

Review of Disabled Elderly in China and Tanzania: The Experience and the Challenges

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Abstract

In everywhere there is a sharp increase in population ageing, where the need for amending or creating laws and management that could cover the needs of the disabled elderly in the population. Though, there is no single converging paradigm and countries are experimenting with a number of different approaches. Providing and financing long-term care of the elderly among the most pressing policy issues facing the aging population. A growing population at risk for chronic disability the the very old promises to generate unprecedented right in the demand for long-term care. China demographic change, fueled by declining levels of fertility, which means that China has one of the fastest growing elderly populations in the world. The health of this population segment will have obvious implications for future formal and informal care costs, an issue that is of great concern to Chinese policy makers (Riley, 2004). Tanzania a least developed country located in east Africa is experiencing a rapid aging of elderly where the elderly are living longer. Scholars have suggested that the rapid aging in countries like Tanzania, occurring under premature levels of infrastructure and economic development, may represent extreme challenges for health and social systems to meet the demand for care of aging populations (Frenk, Bobadilla, Stern, Frejka, & Lozano, 1991; Cutler, 2001). A number of studies have illustrated about urban/rural health inequalities among older adults in specific country's, though, there is no study that have tried to relate or discuss about two developing country and present the experience and challenges such as in this article aim to illustrate about China and Tanzania. The effort of these two countries is important because there is much to be learned by these two countries in defining the range of policy option and in identifying successful and unsuccessful practices. The review of Tanzania is based on the data in the of HBS 2007 and the review of China is based on National Bureau of Statistics. The advantages and shortcomings of the two systems were analyzed with recommendations for future developments. Such comparisons across nations can inform social policy debates in China and Tanzania as to how to prepare for population aging. The originality of such comparison can shed light on issues for LTC service development in other countries especially the emerging economy ones.

Keywords: Elderly Disability, Developing countries, Long term-care and China and Tanzania

Introduction

The number of older persons (those age 65 or older) in less developed countries is predictable to increase from 249 million to 690 million between 2000 and 2030 (Kevin Kinsella and Victoria A, 2001). And because the elderly are at great risk for disease and disability, this population aging will place urgent pressures on developing-country health care systems, most of which are ill-prepared for such requests.

In china elderly population are being classified from the age of 60 years as there represent the 33% of the total population which is 103 million people in China (Flaherty et al., 2007). By 2050, the older population in China is projected to triple to 331 million (United Nations, 2011), which will equal one-third of the population. China is already the home of 17.2% of all people aged 80 and above in the world (Kinsella & He, 2009). This 'old-old' population was recently estimated to be near 19 million (Lan, 2010) and could exceed 100 million by 2050 (Jackson, Nakashima, & Howe, 2009). Another major complication that China is facing an outburst of the ageing population as china's economic development is still at its early stages compared to developed countries like US, UK and Japan. As Jackson et al. state, 'China may be the first major country to grow old before it grows rich' (2009). Neither financing nor administration is yet sufficient to meet the

However, Tanzania is a relatively young country; in 2007 the median age was 19 years and only 10% of the population was 50 years of age or more (Tanzania Household Budget Survey HBS, 2007). However an inevitable application of longer life span and declining birth rates is an increase number and proportion of Tanzanian in their senior years. The UN projects that between 2020 to 2050, the absolute Tanzanian over 60 will almost triple, increase from 2.95 million to 8.39 million. Under the UN medium fertility projection, the percentage of the population aged 60 and over will increase from 5.0% in 2020 to 7.7% in 2050. Compared to other countries, however, Tanzania will be late arrival to the problems of aging population.

OECD nations are already far along this demographic path and many other developing nations such as china can expect more dramatic increase in their elderly population over the next few decades (United Nation Secretariat: World Population Prospects, 2008). Only a handful of studies have tried to decompose the disability burden into diseases among elderly populations. [Jagger C, Matthews R, Matthews F, et al., 2007] And, almost all the studies concern developed countries, e.g. Australia, (Mathers CD, 1999) Netherlands, (Klijs B, Nusselder

WJ, Looman CW, et al, 2001) UK,[Jagger C, Goyder E, Clarke M, et al,2003; Jagger C, Matthews R, Matthews F, et al,2007; Peres K, Jagger C, Matthews FE, et al, 2008] and USA(Reynolds SL, Haley WE, Kozlenko N, 2008).The burden of physical disability in old age for developing countries is likely to be higher than for countries that aged at a more advanced stage of development. More specifically, these countries should institute prevention planning and programming to delay the onset of chronic diseases, enhance care for the chronic diseases that plague elderly populations, and improve the functioning and daily life for the expanding elderly population.

