How an Ever-Greying Population and Looming Immigration Rollbacks Endanger America's Eldercare System *(and How We Just Might Fix It).*

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Eldercare and the Need for an Expanding and Well-Trained Workforce

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One of the greatest concerns of developed countries today is the aging of populations at a faster rate than they are growing. The United States is no exception. In fact, America is poised to experience what is satirically dubbed the impending "gray tsunami." Indeed, by 2060, the aging population in America will have grown roughly 105 percent in just forty-five years since 2015, compared with a total population growth of only 30 percent over the same period (Statista). Therefore, it is not surprising to note that the eldercare industry will have to grow accordingly. However, the industry will only grow weak and brittle as it currently stands, desperately unstable in the face of a population that is aging faster than it is growing. There simply will not be enough able-bodied Americans to fill the necessary positions in the eldercare industry. We all know what happens when extreme pressure is applied to a fragile thing. It shatters.

So, what are Americans to do? The most logistically friendly option is to enhance the current long-term care workforce by beefing up its wages, benefits, and training programs. Right now, the average direct care worker (the individual responsible for carrying out day-to-day activities with elders such as bathing and toileting) makes only fourteen dollars an hour. This is a paltry sum for the demanding and emotionally draining jobs they hold. As Osterman (a labor economist at MIT's Sloan School) reports, increasing wages contributed by decreasing employee turnover in the eldercare industry. Moreover, adding benefits such as health insurance and making training mandatory and continual over a direct care aide's career have also been shown to decrease employee turnover. Hopefully, taking these steps will not only help eldercare industry actors hold on to more employees than they do currently, but also make their jobs more attractive to those who are looking for a job.

In addition to increasing wages, benefits, and training programs for direct care aides to recruit more American employees, the United States must also consider creating an uninterrupted migration channel and path to citizenship for those foreign workers who wish to help take care of our elders. This type of channel does not exist currently, and as such there is unstable flow of foreign labor into the eldercare industry. However, a striking number of migrants (both documented and undocumented) already work in long-term care. Indeed, approximately forty-five percent of direct care workers are foreign-born. Despite their integral place in the eldercare system, the current presidential administration seeks to deport as many of them as possible. It is time to acknowledge their unreplaceable work in our eldercare system by allowing them to not only enter the country legally, but to set them on a path to citizenship so as to ensure continuity and quality of care for our elders.

In this paper, I will discuss these and the many other obstacles that exist to improving eldercare in the United States in greater detail. However, I will also review how other developed countries have successfully (and unsuccessfully) attempted to revitalize their own long-term care systems. From there, I will make evidence-based recommendations on how to improve our own system using the tools we already have in place. Though our current system is unstable, it is by no means unsalvageable.

Current Concerns

America is already facing a severe labor shortage in eldercare-essential jobs such as home health aide and nursing assistant. Because the nature of these jobs is laborious, emotionally taxing, and potentially abusive, those who often step up to take them are desperate populations, namely impoverished immigrants. As of 2016, 26.7% of home health care workers and 18.4% of certified nursing assistants, the two professions that make up the backbone of elder care, are immigrants (Osterman, 5). It is surmisable, though, that a higher percentage of these job-holders are immigrants than what is reported, as undocumented immigrants often do not report their status for fear of deportation, and in the home care workforce, it is estimated that one in five immigrant workers is undocumented (Hess and Henrici). Undocumented immigrants provide labor for the gray market of eldercare, the under-the-table work that arises from the elderly hiring caretakers on their own, likely due to their services (as they are not regulated) costing less than over-the-table workers. While the provision of cheap labor is currently important to the functioning of the industry ("[a]s so much of the funding for long-term care goes to labour costs"), a downside of under-the-table work is that it is not subject to regulation and therefore those working under-the-table are at more risk for any kind of abuse, beyond just that of finances (O'Shea and Walsh).

However, these essential long-term caregivers are at grievous risk, as the Trump administration seeks to deport as many immigrants (legal and illegal) as possible. Among those affected, there are several communities of immigrants who could face deportation in the current political climate. There are 800,000 cumulative DACA [Deferred Action for Childhood Arrivals] beneficiaries in the United States. Many more individuals (around 3.5 million, known as the "Dreamers") are eligible for similar protections to those of DACA when considering the wide swath of bills that have been recently reviewed in Congress (Gelatt and Pierce). Such bills include: the American Hope Act, the Border Security and Deferred Action Recipient Relief Act, the DREAM Act, Recognizing America's Children Act, the Border Security and Immigration Reform Act, and the SUCCEED Act (MPI Institute).

However, with eligibility for protection also comes the potential for deportation, as none of these bills have passed (or will likely ever pass) Congress. Furthering the crisis, Dreamers are not the only immigrants at risk of job loss and eventual deportation. Many of those with Temporary Protected Status, up to 300,000 foreign nationals, face these same fates under the Trump administration (Cepla 2018). Nearly 60,000 Haitian refugees (as of November 2017) were given eighteen months to leave the United States. This same mandate was conferred on Nepalis, El Salvadorians, Sudanese, and Nicaraguans (Cepla 2018).

So what does this mean for the United States, and are these nationalistic policies dangerous? As a federal judge in California succinctly put it, this is: “a chaotic circumstance of the government’s own making" that is fueled by rampant indecision on the part of a confused Congress, never-ending calls from the Trump administration for the gutting of DACA and family based migration, filial border separations, travel bans, and deportations of those with temporary protected status (Kelly). The United States struggles with the moral implications of these circumstances, evidenced by the recent nationwide protests against the Trump administration’s immigration agenda with hundreds of thousands of participants across America (Gomez). However, many other Americans are able to dismiss their emotional reactions to the uncertainty over immigration, in that it does not affect them directly. Yet, perhaps the strongest blow from deportations to the United States arrives indirectly: via the financial and fiscal deflation that inevitably comes from removing hundreds of thousands of economically productive migrants from the country.

