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Review

Cultural Comparisons of Aging Policies and Care for Older Adults in Japan and the United States: A Review

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ABSTRACT

This review article critically examines the health status, healthcare policies, and specialized medical care for older adults in Japan and the United States, with a focus on the cultural underpinnings that shape these differences. The article synthesizes existing literature to provide insights into the challenges and potential solutions for providing care to aging populations in both countries.

Keywords
Aging policies; Care for older adults; Cultural comparisons; Japan; United States; Healthcare systems; Social support; Long-term care.

INTRODUCTION

The phenomenon of global population aging presents a significant and far-reaching challenge across the world. Within this global context, two highly developed nations, the United States (US) and Japan, serve as notable case studies. Japan, often considered the archetype of a super-aged society, has seen the proportion of individuals aged 65-years or older rise to a remarkable 28.9% of the total population. Projections indicate a continued trend, with an estimated 1 in 2.6 individuals being 65-years of age or older by the year 2060.[1] Similarly, the US, while currently having a comparatively lower percentage of older adults at 16.8%, is predicted to experience a substantial increase to 21% by 2030. By the year 2060, it is projected that approximately 1 in 4 Americans will have reached the age of 65.[2] This demographic reality underscores an urgent and escalating demand for comprehensive care and support for the aging population, necessitating a profound examination of aging policies and healthcare systems in both nations. This review is presented as a cultural perspective for healthcare professionals caring for older adults and for policymakers as models of care are refined to address an aging population.

AGING IN THE US AND JAPAN

The aging of populations in the US and Japan introduces unique challenges and opportunities for these two nations. Their responses to the implications of an increasingly elderly demographic play a crucial role in shaping the well-being and quality of life of their older citizens.

In Japan, the concept of a super-aged society has become a focal point in policy discussions and academic research. The substantial proportion of elderly individuals in Japan's population has prompted innovative approaches to elder care, retirement policies, and intergenerational dynamics. These developments reflect not only the achievements of Japan's economic and healthcare systems but also underscore the need to address potential issues such as elder abuse, social isolation, and healthcare sustainability.

In parallel, the US faces a demographic shift towards an older population that necessitates a reevaluation of healthcare systems and support structures for the elderly. As the baby boomer generation enters retirement and requires more comprehensive

medical attention, there is a growing urgency to enhance geriatric care, expand access to long-term services, and reshape societal attitudes toward aging. The interplay between public programs like Medicare, private insurance options, and the role of family caregivers forms a complex landscape that demands careful navigation.

By scrutinizing the aging trajectories and responses of both Japan and the US, we can glean insights into the diverse challenges posed by population aging and the strategies employed to address them. This exploration encompasses healthcare policies, cultural attitudes, societal expectations, and the evolving roles of older individuals in these dynamic societies. As these nations endeavor to create supportive environments for their aging citizens, the lessons derived from each other's experiences contribute to more effective and compassionate models of care and aging policies.

HEALTH STATUS OF OLDER ADULTS IN THE US AND JAPAN

An insightful comparison of the health status of older adults in Japan and the US reveals striking disparities. Evidently, older adults in Japan enjoy a more favorable health profile in contrast to their American counterparts. This distinction is evident through a constellation of indicators, including longevity and chronic disease prevalence.

Life expectancy, a cardinal metric of health status, underscores the disparities vividly. At the age of 65, both men and women in Japan exhibit substantially higher life expectancies than their counterparts in the US. Specifically, Japanese individuals aged 65 can anticipate an additional 20.1-years of life for men and an impressive 24.9-years for women. Conversely, their American counterparts face a less extended life span, with an expectancy of 17-years for men and 19.8-years for women.[3] These disparities have profound implications for the design and provision of healthcare services.

Furthermore, the disability adjusted daily life (DALY) score provides a nuanced insight into the quality of life for older adults. Astonishingly, older Japanese adults demonstrate substantially lower DALY scores, measuring 15,886 compared to the US score of 26,061.[4] This stark difference signifies not only superior longevity in Japan but also a reduced burden of disability-adjusted ailments, affirming the overall better health trajectory of aging individuals in Japan.

