Pacific region, United States, United Kingdom and Europe.

### **Challenges going forward**

The Australian Productivity Commission has identified several challenges for the Australian aged care system going forward (Commonwealth of Australia, Productivity Commission, 2010) to which public policy and service development will need to respond. This will also present major challenges for professions like social work in terms of anticipating, responding to and exercising leadership in relation to the next phase of population ageing. The challenges the Productivity Commission identified were

- an increased preference for independent living arrangements and choice in aged care services,
- greater levels of affluence among older people, recognising that income and asset levels vary widely;
- changing patterns of disease among the aged, including the increasing incidence of chronic disease such as dementia, severe arthritis and serious visual and hearing impairments, and the costs associated with such care;
- reduced access to carers and family support due to changes in social and economic circumstances;
- the diverse geographic spread of the Australian population; and
- an increasing need for psychogeriatric care and for skilled palliative care;
- the need to secure a significant expansion in the aged care workforce at a time of 'age induced' tightening of the labour market and wage differentials with other comparable sectors.

The current Productivity Commission Inquiry is tasked with a whole-of-government response to the above challenges and will report in April 2011. The recognition by the federal government of the major professional workforce shortfalls should mean a substantial boost in funding for social work training places. The challenge for social work education (Scharlach *et al.*, 2000; Volland and Berkman, 2004) is to make sure it has the staffing, curriculum and practicum opportunities in place to take a leadership role in preparing students for the new demands of the 21<sup>st</sup> Century.

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**Indian Journal of Gerontology**  
2011, Vol. 25, No. 4, pp.516-531

## **Japanese Approach to Elder Abuse: Implications for Prevention in Emerging Developed Countries**

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### **ABSTRACT**

*This article aims to share information about Japan's policy interventions for responding to the increasing number of elder abuse cases. Over millennia, many Asian families have followed Confucian virtues in taking responsibility for the care of elderly family members. However, the new economic system (capitalism) and its ideology (individualism) have likely impacted these traditions, with potential implications for the care and treatment of older citizens. We first provide the background on elder abuse in Japan and then organize major findings from recent national studies into micro and macro-level factors that contributed to the increasing discovery of elder abuse cases and the development of elder abuse prevention laws in Japan. Next, we describe a new Japanese law developed in 2006, the Elder Abuse Prevention and Support for Caregivers of the Elderly Act. In addition to the Japanese model of case detection, we endorse the development of more effective social intervention programme to adequately support family caregivers and respond to the needs of elders at risk for abuse and neglect.*

**Key words:** Asian tradition, Elderly abuse and neglect, Japanese policy

Certain Asian countries, including Japan and other emerging developed countries such as South Korea, Singapore, China and India, face a rapidly increasing number of elderly citizens (United Nations, 2002; Nizamuddin, 2003). Currently, the pace of ageing in Asian countries is faster than in the West (Nizamuddin, 2003). In Sweden, for instance, it took 114 years for the proportion of people aged 60 years and older to

double, growing from 7 per cent to 14 per cent of the total population (Cliquet and Nizammuddin, 1999; Gubhaju *et al.*, 2001). Yet, in Singapore, this growth took only 18 years to accomplish, while China and India have been estimated to have done so in 25 to 28 years (Cliquet and Nizammuddin, 1999; Gubhaju *et al.*, 2001). According to the Census of India, as India faced a dramatic increase in its total population from 361 million in 1951 to over 1 billion in 2001, the number of elderly increased from 19 million (4% of total population) to 77 million (7.5% of the total) during the same time span (Bhattacharya, 2005). Effectively meeting the increasing demands for elder care can be challenged by certain ideological changes associated with the rapid socioeconomic transformations in these countries.

In traditional Asian societies that have experienced economic boom, many families continue to follow the dictates of Confucianism that define caring for the elderly as the duty of family members. As a result, many Asian elders have been cared for by their children, children-in-law, or female partners. However, when the old socioeconomic system is replaced by new market-driven economies—such as capitalism—family caregivers may experience different types of psychosocial stress and the challenges of caregiving may be exacerbated. A new economic system and its component ideologies, such as individualism, impact traditional values—namely the value placed upon family-centered collectivism that fostered the intergenerational support structure within extended family systems. Changing values related to family structure, in conjunction with evolving gender roles, can directly affect elder care in a number of ways. Social transformations in Asia may have weakened the traditional care-giving system that celebrated the elderly as deserving of their family members' respect and care. As a result, the elderly who require care and assistance may be neglected or abused by family members who did not expect to take on elder care responsibilities and who do not have adequate caregiving skills or resources.

As an early economic boomer in Asia, Japan experienced a painstaking process of adjusting its elder care systems to meet the needs of the growing ranks of elderly citizens over the past century. The objective of this review is to share lessons learned from Japanese legislative efforts with the policy makers and gerontological

professionals in India, China, and other economically thriving countries with similar family traditions. We first describe the background of elder abuse in Japan and the emergence of research on this social phenomenon. Next, to offer precise insight for other Asian countries, we organize macro and micro-level factors into a socio-cultural transitional framework to explain what preceded the enactment of the Japanese 2006 Elder Abuse Prevention and Support for Caregivers of the Elderly Act (Elder Abuse Prevention Act), which was designed to address the growing number of cases of elder abuse in Japan. After describing this law, we conclude by highlighting the lessons to be learned from Japan's experiences. We believe these lessons, particularly those related to the detection of and response to elder abuse, may be of benefit to other emerging economic powers in Asia.

### **Background Factors Leading to the 2006 Law**

#### ***Increasing Number of Elder Abuse Cases***

Japanese people enjoy great longevity and many Japanese citizens live beyond 65 years (Ministry of General Affairs, 2004). The average female lifespan in 2005 (85.49 years) was the longest in the world, while the lifespan for Japanese men (78.53 years) was the fourth highest in the world (Ministry of Health, Labor and Welfare, 2005). According to national statistics, Japan's elderly (65 years or older) currently total 28.22 million (22.1% of the population) (Ministry of Health, Labor and Welfare, 2008). Further, the increase in those older than age 65 is expected to continue. Data from the Ministry of Welfare and Labor indicate that, by 2050, the elderly will comprise 39.6 per cent of the total population (Ministry of Health, Labor and Welfare, 2008).

Despite its population enjoying a long life, the Japanese government did not pay much attention to issues related to the quality of life among its older citizens (e.g., infringement of elder rights, elder abuse) during the first three quarters of the 20<sup>th</sup> century (Kaneko, 1987). However, a groundbreaking study released at the end of the 1980s ended this trend. Kaneko (1987) investigated a sample of medical personnel, public health employees and social workers who provided nursing home care for the elderly in an urban environment. It was the first study of its kind to reveal that in-home abuse accounted for most elder abuse cases and that elder abusers tend to be the primary family caregivers living with

the elderly. After examining a collection of elder abuse cases from the previous 10 years, Kaneko (1987) found that elder abuse was a significant social problem facing Japanese society.

These alarming results led major research institutions to conduct national studies on elder abuse beginning in the 1990s (Akashi, 2004). Four main elder abuse surveys were conducted in Japan during the 1990s. The first, implemented in 1993 by the Society for the Study of Elder Abuse (cited in Matsumoto, 2002), focused on workers in 400 community support centers for nursing care. Within six months, the survey discovered 144 elder abuse cases among 401 consultation cases. The second survey occurred in 1995, when a researcher collected information on elder abuse cases from nurses at public health centers in three prefectures: Fukuoka, Saitama, and Yamagata (Takasaki, 2005c). A third national study was coordinated by the Osaka Society for the Study of Elderly Abuse in 1996. The subjects of this survey were health care workers serving the elderly (i.e., public health nurses and nurses working in a public health center, a community support center for nursing care, or a mental hospital) (Tanaka, 2005).

Most recently, in 2004, the Ministry of Welfare and Labor commissioned the Institute for Health Economics and Policy to conduct the "National Domestic Elderly Abuse Survey," the largest national survey of elder abuse (Institute for Health Economics and Policy, 2004). The subjects of this survey were professionals (i.e., care managers, visiting nurses and public health nurses) working with elders with long-term care needs. The study involved 17,000 elder care agencies, including community support centers for nursing care. Of the 6,698 agencies with valid responses, 2,865 agencies (42.8%) reported abuse cases within a 12-month period and the total number of reported elder abuse victims was 7,781 (Akashi, 2005; Tatara, 2005; Watanabe, 2005a; 2005b). These findings suggested that elder abuse in Japan was a very serious matter. Half of the elder abuse situations identified in this study were associated with negative impacts on the elders' physical or psychological health; approximately 10 per cent of all abuse cases were life threatening and 6.1 per cent of the abuse cases ended in death (Institute for Health Economics and Policy, 2004; Tamiya & Matsuzawa, 2005). Together, the four studies described above documented the magnitude and dangerousness of elder abuse in the country, raised

concerns about a serious social problem in Japan and led to the establishment of the first Japanese Elder Abuse Prevention law.

### **Social Transition Factors Leading to the 2006 Elder Abuse Prevention Act**

While survey studies demonstrated an increase in the number of elder abuse cases, to the resulting awareness of this growing problem among members of the government and the public led to Elder Abuse Prevention Act. Yet the prevalence data alone do not tell the whole story. A more precise examination of socio-cultural factors will help to further explain the law enactment process in Japan. In particular, specific social transition factors have contributed to the creation of this Japanese law, and similar social transition factors in other emerging economic powers may suggest a need for similar policy developments in those countries.

### **Micro-Level Factors Related to Elder Abuse**

#### *Caregiver stress and unstable family care*

Based on Confucian beliefs, most Japanese children, especially the eldest sons, assume the responsibility for caring of their older parents at home. In particular, a legacy in the traditional family system, called *ie-seido* in Japanese, dictates that the first son must care for his elderly parents. Indeed, 25.2 per cent of the elderly live with their married sons, which is significantly higher than in the United States (1.4%) and Germany (2.6%) (Tamiya & Matsuzawa, 2005). Many young people fear that if they fail to live up to this care-giving obligation, they might face disgrace in the eyes of a society that shares this Confucian belief. As such, this tradition places the heaviest burden and most stress on the oldest son in the family and his wife (Matsumoto, 2002). This stress and burden contributes to the negative physical and psychological impacts of caregiving, major factors in elder abuse (Institute for Health Economics and Policy, 2004; Society for the Study of Elderly Abuse, 1993, cited in Matsumoto, 2002; Tanaka, 2005). In extreme cases, family caregivers can experience so much distress related to long-term caregiving responsibilities that they become severely depressed (Inoue, 2005) or even fatally violent. Japan has recently experienced an increase in the rate of cases of long-term care homicide (Tsumura, 2006).



