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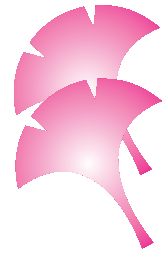
Aging and Social Policy

A German-Japanese Comparison



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Preface

Japan has been termed the "most compared country in the world" (Johann Arnason). Why should this be so? One can easily suspect that it has to do with that widely accepted image of the country as an exceptional counterpart to the West within the non-Western world. But why another German-Japanese comparison?

That the Japanese term *kaigo hoken* (care insurance) is a loan translation from the German *Pflegeversicherung* may not be common knowledge, all the more so since much of the relevant vocabulary, beginning with *keā herupā* (care helper), *keā manējā* (care manager) or *kaunserā* (counselor), is of Anglo-American origin. It nevertheless hints at parallels and interconnections between Japan and Germany. And this is the reason why a comparative perspective on German and Japanese social policy promises to be of particular informative value. Both countries are facing similar structural challenges: They are faced with the necessity of rebuilding their industry-based economic systems and have to cope with demographic changes which require a thorough reform of their social systems. Thus, it is similarities as well as characteristic contrasts which invite a comparative approach. It is hoped that this will not only lead to a more differentiated picture of social policy in Germany and Japan, including, perhaps, practical conclusions, but also deepen our general understanding of the mechanisms and the potentials as well as the pitfalls of social policy in two crucial areas: long-term care insurance and public pensions.

The German Institute for Japanese Studies (DIJ) is dedicated to research on German-Japanese relations as well as to studies in the fields of the humanities, the social sciences, and the economy of modern and contemporary Japan. Located in Tōkyō, it profits from close contacts with Japanese and international researchers and is actively and intimately involved in relevant international and intercontinental exchange. It is this particular position of an "on-the-spot" center for research on Japan which also enables it to seek an active scholarly dialogue between Japanologists and those engaged in the general disciplines and to identify topics of special concern in a globalized context.

Population aging and social policy were the subject of a DIJ symposium held in October 1997 in Bonn, organized by Ralph Lützeler and Christian Oberländer and co-sponsored by the Friedrich-Ebert Founda-

tion.[1] Meanwhile, in Germany the pension system was reformed in 2000 and 2001, and Japan saw the reform of its public pension system in 1999, the implementation of its long-term care insurance in 2000 and its occupational pension reform of 2001, important milestones in the system's development which called for adequate treatment in a volume dedicated to these issues. This book therefore comprises original contributions to the above-mentioned symposium as well as more recent essays that take these new developments into account. All of the earlier contributions, however, have been revised and updated for this publication. Its authors were recruited from among scholars as well as from practitioners. Some of them have actively participated in both countries' reform debates. Their views may have been adopted into the regulations. In other cases, they represent positions deviating from the reforms as they were eventually implemented.

This study will serve to revise the prevailing view to date of Japan's social security as a largely inadequate system. Much has been done to improve the situation of the elderly, and so at least in some important fields Japan now appears to be on par with Germany.

We appreciate the cooperation and patience of the symposium's participants, and we are also grateful to the authors of the new chapters for their willingness to contribute to this volume. Special thanks go to Harald Conrad and Ralph Lützeler whose editorial work now makes accessible a rich array of information and insights on a timely topic.

I wish this book the broad international attention it deserves among scholars as well as policy makers.

Tōkyō, October 2002 Irmela HIJIYA-KIRSCHNEREIT

[1] See the conference report in *DIJ Newsletter* 3 (February 1998), p. 2.

1. Introduction

German and Japanese Social Policy in Comparative Perspective: An Overview

Harald Conrad and Ralph Lützeler

1. Introduction

In recent years, Japan and Germany have been facing very similar challenges: aging populations, changing employment structures, and globalization. Both countries are in a number of respects more socially and politically regulated, and in this sense less liberal, than the Anglo-American economies. Social constraints and opportunities, enforced by social institutions, define the "legitimate place and the possible range of market transactions and markets in the economy-*cum*-society in which they take place" (Streeck and Yamamura 2001: 2). Both countries share several similarities in their financial and economic governance, production systems, and management-labor relations. A comparison of how these two countries, with their similarities in institutional settings, are reacting to similar social and economic challenges may thus provide valuable insights, not only for specialized social scientists and economists but also for policy-makers in general.

This volume concentrates on two fields of social policy where both countries have recently implemented far-reaching reforms: long-term care insurance and public pensions. These social insurances are at the center of current public debate in both countries because population aging translates immediately into a higher demand for elderly care and old age security. Since these schemes have so far received hardly any comparative attention, a closer micro-analysis of institutional arrangements and current changes seems overdue. As the editors of this volume, we hope that these essays may prove helpful to policy-makers in Germany and Japan, and that they may contribute to the literature on comparative social policy and possibly to the development of more general theories of social policy regimes.

Before introducing the papers, which make up the body of this volume (see section 3), the following section discusses several aspects of the German and Japanese welfare systems from a comparative perspective. In the first paragraph we review some important comparative literature on social policy and discuss structural features of the welfare systems in both countries. We then highlight some demographic and economic back-

ground factors of recent social policy reforms (second paragraph). In the third paragraph we analyze from a historical perspective the early influence of German social policy on Japanese policy-making. In the fourth paragraph we discuss the scope of both welfare systems in the light of social expenditure indicators, and in the final, fifth paragraph we make some remarks about the changing objectives and instruments of pension and long-term care insurance in both countries.

2. German and Japanese Welfare Systems in Comparative Perspective

2.1 Structural features of the welfare systems in Germany and Japan

A milestone in comparative social policy research was the publication of Esping-Andersen's *The Three Worlds of Welfare Capitalism* (1990), in which the industrialized societies were classified according to structural features of their welfare systems. Unlike earlier attempts at classification that focused on the level of social expenditure (see Esping-Andersen 1990: 18–21; Schmid 2002: 76–81), Esping-Andersen stressed the fact that different welfare states – basically unrelated to their degree of generosity – were built on different systemic principles which allowed him to group them into three distinct ideal-typical welfare "regimes": a "liberal", a "conservative-corporatist", and a "social democratic" regime. Societies of the first type (mostly countries of the Anglo-Saxon world) are characterized by highly residual welfare systems based on a dualism of means-tested public social assistance for the poor and marketized welfare services for all other citizens. Thus, the degree of "de-commodification", i.e., protection against market forces and income losses, is low. The other extreme is represented by the social democratic welfare states of Scandinavia. Here the role of the state is emphasized as a guarantor of social rights granted to every resident regardless of his or her employment status. As a result, both welfare transfers and social services are predominantly tax-financed and generous, hence redistributive effects are pronounced and de-commodification is high. Lastly, the conservative-corporatist type of Continental Europe is based on the insurance principle meaning that the "right" to receive welfare transfers is mainly acquired by contributions paid during his or her years of employment. The insurance system is usually further segmented along occupational and status lines, hence the depiction as "corporatist". Those who have not participated in the work force or who had shorter-than-average working careers (women in partic-

ular) are in a highly disadvantaged position, relying on family resources or means-tested social assistance schemes. Another feature is the relative scarcity of child care or elderly care services due to the strength of familialism in these societies (ESPING-ANDERSEN 1990, 1999).

Esping-Andersen's approach of stressing structural aspects rather than mere expenditure level considerations[1] has met with enormous positive response not only in social policy analysis but also in the broader context of comparative research on industrial societies. Thus, most critical comments did not question the typological rationale as such, but rather concentrated on the correct classification of particular welfare states. This was not the case with regard to Germany's characterization as a conservative-corporatist welfare state, to be sure. On the contrary, with features like a highly segmented pension system entirely built on the insurance principle without any basic pension elements (see SCHMID 2002: 294), Germany might rather be considered as one of the purest cases of this type.