A poignant observation emerges when scrutinizing the leading causes of death. In Japan, death by natural causes, meaning non-illness-related mortality, claims the rank of the third highest cause of death. This contrasts with the US, where such deaths do not rise to the top of the mortality rankings. This distinctive pattern suggests that a greater proportion of older adults in Japan pass away without enduring the afflictions of chronic illness at the end of their lives, in sharp contrast to their American counterparts.

In sum, the health status disparities between older adults in Japan and the US are vividly apparent. The extended life expectancy, diminished disability burden, and divergent patterns of mortality underscore the profound influence of healthcare policies, cultural factors, and societal norms in shaping the well-being of aging populations.

CULTURAL DIFFERENCES BETWEEN JAPAN AND THE US

Japan is characterized by its ethnic homogeneity, with approximately 98% of its population being of Japanese descent. This demographic uniformity contributes to the prevailing cultural collectivism within the nation. In Japan, societal emphasis is placed on maintaining harmony over discord, prioritizing collective social objectives over individual pursuits, and fostering an environment of cooperation rather than competition. These cultural inclinations profoundly influence daily behaviors, as individuals tend to adhere to social norms, exhibit heightened self-awareness regarding societal perceptions, and often display reticence in expressing personal viewpoints directly. This collectivistic ethos in Japan engenders both positive and negative outcomes. The positive aspects include a notable low crime rate and a culture of compliance with public policies. However, there are also negative aspects, such as the potential for social pressures to conform to the majority, which can stifle individual uniqueness and impede innovative thinking.[5,6] In stark contrast to the collectivism seen in Japan, American society stands as a testament to ethnic diversity and individualism. According to the Hofstede Insights country comparison tool, the US scores 91 on the individualism index, significantly higher than Japan's score of 46.[7] Individualistic societies, like the US, prioritize attributes such as personal independence, autonomy, and the pursuit of individual freedoms and achievements.[8] This cultural orientation towards self-expression and originality allows individuals from diverse backgrounds to manifest behaviors guided by their personal beliefs. Moreover, an individualistic society often demonstrates enhanced economic performance due to the allocation of resources towards innovation.[8] However, this emphasis on individualism comes with its own set of challenges. Citizens in such societies may exhibit a reduced propensity to adhere to government directives, potentially complicating the enforcement of public policies.[9]

DEVELOPMENT OF GERIATRIC CARE IN JAPAN AND THE US

Health Insurance and Public Financing

The differences in the health status of older adults in Japan and the US may further reflect the variations in the health systems of each country. While the US spends a much larger proportion of its gross domestic product (GDP) on health care than Japan (Japan: 10.6% GDP *vs.* the US: 18.6% GDP),[10] the US focuses on curative and procedure-based care and is based on a culture of personal responsibility and choice, placing an excessive burden on family caregivers[11] with a risk of providing excessive or low-value care, producing iatrogenic problems.[12] On the other hand, Japan shows greater respect for aging and invests in social support and community-based care, with society bearing these costs. However, both systems suffer from issues of long-term economic sustainability.

Care for older adults in Japan is based on a community-based long-term care insurance system (LTCI). Funding consists of income-based insurance premiums, with local and national sub-

sidies.[13] The LTCI system provides both community-based care and medical services. Municipalities act as insurers, and persons older than 65-years old can freely choose different care managers and service providers depending on their need for assistance with daily activities and living conditions, regardless of their income levels. As the population ages, the growth of the LTCI system is facing economic challenges relative to labor force contributions, and cost-control measures must be implemented.[14]

In the US, care for older adults is provided through Medicare, a federal health insurance program for those who are over 65-years old and younger patients with certain disabilities and end-stage renal disease. Medicare offers four parts: Parts A, B, C, and D. Part A includes inpatient hospital care, skilled home care, and rehabilitation services. Part B includes outpatient and provider medical services. Part D includes pharmaceutical services, and Part C covers dialysis and Medicare Advantage plans, which are optional managed care plans.[15] The hospital insurance (HI) trust fund funds Medicare Part A through payroll taxes. Enrollee contributions to the supplementary medical insurance (SMI) fund primarily fund Parts B, C, and D. Due to the aging of the US population, the number of Medicare beneficiaries is increasing relative to the working population. Without structural changes, the HI fund is expected to deplete by 2026 with the continued shrinkage of the SMI fund.[16]

One of the biggest differences between Medicare and the long-term care insurance system is the provision of long-term care services. In Japan, the LTCI system covers the majority of the costs for residential, personal care, and hospital services. Individuals with end-stage disease have access to hospice services under Medicare; however, Medicare does not cover non-skilled or residential services. Less than 15% of older Americans have private long-term care insurance,[17] and indigent older adults may have access to state Medicaid plans that provide some home and community-based care services, but the majority of Americans receive no assistance for home-based care and rely on family caregivers who are burdened due to a lack of sufficient social support. Approximately one in five Americans serves as a caregiver, which has a negative impact on their physical and financial health as a direct result of their caregiving burden.