Indeed, of the 800,000 DACA beneficiaries, ninety-one percent of them were or are gainfully employed (Magaña-Salgado and Wong). Notably, “[t]he end of DACA will have significant and far reaching economic impacts on contributions to the Social Security and Medicare trust funds. President Trump’s decision to end DACA will cost these trust funds at least $39.3 billion over ten years, $31.8 billion from Social Security and $7.4 billion from Medicare” (Magaña-Salgado and Wong). Unfortunately, the damage caused by the possible end of DACA (not to mention the end of TPS and other programs) would not stop with hits to just Social Security and Medicare. Considering both the DACA and TPS deportations together, the American economy stands to lose more than one million consumers and subsequently many producers.

This potential and realized workforce deficit is especially affecting the eldercare industry. Several of its key positions are the fastest growing in America at present. Specifically, the roles of home care aide and personal care aide take the second and third spots on the Bureau of Labor Statistics’ *Fastest Growing Occupations* list, with projected growth through 2026 of forty-seven percent and thirty-nine percent, respectively. By 2024 America will require 1.2 million home health aides, some 300,000 more than were employed in 2014 (United States Bureau of Labor Statistics). And, employee turnover in these positions in for-profit settings is high at a median of sixty-one percent. Compare this figure with the ideal one of ten percent. This indicates that for-profit agencies spend lots of time and resources continually recruiting new staff instead of investing in retaining the employees they already have (Osterman, 44). Further, in the realm of the nursing home specifically, there is intense competition to recruit and retain nursing assistants, those who provide the day-to-day care for residents such as bathing and toileting (Rau). Recent federal data has demonstrated that most nursing homes “had fewer nurses and caretaking staff than they had reported to the government for years….With nurse assistants earning an average of just $13.23 an hour in 2017, nursing homes compete for workers not just with better paying

employers like hospitals, but also with retailers. Understaffing leads predictably to higher turnover" (Rau).

What certainly does not help is the impending "gray tsunami," as it is satirically called, or the great transition of the American population into an aging one. Indeed, by 2060, there will be 98.2 million people over the age of sixty-five in the United States, compared to 47.8 million in 2015 (United States Census Bureau). This is a growth of 105.2 percent in just forty-five years, compared with a total population growth of only 30 percent over the same period (Statista). To reduce these numbers even further, I compare the over-sixty five growth rate to the total population growth rate by dividing the elder growth rate by the total population growth rate. For 2015-2060, the U.S. is projected to experience a proportional growth rate (elder vs. total population) of 3.5. Compare this with the same calculation for the sixty-five years between 1950 and 2015, which amounts to only 2.26 (Pew Research Center). As such, though the United States' population is actually growing slower now than it was during the last half of the twentieth century, it faces an elderly population that is (and will keep) growing at a rate that is 3.5 times that of the total population (Pew Research Center).

As the majority of care is currently provided by unpaid relatives (mostly children and spouses) of the elderly, this shift in population growth to skew towards a greater elderly population is particularly dangerous because "the pool of potential family caregivers is expected to shrink relative to the universe of need" (Osterman, 54). Ultimately, this results in an even greater need for paid caregivers as there simply will not be enough younger relatives around to provide the same quantity of care as they do currently (Osterman, 54).

Yet another facet to the issues plaguing the American eldercare system is concern regarding quality of care and the sizeable cost of that care, both to the individual and the government. Quality of care in the current system is questionable, with, in 2014, twenty percent of nursing homes were "deficient in ways that put residents' health in jeopardy" (Osterman, 20). "Recurring concerns [of assisted living facilities and nursing homes] include staffing levels, abuse and neglect, unmet resident needs, quality problems, worker training and competency, and lack of integration with medical care" (Harrington et al.). Regarding the quality of in-home long term care services,"[t]he last several decades also have seen a shift to home care and other community-based services, with few quality measures for these settings available and little empirical evidence available" (Harrington et al.). But here exists a stark incongruity, in that home care workers "have as much impact on the quality of life of their clients as any other member of the health team, if not more" (Osterman, 41). As such, more research on their current role as well as the potential for expansion of that role in the client's life is necessary.

As expected when considering the cost of regular healthcare in the United States, the cost of long-term care is enormous. In 2013, the median annual cost of nursing home care for an individual was $91,250 (Reaves and Musumeci). Total national spending amounts to $310 billion for the year of 2013, with a whopping seventy-two percent of this cost being picked up by publicly funded programs, including Medicare and Medicaid (Reaves and Musumeci). In fact,

Medicaid is the primary payer for long term services, accounting for fifty-one percent of spending for these services in 2013 (Reaves and Musumeci). With the growth of the American elderly population in the coming years, these costs are likely to swell even more, unnecessarily using a great proportion of public funding that could be employed in improving other social programs, such as that of public education and infrastructure.

When considering the sum of all the issues with the American eldercare system as discussed above, it is a daunting task to even imagine a system that could cover all the bases needed to improve quality and cost of care. But, there is certainly reason for optimism: demographic pressures applied to the nation in the form of a growing elderly population relative to the total population will likely spur reform. Yet, it is a mistake to think that our system can be fixed with one omnibus bill. As I will demonstrate via my study of other countries' long-term care systems, reforms are continually necessary to develop and maintain a tolerable system. The ultimate purpose of this paper, then, is to present a collection of evidence-based suggestions (grounded in research and observations of other countries' systems) on how to transform our ailing eldercare system for the better.