Japan's tentative placement into the "liberal" category, by contrast, has been challenged by several authors. JONES (1993), for instance, has rejected any attempt to include Japan in Western welfare state types as eurocentric.[2] Instead, she claims the existence of a distinct East Asian "Confucian welfare state" regime. Moreover, in Japan itself, commentators concur with this argument by denoting the system as a "Japanese-style welfare society" with at least three distinctive features: a high reliance on family responsibility and care, an extensive system of corporate welfare for core sector employees, and a high level of private household savings for old age and other contingencies (UZUHASHI 1994). GOODMAN and PENG (1996: 200–207) admit that Confucian concepts of filial piety or family interdependence were indeed repeatedly and effectively used by East Asian governments as legitimation for refusing or cutting welfare benefits. On the whole, however, these authors argue that what these East Asian welfare states have more in common is a lack of any consistent principle and the adaptation of a "learning-by-doing-approach" for the

[1] This is not to insinuate that such attempts are useless or not illuminating, as will be discussed in paragraph 2.4.

[2] It has to be added that the contention of a presumed "otherness" of the Japanese welfare system predates Esping-Andersen's study. NAKAGAWA (1979) or VOGEL's notorious treatise on *Japan as Number One* (1980) are early examples of this point of view. The volume edited by ROSE and SHIRATORI (1986), by contrast, places Japan together with the U.S. in an "American-Pacific" regime characterized by a highly residual welfare state and a high diffusion of company-provided social benefit schemes. Responses to the arguments of his critics are found in ESPING-ANDERSEN (1997; 1999: 86–92).

sake of nation-building. Accordingly, the Japanese welfare state in its present shape is to be interpreted as a patchwork of very different elements adopted and adapted as a reaction to internal political pressure or economic difficulties (GOODMAN and PENG 1996: 209–213).

ESPING-ANDERSEN himself has subsequently revised his views. In an article published in 1997, he classified Japan as a hybrid combination of liberal and conservative-corporatist welfare regime elements. That is, employment- and status-related social insurance schemes, scarcity of public social services due to the dominance of familialism in society, and unequal levels of benefit were seen as characteristic for the corporatist model, whereas low public expenditure levels and comparatively high private provisions in health care suggested to him a closer relationship to the liberal model. Qualifying his own argument, however, Esping-Andersen pointed out that the hybridity of the Japanese welfare system might only indicate that it has not yet fully matured. Numerous reforms and redesigns of the system that have followed in rapid succession since the 1980s due to economic difficulties, population aging, and waning familialism, were cited as proof of this contention. Only two years later, Esping-Andersen again modified his views: Japan now became an integral part of the conservative-corporatist camp. While pointing at the rapid maturation of the corporatist insurance system – public pensions in particular[3] –, the main reason for this miraculous metamorphosis of a once "liberal" welfare state is not change in Japan itself, but a shift in the relative importance of the criteria used for the typology. That is, less weight is given on income maintenance (de-commodification) in favor of more importance paid to the role of the family as care-provider as well as a target of welfare state policies ("de-familialization") (ESPING-ANDERSEN 1999: 92–94).

A different approach at classifying welfare systems has recently been undertaken by SEELEIB-KAISER (2001), whose study compares the influence of globalization pressures on the political discourse and the development of welfare systems in the U.S., Japan, and Germany. According to his argument, only those welfare policy arrangements which cover social risks with a high degree of reliability (*Erwartungssicherheit*), i.e., being largely independent of budget considerations or individual capabilities, matter as criteria when comparing different welfare systems. These are:

[3] It is interesting to note that even in this recent publication Esping-Andersen does not yet make any reference to the new long-term care insurance law which was already agreed on. Undoubtedly, a consideration of this law would have further supported his revised view of assigning Japan to the conservative-corporatist regime group.

company-based social benefits (fringe benefits), labor policy, and government-led social policy. Based on this reasoning, the U.S. (predominance of fringe benefits as the most "reliable" welfare instrument), Japan (labor policy), and Germany (government-led social policy) represent three distinct welfare systems. Thus, as the major feature of the Japanese welfare system, measures such as comprehensive protection against unlawful dismissal or an active labor market policy to promote and maintain social integration into the labor market are emphasized (Seeleib-Kaiser 2001: 38–46). The same author has to admit, though, that during the years of economic recession in the 1990s it has become increasingly difficult to maintain these principles, pointing at a growing proportion of young people who are excluded from partaking in full employment (Seeleib-Kaiser 2001: 237–240).

2.2 Demographic and economic background of recent reforms

Since the early 1990s at the latest, the restructuring of social security systems has been on the political agenda of almost all industrialized countries. There are many arguments that have been put forward for this, and they are often inextricably linked to each other: the necessities of globalization, population aging, budget problems, or more ideological considerations calling for more responsibility assumed by the individual or the family instead of the state. The globalization hypothesis in particular, that is, pointing at the need to curtail welfare expenses and relax labor regulations in order to compete successfully with other world locations, has recently been stressed more than every other argument (see Seeleib-Kaiser 2001: 21–24). If we suppose that globalization is indeed the single most important force behind restructuring efforts, we would expect all welfare systems eventually to converge in a pattern that would bear the closest resemblance to the "liberal" regime type of today. However, as far as present trends are concerned, this is not the case. To be sure, the introduction of a state-subsidized private insurance component in Germany's pension system in 2001, for instance, can indeed be interpreted as a small shift towards a more "liberal" model. The recent introduction of long-term care insurance both in Germany and Japan, however, implies just the opposite: a reinforcement rather than a weakening of the existing social insurance principle. Thus, Seeleib-Kaiser (2001: 28) is surely right when arguing that at the international level convergence might be apparent with regard to the general target of adapting the welfare system to the requirements of global competition, but that divergence rules when it comes to the concrete means that are employed to reach this target. Obviously, the reasons for divergence have

to be found in the social, political, and economic or financial contexts of the countries concerned.[4]

We, the editors, argue that population aging, in particular, is no less important in this context. Population aging has a dual quality that sometimes throws policy-makers into a dilemma. On the one hand, it poses an economic problem, placing heavy financial strains on existing health, long-term care, and pension systems. On the other hand, it constitutes both a social and an ethical problem, raising the question of how we treat elderly people when they become frail. To regard aging as an economic problem would have the consequence of reducing social security spending, while its quality as a socio-ethical problem calls for further expenditures. Since levels of voting are high among the aged in most countries, policy-makers would risk to be voted out of office if they one-sidedly based their reform concepts solely on the economic argument. Hence, the contradictory strategy of cutting benefits in one area (i.e., in the case of public pensions and health care systems) and extending generosity in another area (i.e., in the case of the long-term care systems), is exactly what we can observe both in Germany and Japan over the past ten years.

However, if population aging is the main driving force behind the problems social policy has to cope with, then it seems that the social security systems of Germany and Japan, or, broadly speaking, of countries which adhere to "conservative-corporatist" principles, are under particular pressure. Demographic aging as such is common to all industrialized nations though it is somewhat less pronounced in classic immigrant nations like the U.S.A. or Australia (see Table 1). What does differ is, first, the consequences aging has on the welfare system and the economy. It goes without saying that social insurance systems which are financed according to the pay-as-you-go principle are more directly affected by aging than, say, systems that are based on taxation. In the former case insurance contribution shares from incomes have to be raised in order to keep pension benefits at the existing level, which thereby also increase non-wage

[4] Two important recent books shed light on the relationship between particular forms of social protection and specific economic systems. Ebbinghaus and Manow (2001) have published a volume on social policy and the political economy in Europe, Japan, and the U.S. which explores the linkages between social protection and areas like industrial relations, production and employment system, and financial and corporate finance. Streeck and Yamamura's book (2001) analyzes the origins of the "nonliberal" German and Japanese capitalist societies, focusing on welfare state building, corporate governance, financial systems, and training regimes. Thus, these books have embarked on the formidable task of forming a synthesis of comparative studies of politics, industrial relations, national systems of production, and welfare regimes.

labor costs. This, in turn, jeopardizes the competitiveness of the economy. In the latter case, by contrast, competitiveness is less directly threatened because taxes can be collected from very different sources.