Elderly Disability

Defines disability as “the negative aspects of the interaction between an individual with a health condition and that individual’s contextual factors personal and environmental factors” (World Health Organization, 2001). Interactions are specified as including impairments (affecting the body), activity limitations (affecting actions or behaviour), and participation restrictions (affecting experience of life).

According to the Global Burden of Disease(Murray CJ and Lopez AD, 1996) estimates for 2004, 68% of the 751 million years lived with disability (YLD) worldwide are attributable to chronic non-communicable diseases, and 84% of this burden of chronic-disease disability arises in countries with low and middle incomes. Although the prevalence and incidence of most chronic diseases are strongly age dependent, only 23% of the disability burden caused by chronic disease in countries with low and middle incomes occurs in people aged 60 years and older, compared with 36% for high income countries, where demographic ageing is much more advanced. However, chronic-disease disability in elderly people in countries with low and middle incomes is set to increase sharply. Between 2010 and 2050, the number of people aged 60 years and older will increase by 56% in most developed regions (from 269 million to 416 million, or from 21·8% to 32·6% of the total population), but by 224% in least developed regions (from 490 million to 1·59 billion, or from 8·6% to 20·2% of the total population). The accompanying epidemiological transition will greatly increase the burden of chronic non-communicable diseases, especially in the most rapidly developing regions (Strong K. et al, 2005)

Little is known about elderly disability in Tanzania because of the limited availability of survey data specialized on aging. But in china several studies have Explained the urban-rural and disability among the elderly such as the Longitudinal studies of disability indicates that there has been a decline in disability prevalence among older adults from the 1980’s to the early 2000’s (Crimmins, Hayward, Hagedorn, Saito, & Brouard, 2009; Cutler, 2001). Methodological advances have been possible also in the measurement and study of disability thanks to the availability of long-term longitudinal.

Scholars of Chinese elderly disabilities find that the decline may be attributable to both delays in onset of disability an increased likelihood of recovery from disability. This was so despite a counter-acting decrease in mortality among the disabled that contributed to slight increase in overall disability prevalence. In general, levels of disability tend to decline with higher socioeconomic levels or status (SES) and older women tend to experience functional limitations more than older men and over longer periods of time (Freedman et al., 2004). Through different studies about china old age disability, consistent predictors of disability or functional impairment are depression, comorbidity, few social contacts, physical impairments, diabetes, stroke, heart disease and smoking (World Health Organization, 2001).

Differences of rural-urban elderly disability

In china cities the emerging “4:2:1” family structure is emblematic of the problem: two adults have to take care of four parents and raise one child (Flaherty JH, et al. 2007). Either way, most older people prefer to live in their own home for as long as possible, making the issue even more pressing. However, their cultural tradition to value and highly regard of filial piety (Johar M and Maruyama S, 2011) . In rural China, financial support for the elderly remains the responsibility of adult children, and is even codified into laws governing the family (Giles J, et al, 2010). Yet, modernization, demographic shifts, and the massive outmigration of young people to cities for work are eroding this tradition, raising concerns that the supportive functions of families have been weakened (Zhang H 2007) and (Ku LJE, et al, 2013). While the resources and infrastructures for aged care are extremely limited; public support systems, such as pensions and health insurance, are underdeveloped or absent (Feng Z, Liu C, Guan X, Mor V 2012); and community-based or institutional-care services remain largely nonexistent, except in a few major urban centers like Shanghai (Wu B, Carter MW, Goins RT, Cheng C, 2005). Most of the care within an older person’s home is informal care provided by family members, although this informal care may be supplemented by formal services provided at home by paid caregivers (Feng Z. et al 2012). Because LTC is a new concept in China, insufficient data exist on the spending and use of the services and on the extent and nature of unpaid informal care that people are receiving; nor has the cost to families in economic, social, and material terms been assessed.