Geriatric Care in Japan and the US

The lack of geriatricians is a problem in both Japan and the US. Several important milestones in the development of the field in both countries can be noted. The American Geriatrics Society (AGS) began in 1942 and helped to promote the field academically, although few physicians identified themselves as geriatricians. The first hospice agency was initiated in Connecticut in 1965, the same year Medicare began. The Veterans Administration recognized the need for care for older veterans and launched its centers of excellence in geriatrics, the Geriatric Research, Education, and Clinical Centers, in 1975. Hospice care was added to the Medicare benefit in 1982. Similarly, the Japanese Federation of Gerontological Societies (JFGS) was formed in 1959, although there remained few physicians identified as geriatricians through the 1980s. The country expanded its long-term care insurance program in 2000, and in 2012, the Cancer Control Act stimulated the provision of hospice care.

In Japan, despite generous LTC benefits, specialized geriatric medicine is not widely available. Geriatric physicians number 1460, representing only 4% of internal medicine physicians, with the number of physicians working in Geriatric Health Service Facilities (GHSF) stagnating.[18] In 2016, there were less than 200 physicians certified in Palliative care.[19] Few nurses are registered to specialize in geriatrics and home-based care, and likewise, the lack of education about polypharmacy and dosage adjustment is still a big issue among pharmacists. Furthermore, post-graduate geriatric education is neither required nor widely available, with only 22 of 80 academic training programs offering geriatric medicine residencies. Since 2016, however, Japan has begun efforts to encourage geriatric exposure in undergraduate medical education curricula.[20] Similar to Japan, the US suffers from a shortage of geriatricians despite the greater availability of educational opportunities. Presently, there are an estimated 7500 geriatricians, with a projected need for over 30,000 geriatricians by 2030.[21] Approximately one-half of the 384 geriatric fellowship positions are filled each year. Similarly, for Palliative Care, in 2016, there were 6351 certified palliative care physicians, with a projected need for as many as 24,000 by 2042, but no expectation of reaching this goal because of insufficient trainees.[22] Reasons for this lack of interest in geriatric and palliative care careers include relatively poor salaries compared to other specialties and an unfavorable disadvantage under fee-for-service Medicare, which favors proceduralists. The situation could change as value-based purchasing becomes more prevalent since geriatric care focuses on cost avoidance and patient-centered outcomes.[23]

AGEISM IN JAPAN AND THE US

Ageism is a pertinent issue both in Japan and the US. While Japan is perceived as a nation that values filial piety and a more respectful attitude toward the elderly, there has been a marked rise in ageism and stereotyping of older adults. Organizations in the US have recently launched a campaign designed to improve the public's understanding of what aging means and the many ways that older adults contribute to our society.[19]

CONCLUSION

The care of increasingly aged populations in both Japan and the US presents unique challenges for each country. Older adults in Japan can expect to live 10 to 20-years longer, and they enjoy enhanced long-term care benefits compared to their US counterparts. Older Americans have access to acute care, but the families of those with chronic illnesses suffer tremendous caregiving burdens. Both countries are experiencing economic instability in providing healthcare to older adults, with similar workforce development challenges. As the most super-aged societies and the countries with the highest healthcare expenditures in the world, Japan and the US, respectively, have the potential to demonstrate sustainable models of care to benefit all older adults and their caregivers. Creative solutions are needed and likely involve policy initiatives to stabilize the cost of care for an increasingly older population, pro-

vider education, and financial incentives to provide geriatric care, as well as social and cultural attitude changes with intergenerational cooperation and understanding regarding the care and value of older adults in society.

CONFLICTS OF INTEREST

The authors declare that they have no conflicts of interest.

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