Table 1: **Aging, fertility, and female labor force participation: selected countries**

	Elderly (65+) in %, latest avail. year	Total Fertility Rate (avg. 1997/99)	Female labor force participation (15+) in %, latest avail. year
Australia	11.9	1.82*	54
United Kingdom	15.6	1.70	55
USA	12.7	2.05	60
Denmark	14.8	1.73	59
Norway	15.3	1.84	55**
Sweden	17.3	1.51	61**
France	15.9	1.74	47
Germany	15.8	1.36	48
Italy	18.0	1.17	35
Japan	17.2	1.37	50

Notes: * 1995; ** estimated from 16–64 years of age participation rate data.

Sources: Council of Europe (2000: 50, 74); Kokuritsu Shakai Hoshō Jinkō Mondai Kenkyūjo (2000: 35, 53); United Nations Statistics Division, *The World's Women 2000: Trends and Statistics* (http://www.un.org.depts/unsd.ww2000/table5d.htm; downloaded March 25, 2002).

Second, according to Esping-Andersen (1996), a lesser known feature of conservative regime countries is that they also *actively* promote population aging in the long run by effecting very low fertility rates. Because of familialistic considerations, child care services are chronically underdeveloped in most of these countries. Thus, women with career ambitions are often left with no other choice but to abandon their wish to have children. Table 1 confirms that – with the notable exception of France[5] – the lowest fertility levels are indeed recorded in countries which are usually grouped under the "conservative-corporatist" category. The other side of the argument is that, third, those women who opt to have children encounter difficulties in reconciling family duties with gainful employment. Hence, the rather modest female labor force participation rates in these countries (see Table 1) which have the side-effect of keeping

[5] A possible reason may lie in the fact that in France (as well as in Belgium) public child care coverage largely exceeds the levels measured in other Continental European countries (see Esping-Andersen 1999: 71).

both social contribution and income tax returns low, the opposite of what is needed in order to ease financial pressure on the social security systems. In sum, "conservative" social security systems are not only least adapted to but even aggravate population aging and the problems connected with it. This raises the question of whether Japan and Germany's welfare systems can be maintained in the long run without completely overturning their "conservative-corporatist" nature.

The existence of other trends that are shaking the very foundations of the conventional welfare system both in Germany and Japan is linked with the push for change.

First, it seems that familialism is losing ground in society. In Germany, to be sure, familialistic attitudes were never that prevalent, except for parts of the predominantly Catholic rural south.[6] From the results of the *6th World Youth Survey* conducted in 1998 by the Youth Policy Office of the Japanese Governmental Management and Coordination Agency (Sōmuchō Seishōnen Taisaku Honbu 1999: 18), we learn that the overall readiness to take care of parents in their old age is lower in Germany than anywhere else. A comparison with earlier reports of the same survey reveals, however, that in Japan during the latter half of the 1980s there was also a distinct drop in the willingness to supply care to elderly parents (for more details, see Lützeler in this volume). Accordingly, the rate of cohabitation with elderly parents, already extremely low in Germany, is decreasing in Japan at a rapid pace. The introduction of a long-term care insurance system that stresses both public and private commercial care providers must also be seen in this context.

Second, the situation of fiscal finances in both countries has been aggravating rapidly over the past years. Although governments in both countries have tried to curb contribution hikes in their pension systems by assigning larger tax-financed federal grants (see both Conrad and Schmähl in this volume) – and thereby blurred, to some extent, the real costs of these systems to their voters –, such "strategies" have their obvious limitations if we consider that Japan is already the highest indebted of all OECD countries and that Germany is currently struggling to meet the public deficit criteria of the Maastricht Treaty.

Obviously, reforms that do not take into account both demographic and social changes as well as the situation of the fiscal finances are bound to fail.

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[6] For instance, Bertram and Dannenbeck (1991: 102–106) report that even today in Catholic rural regions of southern Germany, approval of female withdrawal from the labor market in favor of child rearing is significantly higher than in the predominantly Protestant rural north.

2.3 The early German influence on Japanese social policy

Germany and Japan were both industrial latecomers at the end of the 19th century and in both countries the state elite was the major force behind economic modernization and the development of social programs.

In Germany, the defeat of Prussia in 1807 was the beginning of fundamental institutional reform. The early discourse on economic and social policy formation was strongly influenced by liberal ideas in the tradition of Adam Smith, but during the later half of the 19th century these ideas gave way to a discourse of "socially embedded capitalism" (Lehmbruch 2001: 46). One of the most influential players shaping this new discourse was the "Verein für Socialpolitik" (Social Policy Association), founded by conservative economists like Gustav Schmoller and Adolph Wagner. Lorenz von Stein's concept of "monarchy of social reform", which postulated as a strategy to avoid revolution the integration of the working class into the capitalist society, was strongly influential with the members of the "Verein für Socialpolitik" and later with the social reform bureaucrats surrounding Bismarck who initiated the German tradition of state-led social policy (Lehmbruch 2001: 52–59).

During the early phase of the formulation of Japanese economic and social policy, Germany functioned as an important role model. For example, the Prussian constitution of 1850 served as a model for the Meiji constitution of 1889. In addition, Lorenz von Stein's ideas about social reform were popular with Japanese officials (Beasley 1990: 76–80). The most visible expression of German influence was the establishment of the Japanese "Verein für Socialpolitik" (*Shakai Seisaku Gakkai*) in 1896 by the Japanese scholar Kanai Noboru who had studied in Germany in the 1880s. This group had, for example, initial influence over the debates on bills regarding the "Factory Law" (*Kōjō-hō*), which was enacted in 1911 (see below).[7]

Germany and Japan also shared some similarities with regard to the aims of their first social programs. It is widely acknowledged that the introduction of the first social insurances in Germany in the 1880s, such as public health insurance (1883), accident insurance (1884), and age- and invalidity insurance (1889), was, for the most part, a tactic to control the socialist labor movement and to secure the aristocratic, military, and bureaucratic character of the Hohenzollern monarchy (Schmidt 1998: 31;

[7] In fact, the term *shakai seisaku*, which is still used today in Japan to refer to studies on labor relations with special reference to working conditions, employment, wages etc., was a translation of the German word "Sozialpolitik" (Takahashi 1997: 36–37, 52).

Lehmbruch 2001: 58). In Japan, early social policy-related measures, such as the introduction of the health insurance for industrial workers (*kenkō hoken*) (1922), the system of welfare or district commissioners (*hōmen iin*) (1930), the founding of the Ministry of Health and Welfare (1938), or the introduction of pension insurances for seamen (*sen'in hoken*) (1939) and industrial workers (1941), were foremostly means to enhance national military capabilities by securing scarce skilled labor and to legitimize the existing political order. And, indeed, the explicit purpose of the pension insurance was to accumulate money for the war effort (Yamazaki 1991: 67–71; Tatara 1980: 381–383; Weis 2001: 315–316).

Thus, early social legislation in both countries was not enacted by a benevolent state but implemented strategically in a top-down fashion as a means to control society and economic resources. Although Japanese reformers shared the German fear of labor unrest, they did not simply copy Bismarck's policies. In fact, Lehmbruch shows that the Meiji reformers "drew specific policy conclusions from a German social policy discourse that they regarded as congenial with their neo-Confucian traditions […]" (2001: 62). Lehmbruch (2001: 63–68) describes the "Japanization" of German social policy discourse as a reinterpretation linking Lorenz von Stein's ideas to the Japanese *ie*-system.[8] Whereas in Germany, the underlying key concept of social policy was the notion of civil society (*bürgerliche Gesellschaft)*, in Japan it was the *ie* as the basic social unit. Early Japanese social policy measures were targeted at the enterprise level rather than at society as a whole.

Welfare entitlements in Japan were first directed at those parts of the industrial workforce that were most crucial for economic growth, thus social policy was part of a developmental strategy. Consequently, it was in the state-owned firms where mutual aid associations with compulsory membership were first established in the early 1900s. These schemes

[8] The *ie* was the traditional primary unit of social organization in Japan. It usually denoted a stem family household but – in a wider context – meant a whole family organization consisting of a main household (*honke*) and several branch households (*bunke*). The latter derived their origins from younger male children of the *honke* and were socially subordinated to the main household which was thought to be handed over from the eldest male child (or the adopted husband of the eldest daughter) to the next in an unbroken line of succession. Although officially abolished during the American occupation period, some elements of the *ie* concept have continued to survive, e.g., ancestor worship is still performed by the eldest son, or – more significant with regard to the elderly care topic – the notion that the eldest son (and his wife) are the natural care-takers of elderly parents (Arichi 1993: 1–29).

covered on-the-job injuries and illness and provided lump-sum retirement benefits (MANOW 2001: 95–103).