However in Tanzania population aging is only beginning and, because fertility is falling, it is occurring during a temporary phase of declining dependency burdens. The main source of support has been the household

and family, supplemented in many cases by other informal mechanisms, such as kinship networks and mutual aid societies. With the notable exceptions of Botswana, Mauritius, Namibia, and South Africa, formal pensions whether contributory or not or other social welfare schemes are virtually nonexistent and, when they do exist, tend to pay minimal benefits and cover only a small fraction of the elderly population (Gillian, Turner, Bailey, and Latulippe, 2000). Older people make up a relatively small fraction of the total population, which is expected to increase slowly, although their numbers are increasing rapidly. There are also major differences in the principal health challenges in Tanzania compared with China.

Demographic transition impacts of China and Tanzania

China's working-age population shrank for the first time in 2012 by 3.45 million. Looking into the future, the number of 15 to 24 years old will shrink the most, by 38 million or 21% in the next ten years. China now has 14% of its population aged 60 and above and the number would be 30% in 2050. One-child policy had been widely criticized as the reason for this rapid aging. '4-2-1' describes this family structure, representing four grandparents and two parents to be supported by one child. Intended purposes of the OCP were to control population growth and foster economic development. Unintended consequences are now starting to take effect as the first parents to be affected by the OCP are entering their sixties. Already, increasing numbers of older adults are living in empty nests (Wei, 2010). Total fertility rates have been below the replacement rate of 2.1 for 20 years (Sikken, Davis, Hayashi, & Olkkonen, 2008). Between 2007 and 2040, the average number of surviving children of older adults is projected to decline by 1.6 (Jackson et al., 2010), the fourth-greatest decline noted in a report on 20 nations. The realisation that there were six children for every Chinese elder in 1975, and that by 2035 there will be two elders for every Chinese child (Jackson et al., 2009) demonstrates the enormity of the impending challenge. China is selectively loosening up the rules regarding the OCP, particularly in rural areas, partly in response to the ageing population (Associated Press, 2011). Another result of the OCP now affecting the LTC picture is the large gender imbalance (Jackson et al., 2009).

Exponential population growth indicates that Tanzania is at the second stage of demographic transition, characterized by births exceeding deaths. The major source of population increase in Tanzania is the declining mortality rates and high birth rates as shown in the Figure below. Tanzania is at the second stage of demographic transition where birth rates are still high and death rates have begun to fall markedly. Typically it is still in phase of stylized demographic transition (Eastwood and Lipton, 2011). This outlook suggests that reaching the third stage of demographic transition, so as to keep the population at more or less stable level, will be a rather slow and difficult one. Population growth, during the initial stages of development, is recognized as a valuable intrinsic biological process that generates human resource. Given the state of technological development, during this stage, human resource yincrease was seen as a positive factor that stimulates economic growth.