In addition, some adult children may be more likely to neglect their older parents because of economic stress. Japan has witnessed a significant increase in the number of women who work outside the home, which is related to the growth of individualism and feminism (Tsuno & Homma, 2009). This cohort now includes married women, who were traditionally expected to care for their husbands and parents-in-law at home. Some married women may not have enough time to care for their elderly parents-in-law because they work both inside and outside the home. Conflicting values between individualism and traditional family beliefs have led to additional caregiver stress.

### **Family pathology**

Some caregivers experience personal problems, including psychological issues, addiction issues, hostile communication patterns, and other life complications such as divorce (Institute for Health Economics and Policy, 2004; Kure, 2005; Japan Elder Abuse Prevention Center, 2006; Okuni & Murakami, 2005; Wada, 2005). Such caregivers are less likely to be able to control their behavior or manage their negative emotions and, therefore, may be more likely to abuse elders. Some of the elderly also have difficult personalities or mental health issues of their own, which can exacerbate the stresses of being in a caregiver-care recipient relationship (Takasaki, 2005b). Another issue arises from the high rate of co-habitation in Japan between parents and their (adult) children, which encourages co-dependence between generations. Family members who do not establish an independent identity tend to have pathological parent-child or husband-wife relationships, which may lead to alcoholic or abusive behaviors (Takasaki *et al.*, 2005).

The attributes of early relationships between a child and his or her parents or parents-in-law may set the stage for potential conflicts later in life. For example, caregivers who have a traumatic history of being abused by their parents or their parents-in-law may subsequently abuse their elderly parents, who have become comparatively powerless or frail, as a means of seeking revenge (Takasaki, *et al.*, 2005). According to one national study (Institute for Health Economics and Policy, 2004), an adult son who lives with and cares for his elderly parents is more likely to abuse them if their past relationship was problematic. In addition, many Japanese daughters-in-law have conflicted relationships with their

mothers-in-law. When these daughters-in-law become caregivers, they may abuse their mothers-in-law as a means of seeking revenge against previously harsh treatment (Tanaka, 2005; Tsumura, 2005).

### **New Independence of Elders**

Japan has also experienced an elderly population that, due to economic independence and adequate health, can now be more self-sufficient than ever before (Matsumoto, 2002). In fact, whereas elderly households numbered 1.09 million in 1975, this number grew to 9.01 million in 2007 (Ministry of Health, Labor and Welfare, 1975; 2007). As a result, people now tend to see the elderly as having the wealth and self-reliance to free them from dependence on their adult children (Akashi, 2005; Tsumura, 2005). Another effect of improved health in old age is that increasing numbers of older people are now caring for their spouses and partners (Tsumura, 2005). As compared to younger caregivers, the elderly caregiver may experience more anxiety and worry given their physical challenges, health problems and other age-related burdens (Taguchi, 2007). These increased levels of anxiety and burden might contribute to higher rates of elder abuse and neglect.

### **Eastern-Asian culture of "saving face"**

Eastern-Asian people live in a culture that prioritizes saving face (i.e., avoiding shame), which stems from Confucian values related to shame (Ai *et al.*, in revision). As such, dishonorable familial matters that are exposed to the public can result in family members losing face. Based on these values, many Japanese tend to strongly believe they should solve their own familial matters in private, thus hiding their problems from outsiders. For example, admitting that a family member suffers from dementia or an age-related impairment can lead to embarrassment. Consequently, elder abuse in Japan is difficult to detect (Kure, 2005). By privately shouldering the burdens of care for the elderly without asking for help from outside the family, caregivers may experience so much exhaustion and frustration that they resort to abuse or neglect. The social isolation and stress experienced by family caregivers in such situations only exacerbates the problem. Therefore, legal intervention has been needed to identify and protect these hidden victims of elder abuse and connect isolated and overburdened family caregivers to social services for support.

## Macro-Level Factors Related to Elder Abuse

### *Increasing numbers of elderly with dementia*

Japan has recently experienced a dramatic increase in its population of elderly people with dementia (Matsumoto, 2002; Tamiya & Matsuzawa, 2005). The most recent national study on this issue found approximately 80 per cent of abused elders in Japan had dementia and had been the victims of both verbal and behavioral aggression (Institute for Health Economics and Policy, 2004; Japan Elderly Abuse Prevention Center, 2006; Watanabe, 2005a; 2005b). As is the case in many countries, most elderly Japanese people living with dementia do not go to nursing homes and are cared for at home by their families. These elders often exhibit challenging behaviors which sometimes cause caregivers to feel underappreciated, overwhelmed and frustrated. Because family members are not educated about how to respond to cognitive losses and behavioral issues, caring for an elder with dementia may lead to mistreatment of the care recipient (Inoue, 2005; Institute for Health Economics and Policy, 2004; Takasaki, 2005a). In response to such concerns, Japanese citizens were faced with the need to implement specific legal protections for the elderly with dementia to ensure that they did not suffer from abuse.

### *Impact of economic recession on caregivers*

Poverty intensifies the burdens of long-term care by fostering feelings of psychological and economic exhaustion among those caring for elderly relatives (Ikeda, 2005). Despite the loss of employment or business, which inevitably reduces caregivers' incomes, these individuals must continue to care for the elderly. Further, poverty depletes caregivers' options for hiring home helpers, making them more likely to feel overburdened by their caregiving responsibilities (Ibid, 2005).

### *Inadequate implementation of earlier elder care policies for dealing with elder abuse*

As researchers and practitioners discovered more elder abuse cases since the 1990s, they also began advocating for a regulatory policy to address the mistreatment of older adults. Simultaneously, they recognized that existing policies and social services were insufficient to intervene in elder abuse cases. Prior to the 2006 law, two earlier acts attempted to ensure effective care for the elderly: The Act on Welfare for the

Elderly (1963) and the Act on Health for the Elderly (1982). However, these simultaneous but separate legislative responses have faced various challenges (Matsumoto, 2002). The Act on Welfare for the Elderly relied on a system of institutional placements to meet the needs of high-risk elders, but it was not effectively implemented (Institute for Health Economics and Policy, 2004; Endo, 2005; Kure, 2005; Okuni *et al.*, 2005; Shibao, 2005a; 2005b; Tamiya & Matsuzawa, 2005). In addition, Japan enacted a community welfare and adult guardian policy in 1999 in order to assist the handicapped elderly who often become victims of economic abuse. Yet this effort was also ineffective in dealing with the issue (Okuni *et al.*, 2005). In 2000, the long-term care insurance system began to regulate responses to elder abuse reports. However, the acts and system responses discussed above have not been effective in either preventing or intervening in elder abuse cases (Kato, 2005). Therefore, a new policy was needed to more effectively deal with elder abuse. Researchers and practitioners' impassioned advocacy efforts successfully drove Japanese policymakers to approve policies that would directly address the elder abuse phenomenon.

### **Elder Abuse Prevention Act**

Japan's Elder Abuse Prevention Act, which became law in April 2006, was the first national law created in direct response to the elder-abuse prevention movement that had previously emerged in countries throughout the world. The important feature of the Japanese act was that it regulated the practices of hospital workers, doctors, health center employees, lawyers and other health professionals throughout the country. The Act requires that these individuals must make efforts to intervene in suspected cases of elder abuse through early detection and reporting, meaning those individuals who discover elder abuse are required to report their suspicions to the appropriate agencies (Ikeda, 2005). In addition, the act looks beyond elder abuse committed by family caregivers in the home and targets elder abuse committed by workers in nursing homes as well. This expanded view of abuse demands that workers report instances of elder abuse perpetrated by their co-workers or administrators. The protection of the reporter was also guaranteed by the act. One unique aspect of the act was that it valued support services for family caregivers and defined this support as an essential measure for the prevention of abuse of elderly care recipients (Ibid, 2005).

In conjunction with the previously mentioned regulations regarding the abuse detection and the duty of reporting, the new act emphasized the roles of local government in receiving and investigating reports of elder abuse, as well as the roles and responsibilities of the state and the citizens of Japan; standards of support for family caregivers; expectations of collaboration among elder abuse agencies, including the police; expectations of coordination among different municipalities regarding elder abuse issues; requirements for the training of workers who will investigate and intervene in elder abuse cases; uses of the adult guardian system for elder abuse cases; and the recommendation for further elder abuse research (Takasaki, 2005a). The successful enforcement of this ambitious act depends on effective and comprehensive community support centers, which have been established as the central agencies responsible for managing elder services in the community (Ikeda, 2006; Takasaki, 2005b; Watanabe, 2005a; 2005b).

### **Culturally Sensitive Definitions of Elder Abuse in the Elder Abuse Prevention Act**

The Elder Abuse Prevention Act defined elder abuse as any of the following five acts committed by family caregivers in the home or by professional workers in nursing homes (1) physical violence (inflicting an injury or an assault that may lead to injury); (2) neglect (preventing the elder from eating nutritionally; ignoring the elder for a long time; failing to interrupt physical, psychological, or sexual violence against the elder); (3) psychological abuse (communicating with violent language, or using injurious speech or behavior towards the elder); (4) sexual abuse (committing an act of obscenity toward an elder or forcing the elder to commit an act of obscenity); and (5) economic abuse (improperly distributing an elder's property or unjustly obtaining benefits from such property) (Japan Elderly Abuse Prevention Center, 2006). According to the National Elderly Abuse Study in 2004 (Institute for Health Economics and Policy, 2004), the most common types of elder abuse were psychological, neglect, and physical abuse.

Unlike in the United States and other countries that have created systems for the investigation of elder abuse, Japan excludes self-neglect (neglectful actions by an elder resulting in damage to one's own health or safety) from its definition of elder abuse (Japan Elderly Abuse

Prevention Center, 2006). One reason for this omission is the cultural beliefs of Japanese civilians, who may lack awareness of their rights or abilities to protect their own health and well-being. As a result, they may neglect their own health or safety (Tsumura, 2006).