Root Causes of Current Concerns and the Cycle of Vulnerability

As I embarked on my research, I began to wonder how America's current eldercare system came to exist as it does currently; in a state of general disarray that fuels its costliness. To answer this question, I looked to the development of the larger healthcare system in America. For the entirety of the United States' existence, there has been extensive debate regarding whether or not the government should be involved in regulating medical care (Starr). This public indecision drove the financial market in the early twentieth century to assume governance via economic properties of competition, supply, and demand (Starr). So, our current system of care is exceptionally privatized, with providers of care competing with each other for business, rather than having care be provided by the government (Starr). Because each private member of the system of healthcare in America has different manners of conducting business (especially in terms of billing for services), there is enormous administrative overhead that accompanies communication and payments between companies in the system (Starr). Not only does this fractured system drive up the cost of care, it also reduces incentive for communication between competitors, negatively affecting the quality of care by transferring focus away from the patient (Starr). I have found that these themes from the overall healthcare industry in America certainly apply to eldercare and long-term care, subsets of the larger care industry.

But, the splintered nature of the long-term care industry also arises from the differing needs of its consumers, who form two groups: the elderly, and the young disabled (i.e., those who are under the age of sixty-five but who still need long-term care). For example, young disabled activists push for greater autonomy and control over their care by lobbying for deregulation of home care aide practices, while elders tend to favor a legislative expansion of the home care aides' responsibilities (Osterman 12).

To make matters more complex, in all of my research on the intersection of eldercare and immigration, no concept comes to mind sooner than what I call "the cycle of vulnerability," which drives debate regarding eldercare policies. In other words, the United States' eldercare system currently exists as two interdependent populations: those who need care, and those who provide it. Given that a good deal of long-term care is delivered in the client's own home, the abuse of both parties varies from possible to probable, depending on the situation (Osterman 16). But, who is more endangered by this endeavor? Patients who risk being financially taken advantage of or neglected by their caretakers? Or, are their caretakers (as mostly women and of minority and/or migrant backgrounds), in danger of abuse at the hands of their clients (Campbell, 2-3)? A clear power dynamic exists between these groups, however, in that those who need care have greater representation in the spheres of policy and industry than those who provide care.

This is a result of those needing care having the funds to lobby for policies that favor their agendas over those of their less unified providers.

On the whole, then, what we have is a system built upon the fissures engendered by a laissez–faire approach to federal and state regulation of the eldercare and larger medical industries. Out of this relaxed governmental approach, arises fractured privatization that emphasizes the company over the care *and* the caretaker, leaving both parties certainly vulnerable and potentially neglected.

Perspectives From Abroad: What Have Other Countries Done to Revitalize their Long-Term Care Industries?

In this section, I will report on the promising (or cautionary) aspects of Japan's, Canada's, Italy's, and Singapore's eldercare systems, and what ideas they can provide for the United States. I selected these four countries from an original literature review on most of the developed countries, including these countries because of their noteworthiness in terms of eldercare innovation or relevance to the United States' current eldercare conundrum. Additionally, I will discuss smaller programs piloted by countries such as England, Israel, Sweden, and Germany. Of course, as this review is more conversational than data-driven, keep in mind that none of the claims I make are causal, and are just suggestive analysis. More quantitative research, as always, is necessary to determine the impact of the long-term care quality of a country on its life expectancy, etc.

Japan

The United States is not alone in its battle for quality, accessible long-term care, as well as sorting out its migratory implications. In fact, many developed nations face this same struggle. Japan, unfortunately, is facing more extreme demographic pressures than the United States in that the proportion of its total population is already significantly old (33% people over age sixty in 2013 compared to America's 14% over age sixty-five in 2013) (Świtek). As such, Japan's largest issue is that it faces labor shortages in almost every field, including that of eldercare (Świtek). Currently, there are two widely-reviewed (among the Japanese) options to provide care to the elderly: either robots are further developed to assist the elderly, or Japan becomes home to many more immigrants (Świtek). Because Japan has stringent immigration policies currently (and is not willing to change them), it has turned to forming economic agreements with other countries, such as the Philippines and Indonesia, that send eldercare workers to Japan (Świtek). However, in order to remain permanently in Japan, these workers must past an intensive exam that is exclusively in advanced Japanese, which demonstrates an inclination on Japan's part to set them up for failure (Świtek). But, since these agreements were instituted in 2008, the Japanese media has portrayed them as a favorable step towards loosening immigration restrictions (Świtek). So, it is likely that a mix of both labor options (robots and immigrants) will manifest in the eldercare industry in Japan.

Japan's eldercare situation is an intriguing example, in that its discourse over how eldercare issues should be resolved mirror (in some ways) the U.S.'s. Indeed, as Japan's population is currently even older than the U.S.'s will be in 2050, it may serve as a sample of the future for an aging United States. Moreover, Japan faces nationalism and deeply ingrained ideals of cultural and ethnic homogeneity that prevents it from completely throwing open its borders to many immigrants (Green). While the U.S.'s immigration policies are not as strict as Japan's, and its population that supports ethnic homogeneity is in the minority, perhaps the Japanese solution can be a first step for a still fairly migrant-hostile America (Green). Further, Japan's solution of creating economic engagements with other countries to recruit eldercare workers specifically seems like an encouraging option (in that it is heavily controlled) for an America that needs more long-term care services than it can provide with its native-born population.