Tanzania Population Age Distribution

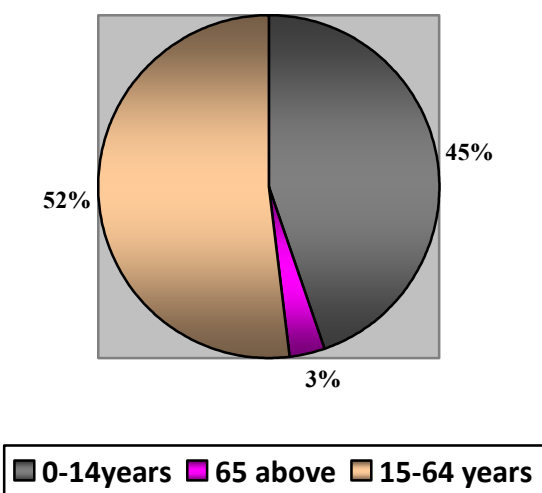


Figure 6: Source World Population Perspective 2012

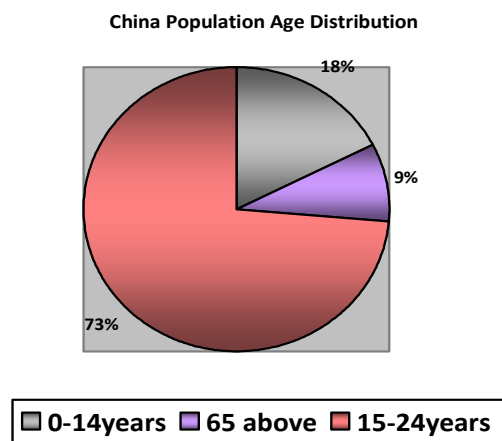


Figure 2: Source: National Bureau of Statistic China 2011

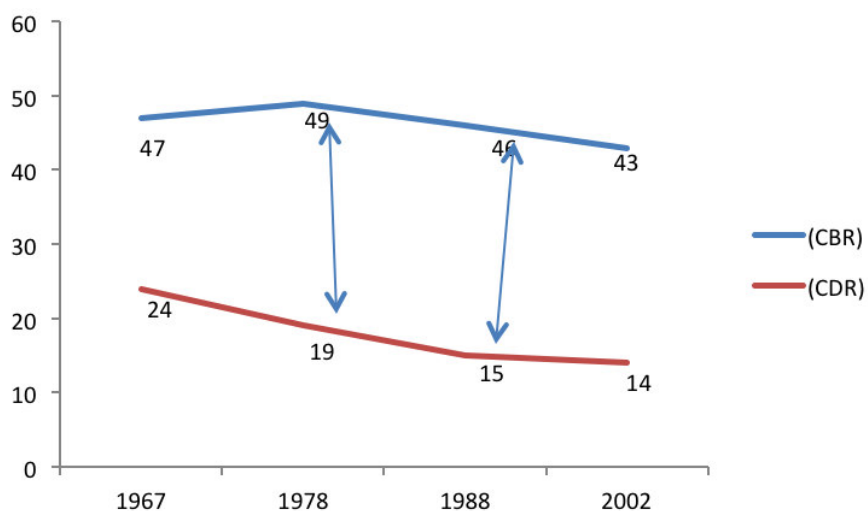


Figure1: Source CIA World Fact book trends in birth and death rates Tanzania

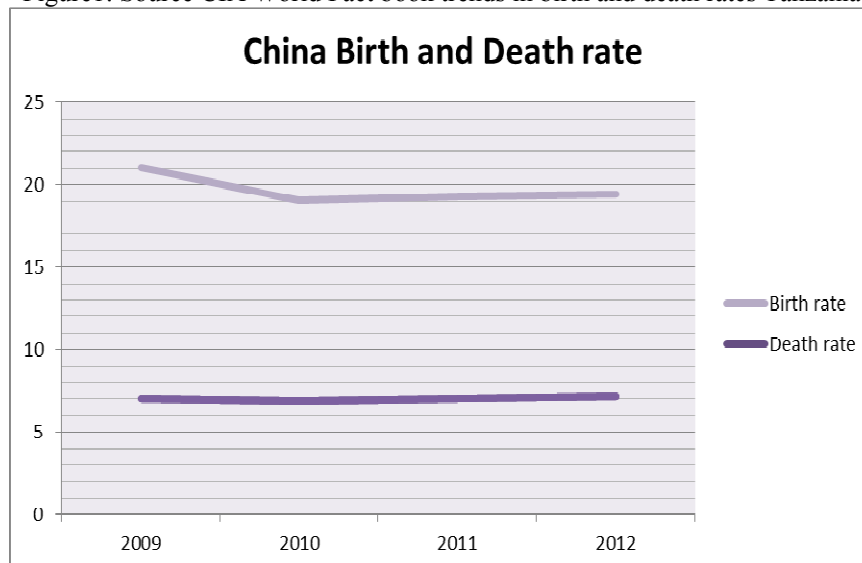


Figure 3. Source: National Bureau of Statistics (2006).

Rural urban Elderly Care Gap

Although retirement pensions have been expanded to cover older adults in the nongovernment sector, less than

30% of those age 60 and above have public pensions (Jackson et al., 2009), ranging from 40% in urban areas to less than 5% in rural areas (Sikken et al., 2008). Reforms are beginning to address this gap; in 2009, a new rural pension pilot program in 10 counties was announced (Wang, 2010). The government has also announced an intention that all citizens should be covered by social security for the aged by 2020, beginning first in the urban areas (Sikken et al., 2008).

The Chinese health insurance system also lags behind, but steps are being taken. In 2003, only 55% of urban residents and 21% of rural residents had any type of health insurance. According to a recent government announcement, eight million more Chinese were to be covered by the country's urban basic health insurance in 2011, raising the total to 440 million, equaling 90% of urban residents (China Daily, 2011). The Chinese plan includes this basic health insurance for urban residents and the New Collective Medical Insurance developed in 2002 for rural residents (Wu, Mao, & Xu, 2008).