Recent data show an increasing number of single-occupant elderly households or elderly couple households, especially in urban areas. Elderly households comprised 46.4 per cent of all households receiving public assistance nationwide according to Society and Support Bureau (2003). Many of these impoverished elders meet the criteria for self-neglect by virtue of their social isolation or their failure to participate proactively in their own health (Tsumura, 2006). Suicide among the elderly—also considered to be an act of self-neglect—has recently increased. According to reports on suicide rates from the National Police Agency in 2000 and 2004, people 60 years of age and older constituted 30 per cent of all suicides in Japan. A study by Tsumura (2006) ranked elders' economic and other related life challenges as highly significant factors in suicide attempts, second only to health issues. Tsumura (2006) assumed that the poor elderly were driven to suicide by their painful lives and suggested that self-neglect among the poor elderly will rise in urban areas in the future. Thus, some elder abuse researchers and practitioners believe that self-neglect should be included in the legal definitions offered in a revised Elder Abuse Prevention Act (Ibid, 2006).

### **Update, Conclusion, and Implications**

It has been six years since the Elder Abuse Prevention Act was established in Japan, and the number of elder abuse cases reported each year has continued to increase since the law was enacted. Specifically, the total number of consultations and reports on elder abuse committed by family members in 2009 was 23,404 cases (15,615 officially recognized cases), which is 7.9 per cent more than in 2008, and 32 elderly victims died due to abuse and neglect in 2009 (Ministry of Health, Labour and Welfare, 2009). The Japanese elder abuse law of 2006 has not yet succeeded in eliminating or reducing elder abuse, but elder abuse detection has increased significantly due to the fact that professional care workers now have more opportunities to enter the homes and lives of the elderly. While some praise this Act for enabling

higher detection rates, others criticize that the law has not led to adequate prevention of the problem. Examination of the micro-level factors related to elder abuse suggests that finding ways to help family members resolve the psychosocial issues associated with caring for the elderly may be essential in the prevention of abuse. This conclusion emphasizes the critical role for social workers and case managers in supporting family care providers. Japanese society must examine whether or not elder care workers actively and effectively try to prevent abuse by supporting those who care for elderly family members. Maximizing the skills and overall competence of these elder care workers in detecting elder abuse is central. However, it is also imperative to implement programs focused on training elder care workers in more effective intervention strategies. Detection alone cannot solve the elder abuse challenge. Rather, the solution for curbing and eventually eliminating elder abuse lies in the intervention activities of local agencies and individual citizens. The major problem in Japan may lie in the overdependence on central governmental initiatives (e.g., new laws). In the coming decade, a multi-level endeavor to reduce elder abuse rates should allow anti-abuse activism on the part of the central government to be passed on to local agencies and then on to individual citizens.

Effective programs for elder care should be established to overcome policy and practice challenges at different levels. At the micro level, for example, the workforce, including gerontological workers, social workers and case managers, should be enhanced and trained to offer essential services for families and the elderly in need. In particular, this workforce should have the knowledge and skills to help resolve psychosocial problems for caregivers. In addition, researchers should help identify stress-related and socio-economic issues among caregivers, as well as determine possible solutions to these issues. Research need not only inform our understanding of the facts of a phenomenon such as elder abuse, but must also serve as a significant source of information to guide our problem-solving efforts.

In conclusion, the socio-cultural conflicts reflected in family relations and individual psychological and socio-economic problems in Japan should be alarming to other economically rising Asian countries. In the near future, other Asian countries may also face a rapidly aging society. Because many Asian countries share similar family cultures,

as well as similar trends of increasing population age, Asian nations might experience the same socioeconomic and ideological transitions as Japan in the future. But other Asian countries must develop culturally appropriate social programs and trainings by taking a deep examination of their own challenges both at the micro and macro-levels of this elder abuse issue. In the future, awareness of elder abuse should also be raised at the human rights level in Asia via continental efforts.

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Indian Journal of Gerontology  
2011, Vol. 25, No. 4, pp.532-552

## Elders' Expectations of Community Health Services in China

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### ABSTRACT

There is a strong cultural expectation in China for families to provide care to elders. Filial piety exerts a particularly strong effect on adult children. However, because of changes in fertility, migration (mainly to urban areas for work) and life expectancy, today's families face unique challenges in caring for their elders. Guided by an ecological perspective understanding of community services, this study uses the 2005 Chinese Longitudinal Healthy Longevity Survey to build knowledge about the elders' expectations regarding the availability of community services. Findings indicate that there is a large discrepancy between what elders report as available and what they expect to be available in the community in regard to personal care services and home visits. Lack of a pension and living alone increased the likelihood of reporting a discrepancy between expectations and availability of these two services. These results suggest that social workers and other community services planners should focus more attention on developing community based health services in areas with concentrations of elders living alone and without a pension.

Key Words: Long-term care, Social work, Community-based services, Population ageing

No country on earth is facing the challenges of population ageing at the scale and rate that China is. Indeed, when it comes to population ageing, China is in a category all its own. With over 100,000,000 people age 65 or older in 2005, China has the largest older adult population on earth. Furthermore, the number is projected to continue growing well into the 21<sup>st</sup> century. In fact, by 2050 the number of persons age 65 or

older in China is projected to more than triple to over 300,000,000 (United Nations, 2009). By 2050, close to one-in-four (23%) Chinese is projected to be age 65 or older (United Nations, 2009). Of particular concern in terms of the increased need for care, is that the age 80+ population is growing at an even faster rate. In 2005 there were 14,000,000 persons age 80+ in China and that number is projected to swell to over 100,000,000 by 2050 (United Nations, 2009).

Aside from the growing number of older adults, China is facing a rapidly increasing percentage of older adults, resulting in rapid population ageing. Indeed, population ageing is occurring more rapidly and much more recently in China than in most other countries. This is especially true when comparing China with European countries, most of which have had many decades to adjust to the increase in percentage of older adults. For example, France had 110 years (from 1865 to 1980) for its older adult population to grow from seven per cent to fourteen per cent of the total population (Kinsella & Gist, 1995). In stark contrast, China's 65+ population is expected to grow from seven to fourteen per cent over the course of only 26 years (from 2000 to 2026).

Not only is population ageing occurring at an unprecedented rate in China (Chen & Liu, 2009), it is doing so as other major societal changes are also well underway, namely urbanization and globalization. Fry (2005) explains that "Globalization is a part and product of urbanization. Globalization, at the same time, is a little different in that it is a time-space compression that is a product of changes in transportation, communication, and organizational technology". Fry sees the rise of supranational organizations (The United Nations, OPEC, and large multi-national corporations) as a major indicator of changes in organizational technology.

The ageing of the Chinese population, in the context of increasing globalization, will have profound implications for society, including in the area of health and social service delivery. While not all the implications can be foreseen, many can. The profession of social work has a role to play in helping Chinese individuals, families, and communities anticipate and address the challenges associated with population ageing, including how to support families in caring for their elders in a culturally appropriate manner in the face of new social and economic realities. China is planning to open 50 new academic social work programmes; these programmes

will be training graduate social workers who will be assisting the country adjust to population ageing.

In their definition of social work, The International Federation of Social Workers (IFSW) states that the field of social work is based on principles of human rights and social justice. They state that social workers intervene at points where people interact with their environments to "promote social change, problem solving in human relationships and the empowerment and liberation of people to enhance social well-being" (IFSW, 2011). Social workers seek to promote positive change at multiple levels, including the individual, family, and community. Social workers have knowledge and skills that can contribute to assisting families and communities in adjusting to individual and population ageing.

One of the areas of social work expertise is the development of community-based services to foster individual and family well-being. While not all older adults require assistance from another person, many do, especially persons age 80 and older. China has a history of providing care for elders in the context of the family, specifically in three generation households. However, societal changes—including the "one-child policy" are expected to challenge these cultural practices. The need to focus on developing community services to support the increasing older adult population in China has been recognized (Yeung, et al., 1999; Leung, 2006; Leung & Wong, 2008).

The purpose of this manuscript is to document the availability of community-based services, from the perspective of older adults, and to document the elders' expectations that the community will provide the services. In this manuscript, we use an ecological systems perspective (Germain, 1979) to guide the study. We focus on two community health services that are considered among the most basic: personal care services and home visits. It is important to document the extent to which there is a gap between the expectation of community-based services and their availability so that appropriate services can be developed.

## Background

### Influences of filial piety on elder care

Confucianism is the fundamental social value system in China, and has been for thousands of years. An important value in Confucianism is "filial piety" which includes the idea that elders should be respected,

supported, and taken care of by the family (Ikels, 2004). Chinese children are raised with the expectation that just as their parents cared for them in their youth, when they grow up they are expected to care for their parents in their old age. This strong cultural value of filial piety is reflected in law. The Chinese government regulates the duty of adult children to support their parents in the Constitution of the People's Republic of China. Article 49 states "parents have the duty to rear and educate their children who are minors, and children who have come of age have the duty to support and assist their parents" (The National People's Congress of the People's Republic of China, 1982, 1988, 1993, 1999, 2004). While all adult children are expected to act in filial ways toward their parents, Chen & Liu (2009) explain that it is sons who are held most accountable for the care of elderly parents. He cites the Chinese proverb, "Yang Er Fang Lao" (having sons makes one's old age secure".

The number of children and living arrangements are important elements in Chinese elders' support systems (Guo, 1996; Guo & Zhang, 1996; Du et al., 2004; Wu, 2009). However, unlike in the recent past, fewer families today have three generations living under the same roof. This is because, in part, many adult children have left their hometowns and migrated to different cities, provinces, or even countries in search of job opportunities. This geographic separation coupled with the reduced number of children limit the capacity of adult children to take care of their elders (Du et al., 2004). When families cannot provide sufficient care, elders might expect to receive assistance from the community.

#### Community services in China

In China, access to services for older adults is related to many factors, one of the most important of which is geography, in particular urban/rural status. In important ways, the amount and quality of community services varies by urban and rural status (Leung & Wong, 2008). Therefore, when building understanding about meeting elder's needs through community services, it is important to understand how China is organized from a geographic and political context.

There are three main levels of geopolitical organization in China: the province, the county, and the township. At the province level, there are four categories, including provinces (23 including Taiwan), autonomous regions (five including Tibet, Xinjiang, Ningxia, Guangxi,

and Inner Mongolia), municipalities (four including Beijing, Shanghai, Tianjin, and Chongqing) and special administrative regions (two including Hong Kong and Macao). Within the provinces, the county level comprises counties and cities. The townships are rural areas within counties. In municipalities and cities, the most local government administrative organizations are street offices (Xinhua News Agency, 2003).