Canada

Few developed countries at present have migration channels specifically for long-term caregivers. "In all four countries [U.S., Canada, Ireland, and the U.K.], admission policies historically tended to favour admissions for family reunification over employment and, with the exception of Canada and a limited entry channel in the UK, none target admission of long-term care workers" (Walsh and O'Shea). Despite this, these English speaking countries depend on foreign-born eldercare workers (Walsh and O'Shea). Like the Japanese, "in the UK, Ireland and several Canadian provinces, government agencies have established bilateral agreements with India and the Philippines to actively recruit nurses...for older persons" (Walsh and O'Shea). In Canada specifically, long-term care provided outside of a hospital is not considered insured under the Canada Health Act and is considered by many to be a patchwork (Allin and Rudoler). However, "[a]ll provinces provide some nursing home care and some combination of case management and nursing care for home care clients, but there is considerable variation when it comes to other services, including medical equipment, supplies, and home support, and many jurisdictions require client contributions" (Allin and Rudoler). So, it is not surprising that Canada is dependent on cheap foreign labor to fulfill its social care needs.

Canada's "live-in" caregiver program (derived from its au pair system) makes it possible for direct legal immigration of long-term care workers from abroad (Walsh and O'Shea). Many of those admitted to the program "have become permanent residents (CIC, 2007). The growth and increasing popularity of the programme indicate that there is place for admission classes targeting social caregivers, but the temporary nature of the programme does little to provide stability to the long-term care workforce. Furthermore, some observers note that workers are underemployed relative to their education; some are also critical of how temporary live-in status affects working conditions (Spitzer and Torres, 2008)" (Walsh and O'Shea).

Another interesting implementation of the Canadian system is that some of its provinces grant job protections and financial assistance to family caregivers (Allin and Rudoler). The vast

majority of caregivers in both the United States and Canada are family members, and providing them with some insurance against job loss as well as financial assistance in caring for their loved one(s) is obviously helpful (Osterman; Allin and Rudoler). However, like the United States, Canada faces extreme demographic pressure in that its aging population will swell in comparison to its young and middle-aged one over the next forty-five years (Jackson and Clemens). Eventually, then, there will not be as many or even enough family members to care for the chronically ailing and elderly. Running a similar program in the U.S. is vital as the remaining family caregivers will desperately be needed *because* of their limited numbers in the coming years.

In a recent study, the Canadian Institute for Research on Public Policy examined the validity of multiple financing solutions to ensure universal long-term care services in Canada. To do so, Grignon and Bernier investigated the success of other countries' implementation of universal long-term care via "private savings, private insurance and universal public insurance" (Grignon and Bernier). The authors found that private savings, while a low-overhead option for the government, never produces the right amount of funding for long-term care:

"First, some individuals will need long-term care services in excess of what their savings can support. Second, if every married individual saved $150,000 over their lifetime to cover the possibility of having to spend five years in a nursing home, a majority of individuals would end up having saved too much, simply because the risk of becoming dependent for a long period of time is concentrated in a subgroup of the population. An estimated 31 percent of people turning 65 in 2005 will not need any long-term care before they die (Kemper, Komisar and Alexcih 2005). From an individual's perspective, it is not efficient to forgo $3,750 a year of consumption (or investment in housing or education) only to leave a large bequest at the time of death" (Grignon and Bernier).

As for private insurance funding of long-term care services, Grignon and Bernier found this option to provide inequitable coverage. Thus, they suggest that publicly-funded long-term care is the most efficient and equitable coverage plan available, as

"...from an economics perspective, the widespread reluctance among Canadians to accept the tax increases that would be required to pay for a public plan should be overcome, simply because the other options are inefficient and inequitable. In the absence of such a plan, Canadians will have to either save large sums of money or buy more expensive and less satisfactory private insurance. Many could be left facing costs that exceed their individual means and may have to do without the long-term care services that their conditions require. Alternatively, many might have to fall back on the public health care system as a last resort, and this would lead to an inefficient and costly misallocation of Canada's collective resources" (Grignon and Bernier).

Because both Canada and the U.S. currently address their long-term care needs by combinations of public and private insurance as well as private savings, it is feasible to conclude that both may find more equitable and efficient care in universal public coverage.

Italy

The Italian long-term care system more robustly demonstrates the pros and cons of relying on an informal migrant population extensively for care work (Fraser). Italy has increasingly done so over the past decades, and this is considered by many to be an inefficient long-term solution in its current form, though it suits the Italian preference for aging-in-place (Fraser). The current system of "...the 'migrant in the home' model has saved the Italian government a considerable amount in terms of economic and administrative resources..." however, and expanding migration for direct care workers is a necessary step for many developed countries (Fraser).

The Italian example demonstrates that it matters *how* migration is established for direct care workers, though. The Italian government often has introduced legislation directed specifically at accepting more migrant long-term care workers when demand in the country exceeds supply, while limiting immigration for most other reasons (Fraser). This constitutes an informal immigration channel with unintended consequences because "[t]he frequent regularizations are rewarding illegal migrants and attracting new migration flows at the same time" (Fraser). What can the U.S. learn from the Italian example? Migrant caregivers can be economically efficient providers for an ever-expanding elderly population, but they must be provided with a stable path through immigration and eventual citizenship. Such a formal channel would reduce the incentive for illegal immigration and lessen the burden of abuse on both sides of the table, for both the elderly and their direct care workers. This burden is currently very real in Italy:

"A recent study – investigating the 'double direction' of violence in the caregiving relationship as a complex reality of abuses in the home involving MCWs [Migrant Care Workers], family carers and cared for older persons (Ligabue, 2010) – reports that abusive acts are perpetrated in 35 per cent of cases by MCWs (mainly physical and psychological abuse), while the latter report abuse (mainly sexual molesting behaviours and verbal aggression) by both family carers (29 per cent) and by older people (23 per cent). Stress related to heavy working conditions by the MCWs and cognitive pathologies and social isolation by the cared for older people represent in this respect crucial risk factors, as does forced cohabitation, thus showing the relevance of adopting appropriate training, information and counselling efforts to support all involved parties (MCWs, families and professional carers)" (Barbabella et al). Thus, creating more formal migration channels for direct care workers would also support the development of better training services for a legal long-term caregiver population.