The first noteworthy social legislation in Japan was the "Poor Relief Regulation" *(Jukkyū kisoku*) of 1874, which was directly influenced by the British "Poor Law".[9] Another important early legislation was the above mentioned "Factory Law" of 1911 (effective since 1916), which aimed to improve standards of working hours, minimum age, or night shifts of women.[10]

A prominent example of the early adaptation of German ideas is the "Elberfelder System",[11] which, together with the British system of "Friendly Visitors of the Charity Society", functioned as a model for the system of welfare or district commissioners (*hōmen iin).* This system became obligatory in all prefectures in 1930. After the war, the Supreme Commander for the Allied Powers ordered the revitalization of this system and today it lives on in the volunteer welfare commissioners (*minsei iin*) who organize, for example, local consultation meetings for mothers of new-born babies (see THRÄNHARDT 1995: 79; WEIS 2001: 311–312).

Another example of the early influence of specific German models is the Japanese pension insurance for workers (1941). Although there was no direct bilateral cooperation on this issue, it is clear that Japanese bureaucrats were strongly influenced by the German experience (WEIS 2001: 314).

After Japan and Germany's defeat in the Second World War, the German influence on Japanese social policy, which had been strong from the Meiji era until the authoritarian phase of the 1930s and 1940s, subsided. There are, in fact, hardly any references to German models in early postwar Japanese discourse on social policy (WEIS 2001: 363). On the other hand, the British "Beveridge Plan" of 1942 gained already some popularity with the Japanese bureaucracy during the Second World War, and in October 1947 the Social Insurance Investigative Commission *(Shakai Hoken Chōsakai*) released what came to be called Japan's Beveridge Plan. However, the American authorities criticized this plan as too expensive

[9] The number of beneficiaries of this scheme remained, however, low with less than 20,000 persons per year during the 1880s and 1890s (NAKAMURA and MIURA 1981: 181).

[10] The law made sick pay and injury compensation obligatory in individual companies with more than 15 employees. Companies were obliged to pay 50% of wages for three months to ill or injured workers. In 1923, the law was revised to meet conventions of the International Labor Organization from 1919.

[11] The "Elberfelder System" was the first volunteer-based, systematic system for poor relief in Prussia.

and broad. Instead, an American commission released a report in 1948 in which it recommended no structural changes, but rather a unification and rationalization of policies. Partly because of these recommendations, but also to guarantee personnel, structural, and institutional continuity, Japanese social policy after the Second World War largely held on to its earlier course (Weis 2001: 351, 363).[12] In the 1950s, the "corporatistic" nature of the welfare system was strengthened by some newly founded pension systems along occupational lines, such as the systems for employees of public corporations and private school personnel. Although there was little structural change in the immediate postwar period, the General Headquarter's order SCAPIN 775 was important because it established three principles (equal treatment, state responsibility, and no financial limit for assistance to guarantee minimum livelihood), which, for the first time, safeguarded legal entitlements. This was a major difference to prewar practices where eligibility had been highly discretionary (Takahashi 1997: 57–62).

Foreign social policy discourses remained an important reference point in the postwar period. For example, by increasing the benefit level of the Employees Pension Insurance in 1973 Japan aimed to meet the replacement rate level which had been laid down in conventions No. 102 and No. 128 of the International Labor Organization (ILO) (Kōsei Tōkei Kyōkai 1997: 31). Developments in Germany were once again monitored carefully, too. However, there is no systematic account on how exactly the German discourse on social policy might have influenced Japanese legislation in the postwar period. Even in the very recent case of long-term care insurance, and with its obvious similarities in both countries, it is not clear to what extent the German model influenced Japanese legislation. Campbell and Ikegami (2000: 38) point out that serious planning of the long-term care insurance started at about the same time in both countries and that the main features of the Japanese plan were already well decided by the time the German program was enacted. On the other hand, it is clear that Japanese bureaucrats and advisory boards studied carefully the drafts of the German legislation and undertook several study tours to gather information.

In retrospect, despite many institutional differences and differing objectives in the early period of welfare state building in Germany and

[12] Somewhat historically ironic, in Germany, the Allied Powers themselves had drawn up a broad reform plan for the highly fragmented social insurance schemes which was also based on the "Beveridge Plan". Here it was the German side which rejected this plan and preferred to continue the existing contribution-based social insurance schemes (see Hockerts 1980).

Japan, it is clear that both welfare states integrated labor and capital and directed entitlements predominantly toward the core industrial workforce. Both countries constituted a fragmented and selective welfare state in the beginning which became more and more unified and universal after the Second World War. Moreover, both systems kept following a "performance/achievement" model where benefits were, and still are, closely linked to employment status and former contributions (MANOW 2001: 119).

2.4 The German and Japanese welfare systems in light of social expenditure indicators

Germany and Japan's welfare systems today follow largely the social insurance principle and are organized along occupational lines. There are four classic public social insurance schemes, namely health, pension, unemployment, and accident insurance. Additionally, long-term care insurance schemes were enacted in both countries in the latter part of the 1990s.

To get an idea about the scope of social benefits in both countries, let us first consider a frequently cited welfare indicator: the gross public social security expenditure as a percentage of GDP. As Table 2 illustrates, in the 1970s Germany's expenditures were four times higher than Japan's and were also well above the average of the 12 European Union member countries (EUR 12). However, in the late 1970s and 1980s Germany reduced its level of spending in various fields, whereas Japan followed an expansive social policy course which subsequently narrowed the difference in spending levels.

Table 2: **Gross public social security expenditure as percentage of GDP**

	Germany	Japan	EUR 12
1970	21.5	4.7	17.3
1975	29.7	7.7	24.3
1980	28.8	10.1	24.3
1985	28.4	11.0	26.0
1990	25.4	10.8	25.5
1995	29.6	13.2	28.4
1998	29.3	14.5	27.7

Notes: Until 1980 as percentage of GNP; until 1990 West Germany, since then Germany.

Sources: BMAS (2001: 9.18); calculations based on KOKURITSU SHAKAI HOSHŌ JINKŌ MONDAI KENKYŪJO 2002 and KEIZAI KIKAKUCHŌ (2000: appendix 14).

In Germany, the unification with East Germany in 1990 brought the consolidation effort to a halt for some time because the German Unification Treaty extended the public social programs to include former East Germany. Consequently, public social security expenditures started to rise again. Nevertheless, the government at the time enacted substantial cuts in a variety of programs which limited further increases in public social security expenditure. Schmidt (1998: 137) estimates that without public benefit cuts during the 1980s and 1990s, the public social security expenditure in 1997 would have been 2.8 percentage points higher than it actually was at that time. Japan pursued its expansive social policies until around the mid-1980s; thereafter benefit cuts, especially in pension and health care provision, were enacted which slowed down the increase of social expenditures relative to GDP.

Today, the German state spends about twice as much relative to GDP for public social policy programs than the state does in Japan. But does this mean that Germans are much better or even twice as well insured against the key social risks of age, sickness, unemployment, or poverty? Although there are substantial differences in terms of legal entitlement, benefit levels, or duration of benefits – varying between programs – we would nevertheless argue that Japan's social welfare arrangements today do a fairly good job to insure against key social risks.[13] If this is so, how then should the above numbers on gross public social expenditure be interpreted?