In China, each resident is registered to a particular geographic area. Access to most government services (including education, health care and long-term care services) is dependent upon one's registration. Even if a person migrates from one area to another within China, he or she is entitled to most government services only in the area in which registered. It is possible to change one's registration area, but it is not easy. Therefore, urban/rural registration is an important factor influencing the accessibility of social resources and services for elders. In urban China, community services are operated by the street offices. In rural areas, township governments operate services. In both areas, the Chinese government provides a portion of the funding necessary for services and the local area is expected to raise the remaining resources through service fees and donations.

The Chinese Household Register keeps track of the basic demographic information of each citizen's family and legal status, including "permanent residence," which is the "cornerstone" of rural-urban migration control (Mallee, 1991; Wing & Zhang, 1999). All Chinese citizens are assigned a registration status as either "agricultural" or "urban." Since 1949, the Chinese Government has emphasized developing economies, social welfare programmes, and public facilities in urban areas. Officials believed that modernization and industrialization were the best ways to improve the economic strength of China, and funds were invested to establish and support enterprise and public services in cities (Yang, 1999; Zhang & Liu, 2000). Consequently, the rural elders have less access to services compared to their urban counterparts. They also are less likely to have access to a pension.

The Chinese Social Security programme consists of two types of work-related pensions, the "basic" pension and the "Cadre pension." The basic pension is provided to retirees whose work organizations have paid toward social security. The cadre pension is provided to retirees who participated in the Chinese Communist Party before 1949 and



occupied higher positions in the government or army. Cadre pensions are higher than basic pensions. People do not receive both a cadre and a basic pension, and many people receive neither. In 2009, the Chinese social security law was amended by adding a new pilot programme for rural pensions; as of fall 2010, Beijing, Shanghai, Tianjian, Chogqing and over 500 counties had rolled out the rural pension (Social Security Administration, 2010).

#### Urban services

Since the 1990s, the Chinese government has been developing community services for elders in urban areas. The objectives of community services are: delivering welfare services to the elderly, disabled persons, and families of deceased veterans and ex-servicemen; providing convenience services for community residents in general; and cooperating with the enterprises and government departments located within the community to provide social services (Yeung et al., 1999). Being responsible for community services is one of the primary commitments of the street offices. Each street office supervises a number of residents' committees. The residents' committees are semi-governmental organizations and usually function as the coordinators of community services. The street offices and residents' committees coordinate to provide community services for residents (Ibid).

Most community services focus on health care. The community services for urban elders consist of nursing homes, social assistance (e.g., economic assistance for elders living in poverty), care groups (i.e., the street offices make arrangements to establish a care group for each elder in need who is living alone and not in institutional care), family mediations (i.e., neighborhood cadres of residents' committees have the responsibility to enforce and monitor family care obligations and ensure that elders in need are taken care of by their children), and home beds (i.e., physicians can provide consultation visits for patients without the need for hospitalization) (Leung & Wong, 2008).

#### Rural services

In contrast to the variety of services provided in urban areas, rural local governments provide five guarantee supports (i.e., food, clothing, housing, health care and funeral) for elders who are no longer able to work and who do not have a family (The Central People's Government

of PRC, 2006). Urban retirees can receive a social security pension and reimbursement of medical service costs from social medical insurance (Liang, 2000; Mu & Miao, 2002; Peng & Song, 2002). Most rural elders rely on support from their families. However, many rural working-age adult children have migrated to cities for better job opportunities diminishing the family capacity to support rural elders (Du, et al., 2004; Wu, 2009). Therefore, compared to their urban cohorts, rural elders may have higher expectations of receiving services from their communities.

#### The Current generation of Chinese Elders

Persons who are currently age 65 and older were born before 1946 and entered their child bearing years before the "One-Child" Policy went into effect. Although they did not face government enforced incentives and penalties to reduce fertility, they faced severe hardships. This generation experienced World War II (i.e., China fought against Japan from 1937 to 1945) and what is referred to as the War of Liberation (the Community Party against Kuomintang from 1945 to 1949). They also faced poverty and famine during the first 30 years of the development of the Peoples Republic of China (from 1949 to 1979). When they were young, for the most part, their families could not secure a formal education for them, and consequently their education level is low compared to their cohorts in developed countries. The rural elders also have lower education levels than their urban cohorts (Mu, et al., 2005). Chinese elders with lower levels of formal education are more motivated to be employed after retirement age because their pensions is relatively low compared to the cohorts whose education level is higher. However, those same elders have a more difficult time finding employment (Zhang, 1999).

Applying the ecological perspective to explain elders' expectations of community services

The design of this study is guided by the ecological perspective which stresses the interdependence between elements in an environment (Hardcastle, et al., 2004). The ecological perspective "is concerned with growth, development and potentialities of human beings and with the properties of their environments that support the expression of human potential" (Germain, 1979). Human beings adapt to their environments

through their continuous transactions with those environments. According to the ecological perspective, an individual's environment consists of the physical and social environment. The physical environment includes the natural world (e.g., land, water, and air) and the built world (e.g., community and buildings). The social environment "comprises the network of human relations at various levels of organizations" (Ibid).

For Chinese elders, the family support and urban/rural registration are two important environmental elements that influence their access to community services. If an elder's needs are not fully met through the family, he or she may expect to receive services from the community. Compared to urban cohorts, rural elders have fewer opportunities to access services. This distinction may also affect the variation of their expectations of community services.

Seen through the eyes of the ecological perspective, the purpose of community services is to improve the transactions between older adults and their environments. Only a few studies (Yang et al., 1999; Jia, 2002; Wu & Xu, 2007) have explored what services are needed from elders' perspectives. Therefore, in this study, elders' expectations of community services are hypothesized to be related to environmental characteristics as well as to individual elders' psychological well-being. In light of the many changes that are currently underway in China affecting the ability of family members to meet the needs of elders, it is helpful to learn about the community services elders are expecting to receive.

The current study uses a national dataset to address the following research questions

1. What percentage of older adults reports that personal care services and home visits are available in their community?
2. What percentage of older adults expects that personal care services and home visits will be provided by their community?
3. To what extent do individual (physical and psychological) characteristics and environment characteristics help explain the discrepancy between perceptions of what is available and what is expected to be provided?

#### Methods

This study uses data from the 2005 Chinese Longitudinal Healthy Longevity Survey (CLHLS) to address the research questions. The

CLHLS<sup>1</sup> was designed to explore how Chinese elders' health longevity is influenced by social, behavioral, biological and environmental risk factors. Data collection was cosponsored by the U.S. National Institute on Aging, the United Nations Fund for Population Activities, and the China National Foundation for Social Sciences. Peking University (Beijing, China) and Duke University provided institutional support for the CLHLS. As of 2010, five waves of CLHLS data have been collected (1998, 2000, 2002, 2005 and 2008–2009). This study uses the 2005 data because they are the most recent publicly available. Zeng & Gu (2008) report the 2005 data have high reliability and validity. The primary purpose of CLHLS is to collect the information about the oldest old (85+) population in China; this purpose influenced the way in which the sample was developed.

#### Sample

The 2005 CLHLS data include 15,613 elders who lived in 22 (of the 34) Chinese administrative regions at the province level, including four municipalities (i.e., Beijing, Tianjin, Shanghai, Chongqing) and 18 provinces (Hebei, Shanxi, Liaoning, Jilin, Heilongjiang, Jiangsu, Zhejiang, Anhui, Fujian, Jiangxi, Shandong, Henan, Hubei, Hunan, Guangdong, Guangxi, Sichuan and Shanxi). While the data do not cover all Chinese provinces, the CLHLS represents the largest dataset of Chinese elders' physical, psychological, and social information.

In order to draw the CLHLS sample, all Chinese aged 100 or older in the randomly selected areas within the 22 areas were identified and invited to participate in the study. Once the 100 year olds were identified, the CLHLS increased the sample size by selecting elders in their 60s, 70s, 80s and 90s who lived in the same community of each 100 year old. Data were collected through personal interviews administered in Chinese by trained research assistants.

In the CLHLS if a respondent could not answer questions because of physical or cognitive limits, his or her family member was allowed to provide proxy responses. Because the current study focuses on elders' perspectives, the sample is limited to the respondents who independently answered the questions (i.e., did not use a proxy respondent). Therefore, the final sample for this study consists of 11,626 elders aged 65+, including 5,499 males and 6,127 females. Table 1 reports the sample

mean age as 83.5 years (SD 11.2), that almost half the sample had reached age 85, and about half the sample was female. Table 1 also indicates that the mean years of formal education for this sample was 2.4 years. About one-in-five respondents was eligible for the basic pension compared to 2.1 per cent for the cadre pension. However, most respondents were eligible for neither. About half of the sample lived in an urban area (43.9%). The vast majority (82.4%) lived with at least one other person. The mean number of living children was 3.6 with a standard deviation of 1.9.

#### Survey instrument

Trained interviewers administered the quantitative interview with older adults in person. While the survey included a broad range of items (Duke University Center for the Study of Aging and Human Development, 2010), for the purposes of this study we focus on a subset of variables related to expectations of services, availability of services, variables representing individual physical and psychological characteristics and variables representing characteristics of the environment. A set of demographic variables are included as control variables.

The following questions were asked: "What kind of social services are available in your community?" (eight types of social services were read including the two services analyzed for this paper: personal care services and home visits), and the respondent was asked to answer "yes" or "no" to each type of service. Personal care services refer to the services to assist elders with daily activities, such as bathing, dressing, grooming, toileting, transferring, and eating (Noelker & Bass, 1989). Home visits refer to the consulting services provided by medical professionals to elders in their homes. In some studies, home visits are called "home bed" (Wang & Schneider, 1993; Leung & Wong, 2008). Respondents were also asked, "What kind of social services do you expect to be provided by your community?" The same list of eight types of social services was read, and the respondent was asked to indicate "yes" or "no" (i.e., yes/no personal care services expected to be provided by the community). In this study, we focus on expectations about personal care services and home visits.

