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Changes in demographic patterns in the developed world mean more people are now living with disabilities. Similar changes can be predicted for the developing world. At the same time the process of development is breaking down the family and community support systems which traditionally provided care for the ill and disabled. In the developed world, immigrant women are an important source of dependent care -which, as this article points out, is not a sustainable arrangement. As life expectancy improves for more of the world's population, and more and more people seek caretaking services through market-based resources in a globally integrated economy, competition between the developed and developing world for caregivers is likely to increase.

DISABILITY AND DEPENDENCY - INDUSTRIAL COUNTRIES

Disability, unlike death or disease, is not a well-defined concept. The operational definition used in this paper relies on a person's is ability to perform such activities of daily living (ADL) as walking, eating, or grooming, or such instrumental activities of daily living (ADL) such as food preparation or shopping. Although assessment instruments exist for evaluating these activities, data are often unreliable or not comparable across countries.

Even with these problems of measurement, "there is clear evidence of a secular trend toward a greater prevalence of disability in industrial countries."[46] One British geriatrician calls this the "survival of the Unfittest". One of the major reasons is the lengthening of the life span due to improvements in medicine, sanitation, nutrition, and public health campaigns. At the same time, there has been no decrease in the incidence of disability among those who live to be very old. One third of those over age 85 experience dependency in at least one ADL. Improvements in lifesaving treatments for premature infants, and victims of serious injuries (especially young adult males) also mean an increase in the disabled and dependent population.

While there are social benefits to be enjoyed from the prolonged presence of elderly relatives and community members, there are also costs. One estimate of nursing home and home health care costs in the U.S. for 1986 was $41 billion, paid mostly by state governments and families. This figure does not include the cost of acute care or related services such as cleaning or assistance with personal hygiene. Neither does this figure include the expenditure (and opportunity cost) of time and effort by relatives and friends of disabled persons in caring for them. One study done found that the cost of informal services provided by families and friends to noninstitutionalized

older adults (valued at the cost of similar paid services) was greater than the the value of formal services received by them. The ratio of informal to formal services is greatest for those who are most impaired.

Projections into the mid-21st Century indicate that the proportion of the population that is elderly will rise sharply and the need for services will also rise. A large share of this caregiving will come from family members, especially children, but declining fertility rates, more geographic mobility and greater female participation in the labor force mean that the need for assistance form outside the family will also rise. "At the same time, nursing home aides, home health aides, and personal care attendants are in short and diminishing supply."[48] These workers face poor pay, benefits and working conditions, and in an expanding service economy, are often able to find better jobs.

As a result, the developed countries have come to rely more and more on immigrant women to provide caretaking services, in some cases actively recruiting health and human services personnel offshore. A different pattern, but one with a similar effect (exporting the problem of dependent care is the movement of older persons from developed to developing countries. In some cases this is a matter of older immigrants repatriating to thir country of origin. In others it is a matter of retired persons moving to less expensive or more attractive locations. When this occurs, the same population of developing country women is employed to give care. "There is no reason to believe that the women (mainly) of developing countries are any more loving, caring, or compassionate that their North American counterparts (though they may be). Rather, they participate in an implicit economic exchange: North Americans defer or delegate to them care of their disabled and dependent population in exchange for financial resources which they need."[49] North Americans are not the only case; there are Japanese retirement communities in Brazil, to cite one other example.

TRANSITION IN THE THIRD WORLD

The populations of developing countries are also aging. By the year 2000 it is projected that there will be as many octegenarians in less developed countries as in more developed countries; by 2025, there will be many more. Although comprehensive formal studies do not exist, it appears that families are the main source of care for the elderly and disabled in less developed nations. "[T]here are few formal paid services in developing countries and little coherent demand (as opposed to need) for such programs."[51] Publicly funded services are also scarce and often limited to special groups such as disabled veterans. Women are the main source of informal care in developing countries, the same women upon whom the developed world depends. "If this process - 'the compassionate care drain' -continues, developed countries needs will be met, but only at the cost of developing countries' most precious resources and at precisely the time of their own growing need."[52]

LESSONS

Developing countries do not need to travel the same path as the industrialized world. While natural growth in disability may not be avoidable, artificial disability and dependency can be reduced if retirement is not mandatory and vocational training is widely accessible. Public

policies and taxation can be directed toward preemptive measures to research disease prevention and effective delivery of care. Measures such as famine relief, inoculation and others which save lives may produce contradictory results if adequate resources are not available to insure the "vitality and viability" of those whose lives are saved.

Countries can support the informal networks which are likely to be the major source of caregiving for the elderly and disabled. Social science researchers can also devote attention to these networks, expanding on anecdotal evidence to develop a more systematic understanding of their role and needs. To the extent that trade in caregivers from less to more developed countries persists, there should be a reciprocal component that ensures that those who emigrate will return with skills appropriate for the growing dependency needs of their home countries.

Finally, a number of inequalities need to be addressed to bring about a more equitable distribution of caregiving services on a global basis: poor pay, benefits and prestige; the concentration of caregiving work (formal and informal) among women, especially poor and minority women. "We must be sufficiently bold and imaginative to both solve our own problems and prevent them from affecting people in other lands." [53]