Although gross public social expenditure as a percentage of GDP is a frequently cited welfare indicator, it does not, in fact, reflect several important factors. One of these factors are informal social arrangements, which can provide a similar kind of risk insurance. For example, if large parts of the elderly population live together with and are cared for by their families – as is still the case not only in most parts of the developing world but in Japan as well – public pension and long-term care insurance systems will not be as essential for the provision of adequate benefits than they are in countries where these informal arrangements have largely disappeared. For obvious reasons, such informal benefits in kind and in

[13] It appears that the greatest differences exist in unemployment insurance and social assistance. For example, unemployment benefits in Japan are paid for a maximum period of six months, whereas in Germany benefits of the *Anschlußarbeitslosenhilfe* (unemployment relief) are paid without any time restriction. In terms of poverty insurance the social assistance system in Japan – as the public social insurance of last resort – appears to be much stricter than the German system not only with regards to legal entitlement but also in terms of the actual practices in allocating benefits at the municipal level.

cash are not included in official statistics. In fact, the economic situation of Japanese elderly is closely connected to their living arrangements. Once elderly reach the age of 60 there is a significant increase in the rate of cohabitation with children. At the age of 65 almost 50% of the elderly in Japan still live in households with three and more members, whereas in Germany only 10% of the elderly do so (OECD 2001: 33). Living in larger households in Japan is, however, not indicative of low income levels and the consequent need to rely upon the income from working children, but it is indicative of a complex inter-generational support system. There are significant intra-household transfers and informal social arrangements that still play a comparatively significant role, e.g., as far as long-term care is concerned.

Other factors, which are also not reflected in the national figures on gross public social expenditure, are private social benefits and the effects of taxation (see Adema 2001). Since most governments claw back spending on social benefits through taxation or have special tax breaks to pursue social policy goals, the real level of government social effort might differ considerably. Moreover, private formal arrangements, which serve a social purpose and contain an element of inter-personal redistribution, provide important social benefits in many countries. These are employment-based benefits paid by employers, which have been made mandatory by the state (such as, for example, incapacity-related benefits in the context of occupational injuries) or which are induced by a favorable tax-framework (such as, for example, occupational pensions). Adema (2001) has developed an indicator of *net social expenditure* to account for the varying impact of the tax system and private (formal) social benefits. Table 3 illustrates that accounting for private (formal) social benefits and the impact of the tax system has an equalizing effect on the levels of social effort across the countries included in the study. It is also remarkable that in general "liberal" welfare states are more generous and social democratic states less generous than previously assumed. With regard to Germany and Japan, the figures show that on the whole Germany spends less and Japan slightly more than what the gross figures indicate. However, even these figures do not reflect several important factors which should be taken into account to get a full picture of the situation in Japan.

Table 3: **Net social expenditure indicators, 1997 (percent of GDP factor cost)**

	Gross public social expenditure	Net current public social expenditure	Net current private social expenditure	Net total social expenditure
Australia	18.7	17.9	4.1	21.9
United Kingdom	23.8	21.6	3.2	24.6
USA	15.8	16.4	8.1	23.4
Denmark	35.9	26.7	0.8	27.5
Norway	30.2	24.4	..	25.1
Sweden	35.7	28.5	2.2	30.6
Germany	29.2	27.2	1.6	28.8
Italy	29.4	24.1	1.2	25.3
Japan	15.1	14.8	0.9	15.7

Source: ADEMA (2001: 27–28).

First, there are the already mentioned informal arrangements which are not accounted for in these statistics on net social expenditure, but which are a vital factor of intrafamilial risk insurance in Japan.

Second, unemployment and the associated costs, as accounted for in national social budgets, have, at least until recently, been lower in Japan than in most western European countries. During the period from 1996 to 1999 the average standardized unemployment rate conforming to ILO definition was 7.1% in Germany, but only 3.9% in Japan (NICKELL *et al.* 2002: 51). Insofar as Japanese unemployment rates have been rising in recent years, we expect higher net social expenditure figures in the future, especially since it is possible that unemployment benefits will have to be raised once unemployment becomes a more common social phenomenon in Japan.[14]

Third, Japan has been pursuing labor market policies whose costs have not been accounted for in the public social budget as part of active labor market policies, but which are a sort of side-effect of enormous public works projects. These public investments in recessionary periods have been dispersed widely to various regions for job creation purposes (YOSHINO 2000: 17). An eye-catching consequence of these policies is, for example, the comparatively high employment in the construction sector, where we find around 11% of all employees, twice as much as for exam-

[14] This is not to say, however, that rising unemployment spending is necessarily indicative of welfare state effort. Some observers even suggest that rising unemployment expenditures in fact demonstrate the failure of the welfare state to protect employees from the consequences of economic downturn.

ple in the U.S. (*Financial Times* 20.04.1998: 21). If these people were paid unemployment benefits or were subsidized directly through active labor market instruments – as is the case in Germany –, public social expenditures would obviously be much higher.

Fourth, the numbers on net social expenditure in Japan do not include substantial lump-sum retirement benefits paid by Japanese companies to employees reaching the company retirement age (*teinen*). The logic behind this is that those benefits are often regarded as a form of deferred wages and do not constitute private social benefits. On the other hand, if we consider that these benefits increase progressively with the length of employment and are substantially lower if the employee retires earlier from his/her job, there is obviously more to these benefits. They could also be regarded as another form of private social benefits, and, thus, should be included in net social expenditure data.

The above named factors might explain in part the rather low net social expenditure in Japan. However, we do not argue that Japan and Germany would have similar expenditure levels if these and possibly other factors were taken into account. Nevertheless, it seems important to point out that Japan is not such a welfare-laggard as it is often portrayed, and that state expenditure levels alone are not sufficient as indicators of total welfare provision.

2.5 Some remarks on pension and long-term care insurance policies in both countries

When comparing social policies it is important to distinguish between the *aims* (*objectives*) of policies and the *methods* (*instruments*) by which those aims are achieved (Barr 1998: 4). Whereas the issue of *aims* or *objectives* is largely ideological and at the heart of political discourse, *methods* concern more technical and positive issues. The following short outline of major differences and similarities of pension and long-term care insurance in Germany and Japan considers both the (changing) aims of these schemes in general as well as the instruments in particular. It seems natural to start with these schemes not only because public pensions have a much longer history in both countries, but also because developments in this field had – at least in Germany – some influence on the eventual design of the long-term care insurance systems which were first introduced during the 1990s.

At the center of the 1957 public pension reform in Germany, which introduced the "dynamic pension" (linking pension calculation and pension adjustment to the development of gross wages), was the notion of securing the achieved standard of living after retirement (*Lebensstandard-*

sicherung) through public pension provision. This *objective* was not put to question during subsequent reforms up to the mid-1990s; benefits of current pensioners remained largely untouched. However, beginning with the 1999 pension reform, which was legislated in 1997, this *objective* did change. Although the new coalition government of Social Democrats and the Green Party suspended some of the elements of the 1999 Pension Reform Act, their own subsequent pension reform in 2000 has lowered considerably the net pension level for the "standard pension" so that it can be expected that a large part of the population will receive in the future public pension benefits which are scarcely higher than social assistance benefits. What we have witnessed in Germany in the field of pension policy is a gradual shift towards neo-liberal ideas and a clear shift in *objectives*. The public pension system is no longer regarded as the key scheme to secure an achieved standard of living, but rather private provisions are supposed to play a much bigger role in future. New policy *measures* such as tax incentives and transfers were introduced in 2001 to facilitate the build-up of private pension provisions.

The same sort of ideological shift can be witnessed in Japan where pension policy up to the mid-1980s seems to have been largely influenced by western European models. During the 1960s and early 1970s the conventions already mentioned, No. 102 and 128 of the ILO, functioned as a yardstick for Japanese policy-makers (Kōsei Tōkei Kyōkai 1997: 31). Although the core public pension schemes, namely the Employees Pension Insurance (reinstated in 1954) and the National Pension Insurance (established in 1961), were originally designed as capital-funded systems, several amendments to the pension law during the 1960s and 1970s resulted in a quick increase in future benefit levels of these schemes, whereas contribution hikes were much lower than what would have been regarded as prudent from an actuarial point of view. By 1973 the future model replacement rate of the Employees Pension Insurance surpassed 60% of the average gross income of the working population. However, in the mid-1980s Japanese policy-makers were alarmed by a slow deterioration of the pension finances and gloomy scenarios about necessary future contribution hikes to levels of almost 40% (Kōseishō 1983: 85–87). Several pension reforms were passed, which intended an eventual shift from an expansive policy to one that seeks to curtail future expenses. These reforms must be seen against the background of the adoption of neo-liberal ideas by the Japanese government. Since the mid-1990s, the officially expressed opinion on this point has been that the state should provide only a moderate level of benefits, and that whatever additional benefits are necessary should be covered by private provisions in the future (e.g., Kōseishō Daijin Kanbō Seisakuka 1994: 7). Thus, the occupational pension

reform of 2001 is of special significance for the future of the public-private pension mix in Japan because the hope is that private provisions will play a bigger role so that public benefits cuts can be compensated (NENKIN SHINGIKAI 1998).