Consistent with key concepts in ecological theory, we reviewed the set of variables collected as part of the CLHS and identified those that could be thought of as representing the environment and those that represent individual characteristics. Explanatory independent variables characterizing the individual include indicators of elders' physical and psychological well-being. Physical well-being is measured by ADL and IADL dependencies. Psychological well-being is reflected by fear ("Do you often feel fearful or anxious?"), loneliness ("Do you often feel lonely and isolated?"), and feelings of uselessness ("Do you feel the older you get, the more useless you are?"). The response set to the measures of psychological well-being was in Likert-type scale format giving the respondent the option of answering 1-5, with one being "always" and 5 being "never." Environmental conditions are measured by three variables: living alone, number of living children, and geographic registration (urban/rural). Socio-economic status (SES) and demographic factors (i.e., age and sex) are included in the analysis as control variables. The SES variables are education (i.e., years of schooling), types of pensions and subjective evaluation of economic status.

#### Analysis

Descriptive statistics are used to address the first two research questions. Logistic regression is used for the third research question that seeks to explain the likelihood that an elder expected that personal care services or home visits would be provided by the community and also reported that the services are not available. In other words, we created a new variable to represent the discrepancy between what the elder reported as available and what the elder expects. A logistic regression equation was calculated for personal care services and a separate equation for home visits. In both cases the dichotomous dependent variable was coded as "1" if the elder expected the services and reported it was not available, and "0" for all other responses (i.e., the elder did not expect the service and it was available, the elder did not expect the service and it was not available, the elder expected the services and it was available).

Results

**Table 1: Characteristics of independent\* respondents in the Chinese Longitudinal Healthy Longevity Survey (CLHLS), 2005 (n=11,626)**

Independent variables	Distribution	Percent/ value
Age	Mean	83.5 years
	Standard deviation (SD)	11.2
Distribution of age groups	65-74	27.6%
	75-84	23.0%
	85-99	39.5%
	100+	9.9%
Sex	Female	52.7%
	Male	47.3%
Year of education	Mean	2.4 years
	SD	3.7
Entitlement to pensions	Normal pension	22.2%
	Cadre pension	2.1%
Current residence	Urban	43.9%
	Rural	56.1%
Co-residence	Live with household member(s)	82.4%
	Live alone	14.8%
	Live in a nursing home	2.7%
Number of living children	Mean	3.6 children
	SD	1.9

\* An independent respondent means the respondent did not use a proxy respondent.

Table 2: Comparison of Chinese elders' perceptions of the availability of personal care and home visit programs and their expectation that community will provide these services, CHLHS data 2005 (n=11, 626)

	Availability	Expectation	The discrepancy between availability and expectation
Personal care services	4.3%	54.2%	50.3%
Home visits	11.3%	70.8%	60.2%

As shown in Table 2, more than half of respondents (54.2%) reported they expected the community to provide personal care services and over two-thirds (70.8%) reported the expectation that communities provide home visits. When asked about the availability of these services, less than five percent (4.3%) indicated that personal care services are available in the community and about ten percent (11.3%) indicated that home visits were. Therefore, findings indicate that there is a large discrepancy between elders' perceptions of the availability of personal care services and home visits, and the expectation that these services be available in the community.

Tables 3 and 4 report the findings from the logistic regression equations used to examine the extent to which environmental and individual characteristics help explain the likelihood of an elder reporting a discrepancy between the expectation that the community provide a service and the availability of the service. Table 3 reports results related to personal care services. Although many variables are statistically significant, none could be classified as strong indicators. In other words, none stand out as appreciably increasing or decreasing the odds of the discrepancy, when controlling for the effects of the other independent variables. Having a pension (either the basic or cadre pension) slightly decreased the odds of the discrepancy more than other variables, and living alone increased the odds, compared to other variables.

Table 4 uses the same set of variables to estimate the odds of the discrepancy between availability and expectation for home visits. Again although many variables are statistically significant, none stand out as meaningfully affecting the odds of the discrepancy. Being a pensioner again slightly decreases the odds of the discrepancy.

Discussion

The most important finding in this study is the presence of a large discrepancy between the availability and the expectation of personal care services and home visits, from the perspective of elders in China. Overall the set of independent variables inspired by the ecological perspective did not meaningfully contribute to building understanding about the discrepancy, although the presence of a pension slightly reduces the odds of the discrepancy.

**Table 3 : Logistic regression estimates for the variables explaining the discrepancy between available and expected personal care services among Chinese older adults, CLHLS data, 2005 (n=11,626)**

	B	S.E.	Wald	df	p-value	Exp (B)	95% Confidence Interval for EXP (B) (odds ratio)	
							Lower	Upper
<b>Socioeconomic control variables</b>								
Age	.005	.002	4.524	1	.033	1.005	1.000	1.009
Sex (male=1)	.161	.043	14.224	1	.000	1.174	1.080	1.277
Education	-.024	.006	13.952	1	.000	.977	.964	.989
Pension (basic=1)	-.305	.057	28.584	1	.000	.737	.659	.824
Pension (cadre=1)	-.277	.143	3.749	1	.053	.758	.573	1.003
Evaluation of economic status	.077	.031	6.448	1	.011	1.081	1.018	1.147
<b>Independent variables representing the environment</b>								
Current residence (rural=1)	.140	.044	10.236	1	.001	1.151	1.056	1.254
Living arrangement (live alone=1)	.319	.057	31.842	1	.000	1.376	1.232	1.538
Number of living children	.020	.010	3.794	1	.051	1.020	1.000	1.041
<b>Independent variables representing the person</b>								
ADL dependency	-.029	.015	3.573	1	.059	.972	.943	1.001
IADL dependency	.012	.005	4.856	1	.028	1.012	1.001	1.023
Fear and anxiety	.013	.025	.264	1	.607	1.013	.964	1.065
Loneliness	.106	.024	19.468	1	.000	1.112	1.061	1.166
Self-efficacy	.025	.018	1.870	1	.171	1.025	.989	1.063
Constant	-1.022	.220	21.519	1	.000	.360		

Model summary: -2 log likelihood = 15039.412.

Nagelkerke R square = .039; Hosmer and Lemeshow Test chi-square = 15.002 (8 DF), p = .059

**Notes:** The variable of evaluation of economic status (how do you rate your economic status compared with others in your local area?) is coded as 1 to 5 to represent "very rich" to "very poor."

The variable of fear and anxiety (do you often feel fearful or anxious?) is coded as 1 to 5 to represent "never" to "always."

The variable of loneliness (do you feel lonely and isolated?) is coded as 1 to 5 to represent "never" to "always."

The variable of feeling uselessness (do you feel the older you get, the more useless you are?) is coded as 1 to 5 to represent "never" to "always."

**Table 4 : Logistic regression estimates for the variables explaining the discrepancy between available and expected home visits services among Chinese older adults, CLHLS data, 2005 (n=11,626)**

	B	S.E.	Wald	df	p-value	Exp (B)	95% Confidence interval for EXP (B)	
							Lower	Upper
<b>Socioeconomic control variables</b>								
Age	.000	.002	.026	1	.871	1.000	.996	1.005
Sex (male=1)	.151	.044	12.017	1	.001	1.163	1.068	1.267
Education	-.027	.006	17.671	1	.000	.974	.962	.986
Pension (basic=1)	-.376	.057	43.384	1	.000	.687	.614	.768
Pension (cadre=1)	-.484	.142	11.642	1	.001	.616	.467	.814
Evaluation of economic status	.124	.031	15.509	1	.000	1.132	1.064	1.204
<b>Independent variables representing the environment</b>								
Current residence (rural=1)	.153	.045	11.586	1	.001	1.165	1.067	1.272
Living arrangement (live alone=1)	.100	.059	2.930	1	.087	1.105	.986	1.240
Number of living children	.043	.011	16.382	1	.000	1.043	1.022	1.065
<b>Independent variables representing the person</b>								
ADL dependency	-.047	.016	9.070	1	.003	.954	.926	.984
IADL dependency	.011	.006	3.842	1	.050	1.011	1.000	1.022
Fear and anxiety	.036	.026	1.933	1	1.64	1.037	.985	1.092
Loneliness	.132	.025	28.006	1	.000	1.141	1.087	1.198
Self-efficacy	.019	.019	1.044	1	.307	1.019	.983	1.057
Constant	-.363	.225	2.604	1	.107	.696		

Model summary: -2 log likelihood = 14525.993.

Nagelkerke R square = .047; Hosmer and Lemeshow Test chi-square = 3.260 (8 DF), p=.917

**Notes:** The variable of evaluation of economic status (how do you rate your economic status compared with others in your local area?) is coded as 1 to 5 to represent "very rich" to "very poor."

The variable of fear and anxiety (do you often feel fearful or anxious?) is coded as 1 to 5 to represent "never" to "always."

The variable of loneliness (do you feel lonely and isolated?) is coded as 1 to 5 to represent "never" to "always."

The variable of feeling uselessness (do you feel the older you get, the more useless you are?) is coded as 1 to 5 to represent "never" to "always."

There are limitations of this study. In the CLHLS, although all centenarians in randomly selected areas were invited to participate in the study, the respondents under the age of 100 were not selected in a representative manner. Elders younger than age 100, who did not live in the same area of a centenarian, had no chance of being invited to participate in the study. This study uses an existing dataset, which did not include all the variables needed for establishing the analysis model. This limitation may have influenced the results from the logistic regressions.

The findings indicate that personal services and home visits are not perceived to be available in most communities. This perception may stem from recognition that the services are not available in these communities. The small availability of community services for elders is not hard to understand given the cultural background and social policies as explained earlier. However, another possibility might be that there are personal care and home visits available but the elders are not aware of these service options. If this is the case, the community service agencies should consider enhancing their marketing efforts. The social workers need to facilitate more referrals to these services for the elders who may benefit from their use.

As shown in Tables 3 and 4, among the socio-economic and demographic control variables, only entitlement to either basic or cadre pension meaningfully (and at that only slightly) affected the odds of the discrepancy between the expectation and availability of personal care services and home visits. The elders who have pensions had employment experience and their social network might be larger than the ones who never work outside families or spent most of their lives in the same rural communities. Larger networks may provide the elders with more opportunities to be aware of the services, so they are less likely to have discrepant perceptions. Also, the elders with pensions may not expect to have the health care services provided by the communities as much as their cohorts who do not have pensions because they can purchase services from private business. Social workers should advocate for enhancing the accessibility of community services for those elders who are not entitled to a pension.

Among the independent variables of environment and individual characteristics, only living alone slightly increases the odds of a

discrepancy between the expectation and the availability of community personal care services (see Table 3). The elders living alone may lack knowledge about health care services in their communities because their living arrangement limits their opportunities to receive such information. They might also need more services to address physical and psychological needs since they do not have anyone at home to support them. From a perspective of social support, community services can be considered as part of elders' formal support they can receive from their environment. Elders' expectation of receiving formal support might be related to their lack of informal support, which includes the support they receive from friends, neighbors and families.