Singapore

The ailing elder's dream. Singapore's overall health care system is universal in nature, but still features private provision of services (Liu and Haseltine). It stands out among most developed countries because it rests upon a system of private savings for health care needs, with all adult working citizens required to save six to eight percent of their salary in a medical savings account (Taylor and Blair). Employers match this contribution as well (Taylor and Blair). Supplementary insurance is available for purchase, and one such type of insurance is ElderShield. It is "regulated by the government and run through designated private insurers" and it "provides monthly direct cash payouts for those who can no longer take care of themselves. Depending on which type of care and setting best suits their needs, seniors and their families can choose nursing facilities or home-based health care providers, including hospice care" (Liu and Haseltine). Moreover, Singapore also pays family caregivers of the elderly to "attend approved training courses in taking care of the elderly or persons with disabilities" (Liu and Haseltine). The government also incentivizes the elderly to hire migrant caregivers by providing $141 (USD) a month to those who do (Liu and Haseltine).

Another interesting facet of Singapore's health care system is its near public ownership of hospitals, and near private ownership of primary health care clinics (Taylor and Blair). "The public sector provides 20 percent of primary care and 80 percent of hospital care through two integrated care networks. The private sector dominates primary health care, providing 80 percent through its 1,900 clinics" (Taylor and Blair). From the United States' standpoint, this is an interesting distribution of the market, as nearly 80 percent of hospitals are privately run in the U.S. (American Hospital Association). In the U.S., health care costs are dominated by hospital stays, which made up 32 percent of health care expenditures in 2016 (Center for Medicare and Medicaid Services). Because Singapore's government mostly runs its hospitals (80 percent), it is able to keep costs as low as possible, compared to the mostly private hospitals in the United States that may charge exorbitant amounts. Keeping hospital bills low should be a goal of new policies for eldercare reform in the United States, to minimize costs to both the government and the individual.

Perhaps the most striking aspect of the Singaporean eldercare system is its cohesive goals as enumerated by their Ministry of Health. In 2014-2015, the ministry held over fifty group discussions and interviews with Singaporeans on what the government could do to help them "age with confidence" (Singapore Ministry of Health). After these idea sessions were complete, the ministry compiled the most popular ideas into an action plan. The ten topics of most concern to the elderly and their caregivers were these: continued employability late in life, lifelong ability to learn, encouraging seniors to volunteer, keeping elders physically healthy and well, fostering greater social inclusion and engagement of elders, aging in place, housing, transportation,

making public spaces more disability friendly, and conducting research to develop evidence-based solutions to improve seniors' care (Singapore Ministry of Health). Though Singapore's small size enables it to have discussions with direct policy implications, and the United States could not possibly do the same, America could still enact a national dialogue via surveys or extra Census questions to determine what Americans' greatest needs are as they age. While I am sure Singaporeans' ten topics on aging are also relevant to Americans, it is essential to conduct location-specific research into exactly what Americans need and how best to address these needs at the local, state, and national level.

Quick Tidbits from England, Israel, Sweden, and Germany

★ Research, Research, Research!

As we have seen under Singapore's example, research is essential for making appropriate policy decisions and reforms, especially in a field so deprived of evidence-based guidelines as eldercare. England is conducting its own eldercare research in the institutional, communal, and acute care settings via its establishment of "vanguard" programs throughout the country (National Health Service). In nursing homes specifically, the following initiatives were found to be most conducive to improving residents' health:

- Resident-centered care ("Putting the needs of the resident or person with care needs at the centre of any changes")
- Supporting family members and caregivers
- Integration of the care team at all levels (governmental, private, voluntary)
- Focusing on quality as "the driving factor for change"
- Using clinical evidence to improve quality
- Leadership and a united vision among elders and caregivers for better care

★ Raise the Retirement Age

Israel, like the United States, faces an incredibly fractured long-term care system and a graying population (Chernichovsky et al.). A potential source of funding would arise from raising the retirement age, given that people are living longer and could therefore work as they age (assuming they are healthy enough to do so).

★ Regression in Sweden?

Sweden once stood out as a model for universal long-term care coverage. Though public funding for long-term care services is generous, in the past couple of decades, it has stepped

away from this model by allowing for the private provision of services (Szebehely and Trydegård). As such, wealthier elders have incentives to purchase more expensive private services, with the option to add on even more services at a reduced cost due to subsidization. Due to the high cost of private care, Sweden's poorer elders' care is administered via the public system and increasingly by family-members (Szebehely and Trydegård). This is dangerous because the quality of care that could be provided by family members and a public system is thought to be lesser than the private system, thus making care fundamentally inequitable. Using educational status as a proxy for wealth status (as those with higher education tend to be wealthier), it has been determined that "there are clear and growing differences in remaining average life expectancy between groups with different educational levels" in Sweden (Statistiska Centralbyrån). Of course, this does not directly mean that the greater privatization of the Swedish long-term care system is what caused this difference, as such a causal claim would need to be made under more robust statistical parameters.