Urban-rural disparity accounts for one of the most prominent social inequalities in China (Sun & Wang, 2012). The latest data show the population is about evenly split, with 49.7% now living in urban regions (Associated Press, 2011). Health care is typically more accessible and of better quality in urban rather than rural regions (Zimmer,

Kaneda, & Spess, 2007). The collectively funded welfare program (hezuo yiliao) were abandoned in most rural areas in the early 1980s, and health care became predominantly employment-based; as a result, the percentage of rural residents with health coverage was 7.4%, in comparison to 36.4% for the urban elders. This coverage gap still existed by 2003, although coverage increased to 12.6% and 49.6% for rural and urban elders, respectively (Peng et al., 2010).

China Rural Urban Population Demographic

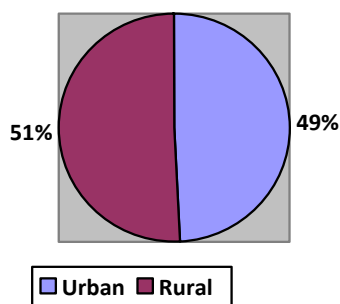


Figure 5: source CIA Fact book 2010

Chinese elders have a different perception of formal LTC in comparison to their Western peers. Chinese elders tend to narrowly interpret formal LTC as institutional nursing care (Zhang, 2006), which traditionally is not favored by most Chinese since it is not aligned with filial piety (Fan, 2007). At 2% (Population Reference Bureau, 2010), the rates of institutional LTC in China are lower than the rates in Western nations (Kinsella & He, 2009). While the development of nursing homes in China is still nascent, it is expanding quickly, mostly driven by nongovernment sources.

Wang (2010) estimates that only 4% of the LTC need is met by institutions, leaving the bulk to be provided in the community. Some older urban residents are served by street offices with sub-divisions known as neighborhood committees, which coordinate and develop community-based services for older adults (Wu, Carter, Goins, & Cheng, 2005; Zhang & Goza, 2006). Since 1990, the government has started to promote community services as alternative welfare sources for urban elders. Originally intended to enrich the social life rather than provide LTC (Zhang, 2007), expanding the neighborhood committee service program into LTC services can be a practical and relatively low-cost approach to meet urban elders' needs. While the idea is being replicated in other areas, there are currently no national standards for these programs (Zhang & Goza, 2006).

Table 1: Shows disabled elderly that get support from institutional care classify it into rural and urban, female and male China

Service use (%)	Rural		Urban	
	Male	Female	Male	Female
Formal care (institutional nursing care)	5.5	6.1	31.7	40.9
Informal care (Community-based)	80.8	92.4	90.2	85.9

Source: doi: 10.1371/journal.pone.0079955.t002

In spite of rapid urbanization in Tanzania, nearly two thirds of the population reside in rural areas and depend on agriculture or agro-based activities for livelihood. Among those involved directly in agricultural production approximately 10 to 15 per cent are found to be large-scale farmers, 45 to 55 per cent are peasants

and 15 to 20 per cent landless labor. Peasants, small-scale farmers and the landless labor lead a mere subsistence level of living.

Population concentration has contributed to undesirable environmental impacts within and in the vicinity of the cities. One of the adverse environmental impacts of urbanization is the continuous disturbance of ecological balance through lateral expansion. Despite the remarkable industrial and service sector developments in many cities of Tanzania, the numbers of urban poor continue to increase as a result of the intense build-up of population coupled with a steady decline in per capita resource and productivity. This in turn has severely constrained income and employment growth, and access to services. The percentage of those living below poverty in urban areas is equally phenomenal as in the rural areas.

Although urban residents already had more financial resources than their rural peers, the income gap is getting wider. The income ratio between urban and rural residents was 2.79:1 in 2000 and 3.33:1 in 2007. Many rural elders live on less than one dollar a day (Sikken et al., 2008). Even within urban areas, however, stark income inequalities exist between the officially registered urban residents and the rural migrant ‘floating population’ (Jackson et al., 2012). In addition, more than 32% of those age 50 and above, or more than 8 million, are estimated to have some disability, including vision and hearing (Qiu & Liang, 2011), with the majority, 75%, in rural areas. The gap in disability prevalence between rural and urban areas increased from 1987 to 2006, particularly in the early retirement years, between 60 and 75. The overall prevalence of disability is consistently higher in rural areas than in urban areas (Giacalone, 2010). The data show that in 2007 about three-fifth of disabled elderly Tanzanians lived traditional extended family settings. One-fifth was responsible for children or adults while one-fifth lived in an informal institution. The HBS also found that one-third of the disabled elderly in rural areas were living below the basic need of poverty line.