Future research in the area of family caregiving is needed to assess the extent to which elders and their families would actually use community-based services, and how best to plan, provide, and pay for these services. Research should focus on new ways to uphold filial piety (from both the perspective of elders and their adult children) given the dramatically changing social circumstances that many Chinese families confront. The need for this research is urgent given the rapid ageing of the "sent-down youth" population and the ageing of the first cohort of adults who were in their parenting years when the one-child policy was enforced. They are called the "sent-down youth" because when they were young adults (in their teens) the Chinese government sent them from cities to agricultural areas as part of the Cultural Revolution (Zhou & Hou, 1999; Zhan, 2002). Outside of China, the "sent-down youth" group (currently in their 50's and 60's) is often overlooked. These persons did not receive as much formal education as those that immediately followed, and their work experience did not generally lead to high employment jobs and to pensions. Many did develop deep and lasting friendships because of the collective memory and identity (Wang & Liu, 2006), and it will be interesting to see if friends might take the place of family—even in a small way—as members of the sent-down youth become elders with care needs.

Many researchers predict that China will face a monumental caregiving challenge over the next decades, because the One-Child policy reduced the number of children available to support elderly parents. At the end of the 1970s, the Chinese government started the One-Child policy, which requires that an urban couple can only have one child and a rural couple can have two at most. The first cohort of the 'one-child'

generation will soon take responsibility for caring for their aging parents. At that time, members of these 'one-child' cohorts will be the only available caregivers in their families of origin because they do not have siblings to share in their filial obligations. Most Chinese families will consist of four elders, a two-adult couple and one dependent child. This structure is called the "4-2-1 family" (Liu & Cai, 1997). When the elders in 4-2-1 families need health care, most families will have to rely on services from the community. Therefore, it is necessary to understand what the future users of elder services expect and what factors influence their expectations.

In conclusion, most elders expect personal care services and home visits to be provided, although often they are viewed as not being available in the community. Elders with pensions were less likely to report a discrepancy between expectations and availability. Results imply the need to investigate the discrepancy, document the availability of services, and plan accordingly as the Chinese population is rapidly aging.

### Acknowledgement

Ms. Lila thanks Dr. Carol Severino, Director of the University of Iowa writing centre for her assistance and the UI Graduate College Fellowship for their financial support.

1. More information about CLHLS is available on the programme website : [http://www.geri.duke.edu/China\\_study..](http://www.geri.duke.edu/China_study..)

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Indian Journal of Gerontology  
2011, Vol. 25, No. 4, pp.553-575

## Advancing Social Work Practice with Family Caregivers

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### ABSTRACT

*A major challenge for social service professionals serving family caregivers is the identification and allocation of resources and services to effectively support family caregivers. In this paper, we provide a short summary of the current state of knowledge regarding caregiver interventions. We then discuss the implications of this knowledge for practice with family caregivers highlighting the need to strategically target services to caregivers' unique needs. Acknowledging the diversity of caregivers, we advocate care management as a logical and effective mechanism for triaging services for caregivers. Finally, we report the impact of a new evidenced-based care management protocol designed for family caregivers on care planning by practitioners and service use by caregivers.*

**Key Words :** Family Caregivers, Caregivers' interventions, Care management protocol,

### Global Ageing and Its Consequences on Caregiving

Modernization and advancement in public health and medical technologies during the twentieth century have led to population ageing at the global level. Reflecting increased life expectancy and decreased fertility rates, the number of older adults is accounting for an increasing proportion of the world population (Lowenstein, 2005). By 2030, it is estimated that older adults will make up 13 percent of the total population in the world (National Institute on Aging, 2007). The projected growth of the older adult population is even more dramatic in developing

countries. Between 2006 and 2030, the number of older adults in the less developed countries is expected to increase by 140 percent (National Institute on Aging, 2007). India, for example, has the second largest older adult population in the world with number of its older adults projected to grow from 76 million in 2001 to 137 million by 2021 (Prakash, 1999). Accompanying the increase in numbers of older adults has been a global increase in the number of older adults with chronic conditions and disabilities who require assistance with daily activities and medical care (Velkoff and Lawson, 1998; Lowenstein, 2005).

Studies consistently have shown that family remains the primary source of both instrumental and emotional support for older adults with care needs in many countries such as India (Prakash, 1999). In both developed and developing countries, family members, the majority of whom are wives, daughters and daughters-in-law, are the primary source of this long term care. Data show that even while experiencing the impact of modernization and urbanization of family structures older adults in developing countries continue to rely on family ties and support with a significant majority of older adults co-residing in the same household with their younger kin (Aboderin, 2005). In China, for example, the dominant attitude toward caring for elders is that family members should provide support and care to the elders, which is reinforced by its government's legislation (Hashimoto and Ikels, 2005).

Similarly, within the United States, family members provide an estimated 80 percent of care to community dwelling older adults (Stone, 2000) and their unpaid labour saves society an estimated \$375 billion per year (Houser and Gibson, 2008). In 2007, it was estimated that 52 million adults provided some care for an older adult relative and it is expected that this number will continue to rise as our population ages (Montgomery *et al.*, 2007). In the European Union, family caregivers provide over 80 per cent of all care for older adults filling gaps of formal care services (Hoffmann and Rodriguies, 2010). The majority of these family caregivers are women and significant numbers are gainfully employed, especially across Europe. Furthermore, in developing countries the participation of women in labour force will only continue to increase (Velkoff and Lawson, 1998; Hoffmann and Rodriguies, 2010).

## Negative Consequences of Caregiving and Need for Support

Although, the provision of care for frail and dependent citizens has traditionally been the responsibility of family members, the caregiving role has been assumed with mixed consequences. Caregiving activities can affect several different domains of a caregiver's life. Given that the caregiving relationship emerges out of a pre-existing interpersonal relationship between the caregiver and care-receiver, caregiving responsibilities have the potential to negatively affect that dyadic relationship. As the caregiver engages in instrumental activities to provide support for the care receiver, these activities can interfere with other aspects of his or her life such as relationships with other family members, work responsibilities, or personal privacy.

The caregiving experience can also lead to emotional stress or anxiety. It is not uncommon for a caregiver to experience burden in all of these domains, nor is it uncommon for caregivers to experience burden in at least one or two of these domains (Savundranayagam *et al.*, 2010). Indeed, numerous studies have documented the negative impact of caregiving on social and physical aspects of caregivers' lives. The responsibilities of caregiving have been shown to be stressful (Schulz and Sherwood, 2008) and often lead to significant negative social, psychological, physical health, and financial consequences (Beach, *et al.*, 2000; Connell, *et al.*, 2001; Bookwala *et al.*, 2002; Vitaliano, *et al.*, 2004; Family Caregiver Alliance, 2006). These deleterious impacts have been shown to occur even when caregivers report the role to be a rewarding or meaningful experience.

Not surprisingly, within the United States, family caregiving has recently been identified as a public health concern (Talley and Crews, 2007). The negative outcomes associated with caregiving have not only been a concern of practitioners and researchers, but they have also attracted the attention of policy makers who fear that the stress of caregiving may ultimately limit family members' abilities to continue to provide care. Given the central role that family members play in the long-term care system, their absence could have serious economic implications for local and national governments (Montgomery *et al.*, 2007). Recognition of potential human and economic costs associated with family caregiving has prompted the development of a wide range of resources and programme to support caregivers.

## Mechanisms of Support

Within the United States a variety of local and state programme were developed under the auspices of National Family Caregivers Support Programme (NFCSP) which was enacted as part of the Older Americans Act in 2001 (Montgomery *et al.*, 2007). Services that have commonly been made available to caregivers include various forms of in-home and community based respite programmes, cash and counseling programmes that provide allowances, cognitive behavioural therapy and counselling, skills training, psycho-education, care management and multi-component services that include a combination of these services. (Administration on Aging, 2000; Hashimoto and Ikels, 2005; Feinberg, *et al.*, 2006; Hoffmann and Rodriguies, 2010).

A variety of outcomes have been associated with the different forms of support services. Cognitive behavioural therapy and counselling have been found to reduce neuropsychiatric symptoms of caregivers (Gonyea *et al.*, 2006), desire to place a relative in a nursing home (Burgio *et al.*, 2003), and actual nursing home placement (Mittelman *et al.*, 2006). Care consultation intervention focusing on providing information and emotional support has been found to reduce depressive symptoms (Bass *et al.*, 2003; Gitlin *et al.*, 2006) while various skills training and psychoeducational services were found to increase knowledge and skills and to reduce depressive symptoms (Bourgeois *et al.*, 2002; Coon *et al.*, 2003; Hepburn *et al.*, 2007).

The effect sizes reported by these intervention studies, however, have been clinically modest and varied across different types of caregivers (Knight and Lutzky, 1993; Schulz *et al.*, 2002; Soerensen, *et al.*, 2002). Recent findings suggest that single component interventions are most effective in reducing caregiver burden when provided in sufficient quantities and targeted to specific needs of the caregivers (Montgomery and Borgatta, 1989; Zarit and Leitsch, 2001; Soerensen, *et al.*, 2002; Audit Commission, 2004; Schulz and Martire, 2004). Moreover, the most promising findings regarding positive impact of support services on caregivers have emerged from studies that include multiple, and a relatively comprehensive set of support services (Belle *et al.*, 2006). Given that caregiving experience is understood as a career with an evolving trajectory with changing circumstances and needs of

caregivers (Montgomery and Kosloski, 2000; Langa *et al.*, 2001; Gaugler *et al.*, 2002; Gaugler *et al.*, 2005) this is not a surprising finding. The fact is such interventions have a higher probability of meeting a caregiver's immediate needs because there is a chance that at least one of the support options is most appropriate for a caregiver at any given time. It is also the case that multi-component interventions will have a higher probability of meeting caregivers' needs as they change over time.