★ *A Dynamic German System*

Germany is actively working on its long term care system. Its long-term care program was initially implemented in 1995, but has underwent reforms since then (Nadash et al). Much like the United States, Germany faces an aging population that demands greater care, resulting in a shift in policy to include more provisions for long-term services and supports. "Demographic pressures were critical, too: the program aimed to address the growing need for LTSS resulting from the aging of the German population as well as the reduced availability of family caregivers, due to the changing role of women and lower fertility rates. Indeed, the proportion of Germans 65 or older is projected to rise to nearly 23 million (32%) by 2050, up from 21% in 2014 and 16% in 1995, when the program was launched (Statistisches Bundesamt, 2015a)" (Nadash et al.). Moreover, "...despite the fact that the proportion of the German population that is elderly (21%, as of 2013) matches the proportion that some fear will bankrupt the United States by 2050, Germany has been successful in maintaining a fiscally solvent, self-funding program of universal coverage for LTSS" (Nadash et al.). This efficiency has been driven by research on German elders' evolving needs and grounding policy in the research.

So, what can we learn from these examples?

By the Japanese example, we observed that a realistic first step towards a reduction in labor shortages in the eldercare system in America is to open a migration channel specifically for eldercare workers. The idea's plausibility derives from its apparent functionality in Japan and Italy, two nations (similarly to the United States) embroiled in national debate over restrictive immigration policy. If they can do it, so too can we.

By the Italian example, we discovered that opening the channel for migrant care workers would not be a viable long-term solution because of its unstable nature and its encouragement of

greater illegal immigration.The Canadian example also demonstrates the instability of a stand-alone migration channel, in that those migrant care workers who participate in the program are likely underemployed given their educational backgrounds and face the potential of abuse due to their live-in status. As such, the United States should consider implementing a clear path to citizenship for migrant care workers who immigrate through the channel, so as to permanently maintain a long-term care workforce in the country and stem the flow of illegal immigrants.

Another interesting facet of the Canadian example is that its policy analysts recommend universal long-term care. They also investigated two other options, private savings planning for old age, and private insurance provision, but determined that they are not viable solutions. Private savings is inefficient in that it rarely produces the right amount of savings (either too much or too little) to serve the elder's needs. Private insurance provides inequitable coverage and thus increases cost to the government in the event that someone who does not have coverage is treated in hospital, as we have seen by the Swedish step backwards from universal long-term care. So, the United States should consider making Medicare and the parts of Medicaid that cover nursing home costs universally available. Since the public already funds 72 percent of long-term care services in the United States, making the transition to universal long-term care coverage would not be as dramatic or costly a switch as intuitively imagined (Reaves and Musumeci).

A few Canadian provinces fund caregiver job insurance in case they are not able to go to work due to caring for their elder family member. Singapore also has a program that monetarily incentivizes family caregivers to receive training on how to properly care for their loved ones. The United States could offer similar services to American family caregivers to improve the quality of care they can deliver to their elders and their own quality of life knowing they still retain their job while being able to care for their loved ones.

Research is another important aspect of the Singaporean system that the United States can learn from. Indeed, as part of its initiative to bolster confident and healthy aging among its citizens, Singapore has discovered through country-wide discussions that research on the actual needs of its people is crucial for the most efficient spending on long-term care services by the government. The United States could enact a similar program by adding a few Census questions for elders or conducting a national survey or poll to best estimate their long-term care needs. Moreover, England also stands out as a bastion for localized research at their "vanguard" facilities across the country. Charging a few specific nursing homes and home care agencies with reporting back on what works best in their communities could be a reliable way to re-energize the United States' system.

By the Israeli example, we learned that increasing the retirement age could reduce the funding inputs necessary to support the elderly community. Because people in both Israel and the United States live significantly longer than they did fifty years ago, it is likely that in the future people would want to continue to work to an older age then they currently do.

But, the most important tidbit from any of the countries has to do with the overall idea of a legislatively dynamic long-term care system. This is the notion that reform is considered whenever the needs of the population shift. Germany stands out as a progressive example. Though its long-term care program was implemented in 1995, Germany has altered it due to the demographic pressure on its population towards elders, especially the realization (from extensive research) that the system needed to involve the considerations and concerns of their caregivers. As such, the United States should avoid the mistaken idea that its eldercare system can be altered with one iteration of one bill. From the German example, we can see that it often takes many more iterations and research initiatives to arrive at a successful and fiscally solvent long-term care system.

Universal Eldercare

I would like to start off this section by reiterating a fact I brought up early on in this work. That is, a large majority (seventy-two percent) of long-term care is already publicly funded in the United States, though this funding is unstable (Reaves and Musumeci). This is reason for optimism, as providing universal long-term care is definitely within reach for America. We are only twenty-eight percent away from it.

It is likely that the U.S. will arrive at universal long-term care before universal health care due to demographic pressure and that the government already pays for more of long-term care than general health care (Himmelstein and Woolhandler). The majority of funding for the entire healthcare system in America comes from the public via taxation as of 2016 (Himmelstein and Woolhandler). Further, "At $5,960 per capita, government spending on health care costs in the U.S. was the highest of any nation in 2013, including countries with universal health programs such as Canada, Sweden and the United Kingdom. (Estimated total U.S. health spending for 2013 was $9,267 per capita, with government's share being $5,960.)" (Himmelstein and Woolhandler). It is fair to say, then, that "we already pay for national health insurance, but we don't get it. It's an outrage that the American people pay sky-high health care taxes, but 33 million are still uninsured" (Himmelstein and Woolhandler). It is not just an outrage, however. The current U.S. system is illogical and harmful. Why are we spending more than any other country to get less?