Thus, in terms of the *objectives* of pension policies, we see a clear shift towards neo-liberal ideas in both countries. Accordingly, public pension schemes in Germany and Japan are likely to loose their predominant role as a source of retirement income in future. At the *instrumental level* of pension policy both countries have enacted various measures to encourage additional private pension provision. Whereas Germany has passed legislation to improve both personal and occupational provisions, Japan's policy-makers are focusing – at least at the moment – mainly on occupational pensions (for more details, see both SCHMÄHL and CONRAD in this volume).

Germany and Japan's long-term care insurance systems are historically much younger than the respective public pension schemes. Therefore, a change in *objectives* as we have seen in pension policies is not to be expected. However, the above described neo-liberal policy shift has, at least in Germany, left its mark on the design of the long-term care insurance. The new statutory long-term care insurance scheme was not organized as a *Vollkaskoversicherung* (fully comprehensive insurance) as had been the case with the statutory public health insurance system which still covers (with some exceptions) 100% of individual health expenditures. Instead, the new system aims to cover only 50% of need. Moreover, the long-term care insurance law specifies that only earmarked social insurance contributions are to cover benefit expenditure and no subsidization via taxes is allowed. Thus, this new social insurance scheme has a rather limited *objective* in comparison to the insurance schemes of the past.

Japan's new long-term care insurance, on the other hand, is much more generous and there are virtually no spending caps. Given the considerable spending cuts in the pension area in recent years, the introduction of such a new generous statutory public scheme comes as a surprise. CAMPBELL's and TALCOTT's articles in this volume analyze some possible reasons for this development.

Several articles in this volume deal with the *instruments* of long-term care in both countries (for more details, see NAEGELE and REICHERT, TALCOTT, and KNÜVER and MERFERT), so we do not need to discuss this issue here at length. However, one factor which is especially important is that although both countries held firm to their traditional social policy approaches and adopted a social insurance model for their new long-term care schemes, market forces are now thought of as an indispensable factor

to encourage the expansion of services and facilities. As in the case of pension reform, where a new mixture of public and private provisions is supposed to produce superior outcomes, private sector involvement is also regarded as essential to encourage a more efficient usage of financial resources in long-term care provision.

3. The Articles

The papers in this volume are grouped into four parts covering various aspects of aging and social policy. Following this introduction (Part One), the articles in Part Two discuss some of the more general demographic and policy implications of the aging societies in Germany and Japan. Arai Makoto gives an historical overview of the development of the social security system in Japan after the Second World War up to the present. He shows how changing awareness of the implications of the aging society has influenced Japan's social policies especially since the beginning of the 1990s. Kojima Hiroshi analyzes the trend in population aging in Japan and its demographic determinants and consequences. Drawing on the results of multinominal logit analysis, he discusses some social policy implications of aging with special reference to the cohabitation of elderly parents with their adult children. Karin Veith focuses on the material situation of elderly households and discusses the resulting demands and limits for social policy in Germany.

Part Three of this volume brings together papers which analyze in closer detail long-term care and pension policies in both countries. Paul Talcott's account of the politics of Japan's long-term care insurance system describes and analyzes the structural features and recent data of the long-term care insurance scheme and scrutinizes in detail the political process which led to its introduction. Gerhard Naegele and Monika Reichert start out with an overview of the long-term care insurance system in Germany, analyze recent income and expenditure data, and point out deficits and possible future directions of reform. Iris Knüver and Matthias Merfert discuss state law regulations with regard to long-term care insurance in Germany and analyze the role of long-term care committees, long-term care conferences, and other local authorities. Thomas Klie discusses in a comparative study the similarities and differences of the long-term care insurance systems in Germany and Japan and highlights some common problems for the future development of these schemes. John Campbell, too, concentrates on similarities and differences of both long-term care insurance schemes and analyzes from a comparative public policy perspective why these programs were introduced in the first place, and

why they differ in various aspects of policy design. Harald CONRAD evaluates Japan's recent public and occupational pension reforms with regard to their effects on financial sustainability, distributive effects, minimum income adequacy, and the newly evolving public-private pension mix. Winfried SCHMÄHL analyzes major pension reforms in Germany since 1957. After discussing the present structure of old-age protection in Germany, he focuses on important revisions over the past years and scrutinizes in detail the implications and shortcomings of the 2001 reform measures.

Finally, Part Four focuses on some more specific aspects of long-term care in Germany and Japan. Heinz ROTHGANG examines the financing implications of the public long-term care insurance in Germany. Using a simulation model he estimates expenditure and contributory income development according to different scenarios and demonstrates the resulting impact on future contribution rates. Ralph LÜTZELER focuses on demographic and regional aspects of aging in Japan and their implications for long-term care. He analyzes the general aging trend and examines regional differences in the proportion of the elderly and their living arrangements highlighting some implications for future policy making. Sabine FRÜHSTÜCK analyzes the state of the nursing homes in Japan during the 1980s, prior to the introduction of the long-term care insurance, and discusses the rhetoric of reform when so-called "community care programs" were introduced for the first time. The volume concludes with a contribution by KIMURA Rihito who discusses the shifts in welfare policy, which led to the introduction of the long-term care insurance, and analyzes the bioethical implications of this new scheme.

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2. Demographic and Policy Implications of the Aging Society

The Aging Society and the Social Security System in Japan

Arai Makoto

1. The Creation of Social Security after the Second World War

As a result of the Meiji Restoration of 1868, Japan embarked on transforming itself rapidly into a modern nation state. The foremost national goal was to achieve economic and military strength comparable to western powers. For this reason, Japanese policy makers closely watched social, economic, and political developments in other countries. Like in Germany, where Bismarck's social policy measures were not simply meant to assure the workers' livelihood in their old age but were a calculated political strategy to control the socialists, the first nationwide social policy measures in Japan, such as the introduction of a health care system for industrial workers in 1922 (enacted in 1927) or the introduction of the Workers Pension Insurance (*rōdōsha nenkin*) in 1941, were not just gestures of a benevolent state, but were explicitly meant as a means to improve national military capabilities (Yamazaki 1991: 67–71).

After the Second World War, the new Japanese constitution served as a foundation for developing a social security system because it guaranteed, for the first time, fundamental human rights and the freedom of citizens. According to Article 25 of the Japanese Constitution, every Japanese citizen is entitled to "the minimum standards of wholesome and cultured living" and also that "the State shall use its endeavors for the promotion and extension of social welfare and security, and of public health." The fundamental concept of a social security system is therefore established in the Japanese constitution, which became a legal source for laws relating to social security in the postwar era.

The "Recommendations Concerning the Social Security System" (1950), submitted by a Consultation Committee (*Shakai Hoshō Seido Shingikai*) set up by the Prime Minister's Office, served as a basic yardstick for the eventual development of the social security system. In this memorandum to the then Prime Minister, the urgent need to create a modern social security system was emphasized (Shakai Hoshō Seido Shingikai 1950). It ascertained that on the one hand, the state is responsible for protecting the lives of its citizens, but that on the other hand, citizens have a requisite

social duty to uphold and operate the system in an ethos of social solidarity and according to their individual capacity.