### Gap in Knowledge to Guide Practice

An important conclusion to be drawn from past studies is that caregiver support programmes are most effective for reducing caregiver burden when the services are provided in sufficient quantities and targeted to specific needs. This conclusion highlights a missing link between research and practice. A major theme in the caregiving literature has been diversity. An extensive body of work on caregiver outcomes shows wide variations, not only in the tasks that caregivers undertake, but also in the costs they incur and the benefits they experience as a consequence of their caregiving role (Haley *et al.*, 1995; Dilworth-*et al.*, 2002). Yet, most efforts to intervene with caregiver supports have not addressed this variability in caregiving experience. Only recently have any intervention studies recognized the importance of targeting and incorporated targeting mechanisms in their intervention plans. Even these efforts to target interventions to caregivers' needs have focused on broad dimensions of the caregiving process, rather than the sources of differential experiences of caregiving burden and stress (Schulz and Martire, 2004; Belle *et al.*, 2006).

Furthermore, few interventions are designed to address the changes that occur in the caregiving experience over time (Zarit and Leitsch, 2001; Schulz and Martire, 2004). The importance of viewing caregiving as a process of change has only recently been emphasized by scholars who have noted the serious implications of this change process for conducting adequate studies and identifying effective interventions (Montgomery and Kosloski, 2000; Langa *et al.*, 2001; Gaugler *et al.*, 2002; Gaugler and Teaster, 2006). Over time, care contexts and the needs of care recipients change in ways that require corresponding changes in caregiving behaviours (Anhensel *et al.*, 1995).

Consequently, caregivers may engage in very different care behaviours over the course of their journeys and experience their roles differently at different points in time (Beach *et al.*, 2000). This understanding of caregiving as a dynamic, rather than a static, process is not only essential for clarifying the links between caregiving and caregiver outcomes, but is also central to identifying effective strategies and resources for supporting caregivers.

Unfortunately, the design and implementation of programmes to support caregivers generally have not been informed by this knowledge. Although it would seem abundantly clear that effective support for such a diverse population would include a care management as a mechanism to assess a caregiver's needs and link the caregiver with appropriate services over time, very few caregiver support programmes include such a service. Instead, current practice has been dominated by a shotgun approach to delivering services to caregivers (Montgomery and Rowe, 2007). Generally, care managers and family specialists have little knowledge about which services are most apt to help a caregiver and simply offer caregivers the services that are available in their communities or those for which the caregiver is eligible. As a result, a common lament of service providers is that caregivers fail to use services or use services too late in the care process to benefit from them. Indeed as many as 30 per cent of caregivers are "brief users" of services, discontinuing the service within 90 days (Montgomery *et al.*, 2002). This is a very inefficient and often ineffective strategy by which to support caregivers. Given limited public and private resources, the provision of comprehensive packages of services to caregivers is not feasible unless mechanisms are developed to enable care managers and services providers to efficiently target interventions (Burgio *et al.*, 2003).

When considered together, findings from previous research point to the need for a service delivery approach that takes into account the diversity of caregivers, the different sources of stressors, and the dynamic, longitudinal trajectories of caregivers' careers.

### Care Management for Caregivers

#### *Care Management in Support of Caregivers*

As professionals in the field have gained a better understanding of caregiving as a diverse, complex and changing experience, advocacy

for care management as an essential service to support family caregivers has emerged (Kelly *et al.*, 2008; Montgomery and Kwak, 2008). Care management, which is often referred to as case management or care coordination, is a service commonly described as a “series of activities undertaken to address a client’s lack of resources and needed services (Naleppa and Reid, 2003; Naleppa, 2006). Care management which can be traced back to the early 1900s when social workers coordinated services for the infirm and poor has evolved largely in response to changing social and economic needs of society (Naleppa and Reid, 2003). Currently, care management is viewed as a critical component in the delivery of health and social services. It has been used to foster effective service delivery in a variety of settings for many client populations including children, individuals with disabilities and mental illness and substance abuse (Austin and McClelland, 1996). Although older adults and their family caregivers are major client population in the long-term care system, care management has been primarily used to assess and address the needs of the older adult. Care management programmes specifically designed to serve family caregivers are rare although many potential benefits of care management for caregivers have been identified. Using a viable care management process, social workers or other health professionals can identify the unique needs of individual caregivers and target services to meet the specific needs (Teri *et al.*, 1997; Gitlin *et al.*, 2006). Moreover, care management has the potential to foster service use by caregivers by helping them surmount barriers that are often created by service providers (Kosloski *et al.*, 2002) and thereby, positively affect caregiver outcomes (Zarit *et al.*, 1999; Dilworth-Anderson *et al.*, 2002; Gaugler *et al.*, 2003a; Gaugler *et al.*, 2003b; Weirer *et al.*, 2003; Gitlin *et al.*, 2006).

Generally, six activities are performed by social workers who provide care management. These include: (1) a multidimensional assessment, which is the process of gathering information about the client’s situation and needs; (2) planning, which is the translation by the care manager of information gained through the assessment process to identify services appropriate for the client and then develop a plan of care; (3) coordination and implementation, which is the process of helping the client access resources and putting the plan of care into action; (4) monitoring, which is the process of staying involved with the client to

assist them with achieving desired goals; and (5) reassessment, which is the process of gathering information about the client’s to identify changes that have occurred since the previous assessment; and (6) evaluation, which is the process of measuring desired goals and outcomes (Austin and McClelland, 1996; Naleppa, 2006; Rothman, 1994).

Recognizing these potential benefits of care management, our research team collaborated with experienced care managers to design a protocol for use with family caregivers and assess the impact of the protocol on care planning, service use, and the well-being of family members assisting persons with cognitive impairment. The focus of this paper is on the impact of the protocol on care plans and services used. Findings regarding the positive impact of the protocol on caregiver burden and depressive symptoms will be reported elsewhere.

#### Study Design

##### Tailored Caregiver Assessment and Referral® Protocol

The Tailored Caregiver Assessment and Referral® (TCARE®) protocol is a six-step caregiver assessment and referral process that leads to an individualized care plan (Montgomery and Kwak, 2008) that was designed to incorporate elements that have been deemed essential for good care management practice. The TCARE® protocol was developed in collaboration with staff from numerous provider organizations. The protocol guides care managers through an assessment process to examine the care context, identify the sources and types of stress that a caregiver is experiencing, and develop and recommend a care plan for the caregiver consisting of a set of targeted services. A central feature of the TCARE® protocol is a set of decision algorithms that integrate information gained from the assessment tool and help the care managers identify appropriate intervention goals, strategies, and services to be recommended. The protocol includes six tools that are used to implement the six steps of the process which are to: (1) assess the caregiver’s needs using the TCARE® Assessment form; (2) interpret the scores on key measures to determine the types and level of need using the Assessment Summary Sheet; (3) identify appropriate goals, support strategies, and services using the Decision Algorithms, and the Guide for Selecting Support Services; (4) consult with the caregiver to create a care plan that is both appropriate and acceptable

to the caregiver using the Care Plan Consultation Worksheet; (5) create a mutually agreed upon care plan using the Caregiver Care Plan; and (6) conduct a follow-up assessment with the caregiver at approximately 3-month intervals.

### Hypotheses

Our expectation was that the TCARE<sup>®</sup> protocol would provide care managers with a more complete understanding of the caregiving context and foster the identification of multiple caregiver needs. Consequently, it was hypothesized that care managers using the TCARE<sup>®</sup> protocol would recommend a wider variety of services in order to target multiple needs of caregivers than care manager following usual practices. It was also hypothesized that the protocol would promote increased compliance by caregivers with recommendations, which in turn, would lead to more use of support services by caregivers.

### Sample

**Organizations and care managers.** Twelve care managers participated in the study. They were employed by the three Area Agencies on Aging (AAAs) selected by the State of Georgia Division of Aging Services (DAS) to participate in the study. Six care managers were assigned by their organizations to use the TCARE<sup>®</sup> protocol. They participated in an initial two-day intensive training session, a one-day practicum training, and a web-based application training. The remaining six care managers were assigned to the control group to serve caregivers following their usual and customary practices. All of the care managers have been working in the social services industry for at least five years, with the majority working in social services for ten years or more. The length of time that these care managers have been working at their particular agencies ranged from one to twelve years.

**Caregivers.** The sample of caregivers served by 12 participating care managers included 94 family caregivers who contacted the three participating AAAs for services. A brief standardized screening tool was used to identify eligible participants. Caregivers of persons with cognitive impairment were eligible for the study if their scores were in the medium to high range on one or more of the five major outcome

areas (caregiver identity discrepancy, objective burden, relationship burden, stress burden, or depression), or, they indicated that they "probably would" or "definitely would" place their care receivers in a nursing home in the near future. Eligible caregivers were randomly assigned to the intervention (n=51) or control group (n=43) using a computer-generated algorithm. Over 80 per cent of participating caregivers scored medium or high on both objective burden and stress burden. Eighty eight per cent of caregivers also scored medium or high on both objective burden and depressive symptoms. These scores indicated that the majority of caregivers in both groups had multiple areas of needs requiring services to address instrumental support and mental health support needs.

The demographic characteristics of the two groups of caregivers did not differ significantly. The majority of caregivers were female (84.5%), married (64.2%), and caring for a parent (53.6%). The average age for caregivers was 63 (SD =12.37) years. Fifty-four per cent of caregivers were White and 42 per cent were Black or African American. Over 70 per cent of care receivers were diagnosed with probable Alzheimer's disease. Caregivers reported that 47.4 per cent of care receivers could not perform two or more ADLs without help and 95.9 per cent could not perform two or more IADLs without help.

### Data Collection Procedures

Data pertaining to demographic characteristics and key outcome measures for individuals in the intervention group were obtained by care managers as part of the TCARE<sup>®</sup> protocol. Comparable data were obtained from persons in the control group by trained interviewers using the TCARE<sup>®</sup> assessment tool. Recommendations for care plans were drawn from care plans submitted by care managers. Service use information was drawn from service use forms completed and submitted by care managers three months after individual caregivers' care plans were created and implemented.

### Fidelity of Implementation

To monitor and facilitate accurate implementation of the TCARE<sup>®</sup> process by care managers, all TCARE<sup>®</sup> forms completed for each

caregiver were reviewed by staff at the time of the baseline assessment, and at the six month and twelve month follow-up assessments. A 27-item checklist was used measure the fidelity of care managers with the protocol along two dimensions. The score for mechanics reflected the extent to which a care manager correctly recorded information on the TCARE® forms. The process implementation score reflected the extent to which the care manager created a viable care plan that accurately reflected the TCARE® protocol. To assure a minimal level of competence, care managers were provided one-on-one technical assistance if their score for any caregiver on either measure was below 70 per cent. The competency of care managers on both dimensions of implementation increased over time. At baseline, the average fidelity score was 68 per cent for mechanics and 85 per cent for process implementation.