Since we are already paying for it, our elderly should have universal access to care. The advantages of implementing universal eldercare are manifold. Universal care in general provides more equitable coverage than any other financing option (Grignon and Bernier). A single-payer system reduces administrative overhead by at least fifteen percent (Aliya et al.). It also is just easier for the individual (who is already facing the stress of illness) to have only one tax to pay instead of having to sift through bills that come from all over (hospitals, doctors, nursing facilities, and pharmacies). Moreover, we'd be better off with the government, which inherently serves only the American people, being the only payer for care costs, rather than allowing insurance companies that entirely serve themselves pay for care. Enforcing stricter cost controls on providers of medical goods and services, including those pertaining to long-term care, are essential to stem growth of care costs (Weiner et al.). In the typical Catch-22 fashion, cost containment measures are so vital to ensuring the sustainability of a universal long-term care system that we cannot build a strong system until care costs have lowered (Khazan). As such, America's first step towards universal long-term care should be to implement greater cost control

measures, including raising the retirement age as people live longer and can continue working into their seventies and eighties. Once the United States' care spending has slowed, universal access to long-term care can be assured.

Concepts of Fabulous Care

Expanding Home Care Aides' Roles

Now that the elderly all have access to care, what would that care look like? As most broadly put by Paul Osterman, author of *Who Will Care For Us? Long-Term Care and the Long-Term Workforce*, "the most fundamental change [from the current system] is to reconceive long-term care as central to the quality of life of millions of people who need it, rather than as the stepchild of the health care system, as it is seen today" (Osterman 9). In his work, Osterman presents the advantages of expanding roles of home health aides specifically because they are an underutilized workforce already present in the system, providing a logistically ideal avenue for improvement. Moreover, the current modes of health care delivery bolster enlarging the home care aides' roles. Specifically, "[t]hree recent trends in the delivery of health care point directly to an expanded role for home care aides. First is the growing focus on the creation of health care teams, as opposed to the traditional top-down, doctor-focused practices. Second is the increased attention to the management of chronic conditions. The third is new interest in managing transitions from hospitals after acute incidents" (Osterman 77). Indeed, Osterman concludes that "the people who spend the most time with the young and elderly disabled are home care aides," and thus know the most about their clients (Osterman 8). Because they are the caregivers that are closest to many clients, it is wasteful to ignore their input. However, this is often the case, and "they are not taken seriously as members of the care team" (Osterman 29). Despite the disrespect they face from the medical community, many home care aides are willing and capable of doing more for their clients besides bathing them, cleaning, and cooking for them, which is the basic extent of their responsibilities currently (Osterman 52). Couple this eagerness to learn and grow as professionals with our nation's increasing need for long-term caregivers.

As such, Osterman advises that wages for home care aides and nursing assistants be increased. Indeed, as the average pay for a nursing assistant in 2017 was only $13.23 an hour, recruiters for these positions struggle to find candidates because they are competing with retailers in terms of compensation. The benefit of increasing wages is to attract more staff and reduce turnover (Osterman 50). While wages for nursing assistants and home care aides should certainly be increased, they should still be less than those for nurses and physicians, so as to maintain the "substantial cost savings" that result from "the delegation of many medical functions to nonphysician team members" (Osterman 78). Instead, more resources should be put into training home care aides and nursing assistants so that they could perform more extensive services for their clients, such as caring for wounds and administering medication. Because

"isolation is inherent in the home care aide's job," giving them more medical autonomy would reduce their dependence on their case-laden care coordinator, who is often hard to reach (Osterman 33). Further, greater training could help home care aides provide better assistance to their clients by themselves, reducing the number of unnecessary emergency room visits, and thereby lessening overall costs of care (Osterman 33).

Additionally, increasing training for home care aides has been shown to reduce employee turnover, which is currently a large issue in eldercare (Osterman 49). "An industry survey of for-profit agencies reported a median turnover rate of 61 percent, and the firms surveyed said that turnover was their biggest business challenge. Certainly, turnover can be a problem if it indicates that workers are fundamentally dissatisfied with the work. Turnover can also be a challenge because it compels employers to invest resources in seeking out new employees. And of course, turnover can reduce the quality of care. With continuity, a home care aide can learn a good deal about a client's needs and better meet them; turnover disrupts what is often a very personal relationship between a client and a home care aide" (Osterman 44). Other ways to improve home care aides' job satisfaction are carefully selecting applicants, introducing peer mentoring programs for new home care aides, and providing coaching for their supervisors (Osterman 49).

Another obstacle to enlarging the role of home care aides and nursing assistants is the issue of unstable immigration. Because such a great proportion of home care aides and nursing assistants are immigrants (forty-five percent), it is clear that the United States depends on foreign labor to fuel its long-term care system (Osterman 5). The necessity of recruiting foreign eldercare workers is hindered by the lack of a solid migration channel for immigrants who seek to work in long-term care (Hess and Henrici). But, the absence of a migration channel is not the only issue. Should a migration channel be established, it is vital that a clear path to citizenship for its entrants be available so that the United States may maintain its long-term care workforce and thus provide stability to the entire eldercare system.

Better Integrating Care into Daily Life for Elders

For those elders who live independently, accessing care can be difficult as they are often unable to transport themselves to and from a doctor's office. Further, going to a doctor's office specifically is inefficient when considering an alternative: one stop shopping at pharmacies or supermarkets with geriatric clinics. Ideally, pharmacies would either hire geriatricians or train pharmacists in geriatric care so that seniors may visit a licensed practitioner while picking up groceries and other needed items such as toiletries. Of course, demonstration programs are the next step in determining if such a care model could provide effective care to elders.