Tanzania Rural Urban Population Demographic

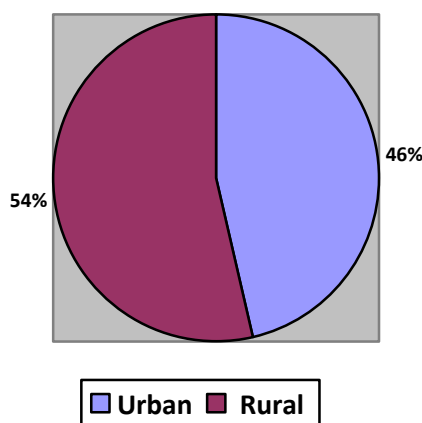


Figure 6: Source NBS 2014

Table 2: Shows disabled elderly that get support from institutional care classify it into rural and urban, female and male Tanzania

Service use (%)	Rural		Urban	
	Male	Female	Male	Female
Formal care	**	**	1.4	1.6
Informal care	1.2	1.4	2.1	1.8

Source: NBS 2012 Census,
 **insufficient number of observation

Conclusion

In this research it was hard on having basic agreed definitions of the following terms such as elderly people because of the different standard of the two countries in the paper. In china elderly person is being classified from the age of 65 years and above but in Tanzania the same elderly person is from the age of 55 years and above this is due to the life expectancy, extended family structure. There so the definition used to define the term elderly person in china is the same used in the industrialized countries and the same term is differently defined in Tanzania which in this context represents the least developed countries.

Nevertheless, the hardship and lack of empirical research and the dearth of comprehensive data needed to rectify the two countries experiences and challenges as they are both still very young in the phenomena of LTC of disable elderly. Persistent lament throughout the working of the paper is the lack of careful empirical

research and the dearth of comprehensive data needed to rectify this situation in the case of Tanzania.

Interestingly, one study about china indicated that concerns about filial piety were stronger among the adult children of parents who had moved into a LTC institution than among the older adults; the children were worried about how others would judge them (Zhan, Feng, Chen, & Feng, 2011). Still, there is some evidence that expectations about filial piety are decreasing (Jackson et al., 2012), with 36% of current workers agreeing that parents and children would be happier if parents were more independent. The Chinese government can no longer assume that families will be able to handle all LTC needs for their elders. Although that assumption is still reflected in the most recent five-year plan, the government is aware that other more sustainable avenues must be developed and pursued. More people will be turning to formal LTC on a larger scale for the first time in Chinese history. Therefore, there is a growing need for formal LTC, but meeting this need is fraught with challenges, including the level of economic development and the resultant lack of financial and insurance support for Chinese elders, the shortage of LTC facilities and community-based program, the lack of staff and the lack of training, and the need for regulation and a quality-monitoring system.

Recommendation

Build sufficient financial supports

Chinese and Tanzanian policy-makers should be encouraged to continue expansion of pension and health insurance programs and to reform current LTC financing into a multi-pillar security system, consisting of government-sponsored insurance, employer-sponsored pensions, private savings and private insurance, in addition to family support. Only a minority of elders are eligible for government retirement pensions. It is also unrealistic to expect a large percentage of these two developing country elders to remain financially self-sufficient since few have adequate private savings.

Respect and support filial piety

Developing the formal LTC network should also take cultural influences into consideration. Institutional care may not be the optimal choice because it is not favored by either country's elders and their adult children. Therefore, efficient LTC delivery and administration should integrate the filial piety value of serving these elders. However, there is a small study that suggests that it is the children who feel worse about institutionalizing the parent, rather than the parent (Zhan et al., 2011). Therefore perhaps the children need attention and support as well in order to make this cultural shift. Furthermore, with no government payment for institutions, the financial responsibility falls on the family or community.

Implement regulation and quality monitoring of LTC services

Both formal care facilities and informal care-based program require strong political support and regulatory guidelines to ensure service quality and safety, especially for frail elders and those without family members. There is a need for development and implementation of quality standards and systems for both formal and informal-based care. Taking care of older adults as they age and become more frail is not an easy task. China is greying rapidly with a massive number of elders in need of LTC services, while Tanzania elderly population is expected to triple in the coming decades, with little financial or insurance support to pay for them. Most of these elders still rely on their close family members for care. This family-oriented care will continue to be a vital part of meeting the demands but is unlikely to be sufficient to meet the growing needs in the future because of the shrinking pool of caregivers and the high cost of such care.

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