Statistical Analyses

Although data were collected for 22 services, analyses were restricted to the seven types of services that were recommended for more than 10 percent of caregivers in either group. The service types included adult day services, assistive technologies, education for caregivers that provides information or skills training, counselling or socio-psychological education, in-home services, medical or behavioural health evaluation, and support group. Independent samples t-test and chi-square tests were conducted to examine differences between the groups in the variety of services recommended, compliance and service use. This research project was approved by the University of Wisconsin-Milwaukee’s Institutional Review Board (IRB) on September 27, 2007 (IRB # 08.064).

Results

Service Recommendations

There were significant differences between the two groups in the number of different types of services that were recommended. The mean number of service types included on care plans was 3.4 (SD=.806) for the intervention group and 1.4 (SD=.623) for the control group,  $t(92) = -13.504, p < .001$ .

Table 1: Service Recommendation and Compliance<sup>1</sup>

	Initial Care Plan		÷ <sup>2</sup> (1,94)
	TCARE® (n=51) N (%)	Control (n=43) N (%)	
<b>Service Category</b>			
<b>In-home services</b>			
Recommended	42 (82.35)	37(86.05)	0.237
Complied	37 (88.10)	33(89.19)	0
<b>Medical or behavioural health evaluation</b>			
Recommended	38 (74.51)	1 (2.33)	47.146***
Complied	10 (26.32)	0 (0.00)	N A
<b>Counselling or socio-psych education</b>			
Recommended	27 (52.94)	11 (25.58)	7.251**
Complied	16 (59.26)	4 (36.36)	1.089
<b>Support group</b>			
Recommended	31(60.78)	0 (0.00)	36.297*
Complied	10 (32.26)	0 NA	N A
<b>Education for caregiver that provides information or skills training</b>			
Recommended	23 (45.10)	1 (2.33)	20.255***
Complied	6 (26.09)	1 (100.00)	N A
<b>Adult day services</b>			
Recommended	10 (19.61)	4 (9.30)	1.226
Complied	4 (40.00)	2 (50.00)	0
<b>Assistive technologies</b>			
Recommended	4 (7.84)	6 (13.95)	0.386
Complied	1 (25.00)	5 (83.33)	1.406

\* p <.05; \*\* p<.01; \*\*\* p<.001

<sup>1</sup>Compliance is indicated by the number and ratio of caregivers who used a given service when recommended to the total number of caregivers who were recommended for the service in each group.

Table 2. Service Use Regardless of Recommendation<sup>1</sup> and Service Use Without Recommendation<sup>2</sup>

Service Category	Initial Care Plan		÷ <sup>2</sup> (1,94)
	T C A R E® (n=51) N (%)	Control (n=43) N (%)	
<b>In-home services</b>			
Overall	43 (84.31)	37 (86.05)	0.055
Without recommendation	6 (13.95)	4 (10.81)	0.005
<b>Medical or behavioural health evaluation</b>			
Overall	11 (21.57)	0 0.00	8.520***
Without recommendation	1 (9.09)	0 NA	0
<b>Counselling or socio-psych education</b>			
Overall	19 (37.25)	16 (37.21)	0
Without recommendation	3 (15.79)	12 (75.00)	8.991**
<b>Support group</b>			
Overall	17 (33.33)	3 (6.98)	8.166**
Without recommendation	7 (41.18)	3 (100.00)	6.098**
<b>Education for caregiver that provides information or skills training</b>			
Overall	27 (52.94)	18 (41.86)	1.148
Without recommendation	21 (77.78)	17 (94.44)	9.864**
<b>Adult day services</b>			
Overall	7 (13.73)	3 (6.98)	0.521
Without recommendation	3 (42.86)	1 (33.33)	0
<b>Assistive technologies</b>			
Overall	8 (15.69)	6 (13.95)	0.055
Without recommendation	7 (87.50)	1 (16.67)	2.457

\* p <0.05; \*\* p<.01; \*\*\* p<.001

<sup>1</sup>The total number and ratio of the number of caregivers who used each service regardless of recommendation to the total number of caregivers in each group

<sup>2</sup> The total number and ratio of the number of caregivers who used each service without recommendation to the total number of caregivers who used the service in each group

The data in Tables 1 and 2 provide more in-depth information about differences between the two groups in the types of services that care managers recommended, caregivers' compliance with recommendations, and use of these services. As shown in the Table 1, in-home services were recommended for the large majority of the intervention group (82%) and the control group (86%). Similarly, the two groups did not differ significantly as to the number of recommendations made for the two types of services that were least often recommended. Assistive technologies was included on care plans for only four caregivers in the intervention group (8%) and six caregivers in the control group (14%). Adult day services were included on care plans for 20 per cent of the intervention group and only nine per cent of the control group.

Significant differences were observed between the groups in the number of persons for whom the other four service types were recommended. Over half of the care plans for caregivers in the intervention group included recommendations for medical or behavioural health evaluation (75%), support group (61%) and education for caregivers that provides information or skills training (45%). In contrast these three types of services were included for only one or none of the caregivers in the control group. Similarly, more than half of the care plans in the intervention group (53%) included a recommendation of counselling or socio-psychological education, but recommendation for this type was included on only 26 per cent of the care plans for caregivers in the control group.

Compliance

For both groups, compliance with service recommendations, indicated by the proportion of caregivers who used a given service when recommended (see Table 1), was highest for in-home service with 88 per cent for the intervention group and 89 per cent for the control group using these services. The intervention group had a higher compliance rate for counselling or socio-psychological education (59%) than the control group (36%) whereas the control group had higher compliance rates for adult day services and assistive technologies (50% and 83%) than the intervention group (40% and 25%). These differences, however, were not significant. Unfortunately, meaningful comparisons could not be made between the two groups for compliance with the other three service types due to the small number

of persons in the control group for whom the services were recommended.

#### Service Use

Regardless of recommendations, caregivers in the intervention group used a greater variety of services overall than those in the control groups, [3.43 (SD= .81) vs. 1.39 (SD=.62),  $t(92) = -13.504$ ,  $p < .05$ ]. To a large degree the pattern of service use by the two groups reflects the pattern of recommendations. As shown in the Table 2, in-home services, the type of service most frequently recommended, was also the type of service most frequently used by both groups. Similarly, the low use of adult day services and assistive technologies both groups of caregivers mirrors the low frequency of recommendations made for these services. The two services for which there was a significant difference in the rate of use were medical or behavioural health evaluation and support group. Both of these service types were recommended for more than half of the caregivers in the intervention group, but none or only one caregiver in the control group. Significantly higher proportion of the intervention group caregivers used these two service types than those in the control group.

The other services most commonly used by caregivers in both the intervention and control groups were counselling or socio-psychological education (37% vs 37%) and education for caregivers that provides information or skills training (53% vs 42%). Notably, despite a significant difference between the two groups in the number of persons for whom these educational interventions were recommended, there was no difference between the groups in the number who used them.

#### Discussion

Several conclusions can be drawn from the findings reported here. First, the differences observed in the number and types of services included on care plans suggest that professional staff using the TCARE® care management protocol were better able to identify multiple needs of caregivers and, therefore, recommend multiple types of support to meet these needs. Care plans for the intervention group all included recommendations for multiple services many of which address the emotional and/or physical needs of the caregivers.

The data pertaining to compliance of caregivers with recommendations is not readily interpretable. This is partially due to the fact that, with the exception of in-home services, very few recommendations were made for caregivers in the control group. Consequently, it is not possible to make valid comparisons between the groups. Our findings, however, do suggest that the inclusion of a service on a care plan increases, but does not guarantee, the likelihood of service use. For example, the inclusion of medical or behavioral health evaluation or support group on care plans for caregivers in the intervention group did translate into meaningful difference between the groups in the use of these services. The importance of including a service on a care plan is further underscored by the fact that, apart from education for caregivers that provides information or skills training, few or none of the individuals in the control group used services that were not included on their care plan.

Third, comparable rates of use of the two types of caregiver education programmes by control and treatment groups is an intriguing finding that deserves further exploration. Careful examination of the data in Tables 1 and 2 pertaining to counselling or socio-psychological education programmes suggests that care managers in the intervention group were better able to identify a need for this type of education than were care managers in the control group. Indeed, for the caregivers in the intervention group the second highest compliance rate was observed for counselling or socio-psychological education programmes. Moreover, of the 19 individuals in the intervention group who used this service only three did so without a recommendation. In contrast, 12 of the 16 individuals in the control group who used the service although it was not recommended to them.

The data pertaining to education for caregivers that provides information or skills training paint a somewhat different picture. The majority of caregivers who used this type of service did so on their own volition with little influence from care managers. This pattern would suggest that caregivers have a greater recognition of their need to learn new skills or gather information than their need for help with social-psychological issues.



### Limitations

Although the findings from this study provide evidence that care management is a service that can benefit caregivers, it is important to acknowledge the limitations of the study that are associated with the small size of the sample of caregivers and the limited number of participating organizations. Also, the dichotomous measures of service use did not allow analysis of frequency of use or extent of compliance. Equally problematic, we did not gather information directly from the caregivers regarding their reasons for compliance or non-compliance with service recommendations. Given the great variation in patterns of compliance across the different types of services, this information would be valuable for gaining a better understanding of the ways in which care managers might encourage use of services.

### Conclusion

The ageing of the global population has not only created a new role for family members, but it has also created a new client population needing services of skilled social workers. More than 25 years ago, Brody (1985) declared parent care as a normative role. Since then a large body of literature has emerged documenting the diversity of family caregivers, the negative consequences of caregiving and the changing nature of the role. Although numerous caregiver support interventions have been developed in the past decades, care management has only recently been recognized as an essential service for family caregivers. The findings reported here provide initial evidence that implementation of a care management protocol specifically designed to assist family caregivers, does indeed, lead service providers to offer a more diverse set of support services to caregivers and enhance the probability that caregivers will use the services, and ultimately benefit from them.

**Funding:** This research was supported by a grant to the second author from the Hartford Foundation's Geriatric Social Work Faculty Scholars Program and a grant to the third author from the Hartford Foundation's Doctoral Fellows Program in Geriatric Social Work.

**Acknowledgements:** The collaboration with the Georgia Division of Aging Services (DAS) is gratefully acknowledged. We also acknowledge the participation of care managers, family caregivers, and older adults in the State of Georgia who participated in this research study.

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