The duty of the state to guarantee every citizen, *inter alia*, the right to live and to improve social welfare and public health was established in the constitution, which came into force in May 1947. Under the decisive leadership of the Supreme Commander for the Allied Powers (Occupation Headquarters), the expansion of individual social security systems and the reorganization of the administrative structure were initiated. The influence exerted by Occupation Headquarters extended across the entire social security system. For example, the three basic principles of the public welfare system, i.e., duty of the State, equal treatment, and the guarantee of a minimum standard of living can be traced back to instructions from Occupation Headquarters (KŌSEISHŌ 1999: 16). Occupation Headquarters, furthermore, sought to establish scientific and specialist approaches in the areas of jurisdiction responsible for public health and social welfare. An example of this policy was the system of public health departments staffed by experts from the medical professions, such as doctors and state-registered nurses, and a system of social security offices whose managers were recruited from the social welfare professions.

The key concepts of this period were "poverty relief" (*kyūhin*) and "basic maintenance" (*kiban seibi*). The social security system in particular played a central part in the measures for poverty relief. In 1950 social security expenditure constituted 46% of the budget of the Ministry of Health and Welfare. Almost two million Japanese were classified as needy persons, which represented 2.5% of the total population at that time (one in every 40 Japanese citizens) (KŌSEISHŌ DAIJIN KANBŌ TŌKEI CHŌSABU 1969: 311).

2. INTRODUCTION OF THE NATIONAL HEALTH AND PENSION INSURANCE

Economic reconstruction had already begun in the late 1950s, but an economic boom that began around 1955 accelerated the process of rapid economic growth. The standard of living amongst the population rose considerably. Rapid economic development continued for 20 years until 1974, the year of the oil crisis, in which negative growth was recorded for the first time in the postwar era. According to the annual economic white paper from 1956, the GNP of the previous year had exceeded the maximum recorded in the prewar era, thus heralding "the end of the postwar era". Twelve years later Japan's GNP was the second largest in the world, after the United States. Accordingly, in the 1970s, the phrase "Japan as an economic superpower" (*keizai taikoku Nihon*) was coined.

With an increase in incomes, rapid economic growth contributed to a considerable rise in the standard of living. During the decade after 1955, people spoke enthusiastically about the three "wonder goods" (the television, refrigerator, and electric washing machine) as images of prosperity; in the decade after 1965 the "three C's" (a color TV, car, and cooler [air conditioning]) were added to the list of affordable and desirable products to own. The spread of these goods within a short period of time became representative of the raised standard of living. At the same time, Japanese society was undergoing great change. New claims on social security were making their presence felt. The structural change in production, i.e., from agriculture, forestry, and fishery to manufacturing industries, and from light industry to heavy industry and chemical industry, triggered numerous problems: the depopulation of the countryside and the overpopulation of the large cities as a result of massive migration from the rural areas, a lack of medical provision for rural districts and even larger regions, the emergence of a new income underclass which could not participate in the raised standard of living, a polluted environment and the destruction of nature, and a poorly developed infrastructure, e.g., water supply and drainage, sewage works, and waste disposal. These problems led to demands for an increase in social spending and the term "welfare state" (*fukushi kokka*) came into the center of public debate during this time.

In parallel with the increase in the general standard of living as a result of the economic growth after 1955, emergency measures for the poor and needy were strengthened. However, there was also a growing need to protect ordinary citizens from sinking into poverty as a result of illness or old age. In the mid-1950s there were still 30 million people in Japan without health insurance, which represented approximately one third of the population, including in particular the self-employed and farmers as well as those employed in small businesses (Kōseishō Daijin Kanbō Tōkei Chōsabu 1969: 257–259). In the event of accident or illness resulting in loss of income and additional expenses due to the cost of treatment, many of these people very often became cases for social assistance and therefore a serious societal problem.

The demands of the public were important factors in the introduction of a social security system for all citizens during this period. In order to guarantee medical care for the large group of hitherto uncovered citizens, the new National Health Insurance Act (*Kokumin kenkō hoken-hō*) was passed in 1958. This bill required all citizens, including the self-employed and farmers who had hitherto been uninsured, to belong to a health insurance scheme. In this way, a system of universal insurance was established. After a four-year preparatory planning phase, the National

Health Insurance went into operation in municipalities throughout Japan in April 1961.[1]

After the war, the hierarchically structured extended family and the system of succession by inheritance specified in the Civil Code were revised, thus substantially changing the state of political awareness regarding livelihood. Under these new circumstances, there was great uncertainty in planning for old age amongst those who did not belong to a public pension scheme. The Employees Pension Insurance[2] (*kōsei nenkin*) had already been reinstated in 1954, and there were also several mutual aid associations (*kyōsai nenkin*) for different groups of employees outside this system. However, a large proportion of the population, especially the self-employed and farmers, were not covered by any public pension insurance. Therefore, from around 1955 discussions started surrounding the creation of a pension system for all citizens. In 1959 legislation was passed on the National Pension Insurance (*kokumin nenkin*), which was enforced throughout the country in April 1961. Until the pension reform of 1985, the National Pension Insurance covered this large group of non-employees (such as farmers and the self-employed).

Since the establishment of a universal health and pension insurance in 1961, all citizens have been insured through some scheme or another both during sickness and in old age. These universal insurance systems have remained the cornerstone of the Japanese social security system up to the present day. The concept of "provision for poverty", which had dominated largely until about 1960, was replaced by the key words "universal insurance" (*kokumin kai hoken*) and "universal pensions" (*kokumin kai nenkin*). Thus, the weight was shifted from social assistance to social insurance.

[1] Today, Japan's three categories of health insurance are: 1. Society-Managed Health Insurance (*kumiai hoken*) covers the employees of large companies and consists of 1,800 insurance pools. 2. Government-Managed Health Insurance (*seifu kanshō*), which covers the employees of small companies and is a single pool administered at the national level. 3. National Health Insurance (*kokumin kenkō hoken*), which covers non-employees such as the self-employed and retirees. This insurance consists of roughly 3,200 insurance pools at the city, town, and village level.

[2] In 1941, the Workers Pension Insurance (*rōdōsha nenkin*) was introduced, and was extended to include employees in 1944. Accordingly, the name of the new system was changed to Employees Pension Insurance (*kōsei nenkin*).

3. Improvements in Social Security and the Beginning of a "Welfare Era"

Further improvements in the field of social welfare were achieved by passing the so-called "Six Welfare Acts"[3] of the 1960s, of which the Old Age Welfare Act (*Rōjin fukushi-hō*) was said to be the first specialized legislation of this kind in the world. Individual schemes were gradually expanded. For example, with the increasing proportion of gainfully employed women and the growing number of nuclear families, the need for day nurseries grew. As a result of this, local government bodies strove to build temporary facilities.

During the period of high economic growth in the 1960s the level of consumption rose considerably. At the same time, however, resultant problems attracted public attention: a poorly developed infrastructure, a polluted environment, and a still low level of social security. Subsequently, several measures were taken to protect the environment and improve public infrastructure. Restrictions on medical costs in the various health insurance schemes were removed, and the benefit level of public pensions and public assistance was raised several times during the 1960s. The financial means for these measures came from increased tax revenues facilitated by economic growth and increasing contributions from the insured.

However, in specific areas considerable financial problems remained. A typical example of this was the deficit of the Government-Managed Health Insurance, which in the 1960s, along with the Japanese State Railway and the rice management system, was one of the government's three "problem children" (also dubbed the "three K's": *kome* [rice], *kokutetsu* [State Railway], and *kenkō hoken* [health insurance]). Emergency measures were taken until the accumulated deficit was finally frozen at the end of fiscal year 1973, and the way was prepared for consolidating public finances through measures such as increasing contributions and setting fixed percentage rates for state subsidies.

1973 was dubbed "Year 1 of the welfare era" (*fukushi gannen*) because in that year the system of subsidies for health insurance schemes was introduced, which facilitated free medical treatment (without co-pay-

[3] The "Six Welfare Acts" include the "Public Assistance Act" (*Seikatsu hogo-hō*), the "Child Welfare Act" (*Jidō fukushi-hō*), the "Act on Social Welfare for the Physically Disabled" (*Shintai shōgaisha fukushi-hō*), the "Old Age Welfare Act" (*Rōjin fukushi-hō*), the "Act on Social Welfare for the Mentally Handicapped" (*Chiteki shōgaisha fukushi-hō*), and the "Act on Social Welfare for Mothers, Children and Widows" (*Boshi oyobi kafu fukushi-hō*).

ments) for people 70 years and older. In addition, a system was introduced to cover the costs of particularly expensive special treatments. At the same time, benefits for health and pension insurance subscribers were increased across the board. In pensions, a system of indexing benefits to wage and price increases was introduced, by which public pensions were intended to eventually become the main source of old age security.