Another program that could be expanded is Meals on Wheels, a charity that has been successful across America in bringing two meals a day to elders in poverty. In fact, Meals on Wheels has already piloted a program, More Than a Meal, in which researchers at Brown University have compared "healthcare utilization and costs for [14,000] Meals on Wheels clients

prior to and following receipt of Meals on Wheels services over a 30-, 90- and 180-day period" (Netterville et al.). They found that "Meals on Wheels recipients' healthcare utilization and costs declined post-enrollment periods compared to the equivalent amount of time before enrollment" (Netterville et al.). Indeed, more expansive studies are necessary to fully evaluate the effect of Meals on Wheels services on elders' overall health, but expanding Meals on Wheels could be a viable option for strengthening our eldercare system.

A further step to integrating care into the daily lives of elders is facilitating the development of greater assistive technology. Osterman ponders whether robots "...will actually reduce the need for caregivers and hence ease prospective [labor] shortages" (Osterman 122). He arrives at three conclusions: "[f]irst, it is certainly true that over time and in the near future technology will make staying at home easier. Second, technology may transform home care in some distant future, but this will not happen anytime soon….And third, smaller innovations, such as the use of iPads to record health status or refrigerators that signal when new supplies are needed, will certainly improve care, but they will not change the fundamental nature of care and the need for engaged health care teams and aides. Nor will simple robots that help with chores such as cleaning. This conclusion is supported by a recent careful review of the literature on new technologies and home-based care" (Osterman 122). Eventually, though, technologies such as artificial intelligence and autonomous vehicles will match and eventually surpass human ability (Kurzweil). So then the question becomes, if a robot can take better care of your mother then you can, why stand in its way? Keep in mind that utilizing robotic assistance in eldercare theoretically can remove some of the more strenuous aspects of care (such as bathing and toileting an elder) from human responsibility and replace them with time for higher personal connections with parents, such as looking through photo albums or cooking together.

Where to Live?

There is no such thing as one-size-fits-all care, as every elder needs different levels of care. Indeed, in a study that asks "(a) What are the relationships between types of living arrangements and psychological well-being for older adults? and (b) How do these relationships differ by gender?," Henning-Smith determines that "...there are significant differences in psychological well-being for older adults, depending on type of living arrangement, and that those relationships differ by gender. The current focus of much of the policy agenda around housing an aging population is on "aging-in-place," or keeping older adults in their own homes as they age. While this is a laudable goal, given that the majority of older adults would prefer to remain in their homes (AARP Public Policy Institute, 2010), it is clear that the effects of living arrangements are not uniform across the entire older adult population" (Henning-Smith).

Moreover, the study finds that there is an increasing trend of older adults living with their family members and that "these individuals may be at particular risk for depression and poor quality of life. In each measure in these analyses, this group fared worse than both older adults

living with a spouse/partner only and as poorly as those living alone….These findings held true for quality of life, even when controlling for health status, which may contribute to older adults living with younger generations. Much attention has been paid in research and policy to the plight of younger caregivers, but more attention may be warranted toward the well-being of the older adults being cared for" (Henning-Smith). Along this same vein, should the most reasonable and desirable option for an elder be to age-in-place, Johnson and Appold found that "major efforts are required to modify existing and design new single-and multifamily housing units, all public and private sector buildings, and the community level infrastructure of streets, pedestrian walkways and crossing signals, signage and lighting, as well as outdoor parks, recreation, and entertainment facilities to accommodate an aging population (Lawler, 2015; Feather, 2015; Hodin, 2015; Irving 2016)" (Johnson and Appold).

Another study "investigates the risk of older adults' disability progression by type of living arrangement (e.g., household composition, housing type) and whether the relationship varies by socioeconomic status" (Henning-Smith et al.). The study found that disability was highest among those elders living alone or with other non-family members (Henning-Smith et al.) However, the authors found that disability risk was (not surprisingly) associated more with socioeconomic status. The poorer an older adult, the more likely they are to have a disability (Henning-Smith et al.) Interestingly, an inverse relationship was discovered. Among wealthier older adults, living alone was associated with decreased disability risk, while for poorer elders, living alone was correlated with increased disability risk (Henning-Smith et al.). This inverse relationship demonstrates that the need for equitable universal long-term care is paramount, as wealth (and thus ability to afford long-term care services) is a significant factor in disability risk for elders.

Beyond this research, nationwide demonstrations should be conducted to identify the strengths and weaknesses of nursing homes, assisted living facilities, and aging in place arrangements, much like the British "vanguard" programs. Ideally, there would be a national service provided through universal eldercare that would evaluate elders' needs to help them find the best living arrangements. As such, I recommend that all levels of care available currently should be sustained to provide the most client-centered care possible.

Concluding Remarks

Our eldercare system desperately needs reform. Pressure for such reform comes from all sides: increasing demand for long-term care based on an expanding aging population, deportation threats to long-term care employees who are immigrants, reduced family sizes leading to decreased availability of family caregivers in the future, and the exceptionally high cost of caring for our older adults. However, it is exactly these difficulties that will help us achieve a higher-quality, cheaper, long-term care system. We already have many of the pieces to make a great system. All we need do is to take advantage of what is already in place. For example, expanding the role of home care aides and nursing assistants will help elders continue to live as active and independently as possible, while ensuring greater job satisfaction (and consequently less employee turnover) for their caregivers. And, since the government, when taking into account spending at both the federal and state levels, is already paying for seventy-two percent of long-term care, the step towards publicly financing such care is within reach. Especially if the retirement age is raised as people live longer and fuller lives. Supporting charities such as Meals on Wheels whose participants have experienced not only fuller stomachs but healthier lives, is crucial. But by far, the most important step the United States can take towards providing better care for its elders is to actively engage in nationwide and local research on how to do just that.

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