Due to the aforementioned expansion of the social security system, the costs for social security benefits rose sharply from ¥ 389.3 billion (¥ 4,400 per capita) in 1955 to ¥ 11.76 trillion (¥ 105,100 per capita) in 1975 (KŌSEISHŌ DAIJIN KANBŌ TŌKEI CHŌSABU 1975: 239). State expenditure for social welfare also rose markedly in this period. Outlay for these costs in the 1955 financial year was slightly more than ¥ 10 billion and made up 10% of the government budget. In 1975 this figure was ¥ 3.92 trillion (KŌSEISHŌ DAIJIN KANBŌ TŌKEI CHŌSABU 1975: 239).

In 1970 the proportion of elderly people exceeded 7% of the general population. According to the definition of the United Nations Office, this constituted an aging society. In 1972 the novel *Kōkotsu no hito* ("An Entranced Person") was on the bestseller list for six months, selling 1.4 million copies. This book depicts the condition of senile dementia, but also highlights the concerns and hardships facing families looking after old people in need of care. It was through this book that the care of the elderly was first thrust into the public eye.

4. The Revision of the Social Security System from the Mid-1970s to the 1980s

In 1973, the year in which there was a substantial benefit increase in health and pensions insurances, the "oil crisis" began. This triggered a radical change in the national economy, which had been accustomed to low crude oil prices. The jump in crude oil prices led to "galloping" inflation with an almost 22% annual rate of increase in consumer prices for the 1974 fiscal year, and, with a resulting decline in corporate earnings, brought the period of high economic growth to an end. In 1974 negative growth in real terms (of minus 0.2%) was recorded for the first time since the Second World War. In contrast, social welfare benefits were increased in order to adjust the benefit levels of pensions, health insurance schemes, and the public assistance system to rising inflation. For example, in fiscal year 1974 the rates of compensation for medical treatments were increased by 36%; social assistance benefits rose by 20% (KŌSEISHŌ DAIJIN KANBŌ TŌKEI CHŌSABU 1975: 239). The result was a marked increase in social security costs.

Notwithstanding the increased demand from the national budget, the rise in tax revenue slowed down with the weak economy. The economic policy in operation intended to boost domestic demand, therefore resulted in a substantial public-sector expenditure increase. For this reason, in fiscal year 1975, public loans were raised for the first time in the supplementary budget. From then on there was a steady increase in public debts. In the budget for 1979, public debt had reached approximately 40%, the highest level to date. To remedy this situation, the "reorganization of the public sector" was initiated at the beginning of the 1980s, resulting in a limitation on spending from fiscal year 1983.

In 1980 the "Second Emergency Committee for Administrative Reform" (*Dai 2-kai Rinji Gyōsei Chōsakai*) was convened, in which serious discussions were held about possible public finance reforms. Based on the findings of this reform committee, expenditure was further reduced and rationalization measures were promoted; administrative structures and subsidy packages reviewed, and the three government-owned enterprises (including the State Railway) privatized. At the same time, the subsidy system of medical provision for the elderly and the insurance system for medical care were reviewed.

The oil crisis affected other industrial nations as it did Japan. Triggered by the increasing burden on the public sector from the social security system, accompanied by stagnating economic growth, rising unemployment, and the aging of the population, people spoke of a "crisis in the welfare state". In Europe and the United States, this led to a review of the social security systems, financial systems, and the administrative structure of the state. The policies implemented in Great Britain and the United States under the catchphrases of "Thatcherism" or "Reaganomics" were more about controlling the rate of increase in social security benefits and a partial review of programs than about broadly reducing social expenditure. In carrying out their revision, these countries also understood that adhering to a system of social security was imperative for the stability of public affairs. Within this context, the aim was to adjust to their respective financial problems. In the 1980s, the revision of various social security systems was also a factor in the structural reform of public finances; at the same time, the aim was to guarantee the necessary budgetary funds for social security payments.

The 1980s were a period of comprehensive reforms. They were necessary to adjust the social security system, which had expanded at a time of high economic growth, to the new situation of slow economic growth. Adjustment to the deteriorating status of public finances was also necessary. To remedy their poor condition, cuts were inevitable. Finally, adjustments also needed to be made to account for the aging population of the future.

Catchphrases typical of this time included "rationalization and enhancement of the effectiveness of costs for social security" (*shakai hoshōhiyō no tekiseika, kōritsuka*), "fair benefits and costs" (*kyūfu to futan no kōhei*), and "reorganization of public finances" (*zaisei chōsei*).

The Health Care for the Elderly Law (*Rōjin hoken-hō*), implemented in 1983, is a typical example of the reforms of that time. This bill added a small co-payment to what had been free medical care for the elderly, and introduced a system of cross-subsidization, from the employee health insurance to coverage for older people. Free medical care for the elderly, which had been introduced in 1973, had resulted in a drastic increase in treatment costs for senior citizens. Through the new system, the National Health Insurance, which was under particular strain because of the high proportion of senior citizens, was relieved of a huge financial burden.

Furthermore, as a result of a partial amendment to the Health Insurance Act in 1984, a co-payment of 10% of medical costs was introduced for the members of Society-Managed Health Insurances. Normal employees had previously faced becoming members of the National Health Insurance after retirement and accepting a reduction in benefits in the process, even if this resulted in a rationally untenable cost burden for those insured long-term with the National Health Insurance. However, with this reform, a new medical benefit system for pensioners was introduced.

In 1985, the public pension system was also restructured in order to integrate the various insurance schemes. The members of the Employees Pension Insurance and the mutual aid associations were, together with their spouses, integrated into the National Pension Insurance. Thus, the National Pension Insurance, which had hitherto only covered non-employees such as the self-employed, became what is referred to as a basic pension system for all citizens between 20 and 59. Even after various reforms, this system is still in operation today. The non-employed receive basic pension benefits only, whereas the members of the Employees Pension Insurance and the mutual aid associations receive basic benefits from the National Pension Insurance and remuneration-proportional benefits from their respective insurance schemes. A major outcome of the 1985 pension reform was also, for the first time, a considerable cut in benefit levels. Another important aspect of this reform was the introduction of a basic pension for spouses. Previously, this group had not had their own pension rights in case of divorce.

5. The Creation of a System Adjusted to the Aging Society (1990s)

Since the 1980s, finding a way to deal with the aging society has become a major issue. The drastic fall in the birth rate and the increase in average life expectancy has resulted in a rapid increase in the proportion of elderly people, to a level which will eventually be higher than in Europe and the United States. As a matter of fact, the proportion of senior citizens has doubled from 7% to 14% in less than 24 years (Kokuritsu Shakai Hoshō Jinkō Mondai Kenkyūjo 1999).[4] According to latest predictions, by 2050 one in three people will be 65 or older (Sōmuchō Tōkeikyoku 2000: 33). In the light of such rapid aging, and a simultaneous trend towards smaller families, the issue of care in old age has become the most serious concern for both senior citizens and the public in general. Nationally, a rapid increase in the number of senior citizens in need of care is predicted, from approximately 2 million in 1993 up to 3.9 million in 2010 (Sōmuchō Chōkan Kanbō 2000: 133).

In the 1990s, parallel with various responses to the problems of aging, a declining birth rate became apparent. The catchphrase "1.57 Shock" voiced the concern that, at 1.57 (children per woman) in 1989, the Total Fertility Rate was for the first time lower than in the year 1966, when it had reached 1.58,[5] the lowest value since the end of the war. Since the early 1990s the development of political programs to counter this trend has become an important political issue.

It is true that from the mid-1970s, birth rates showed a downward trend towards families with fewer than two children, but the demographic forecast predicted a return to the two-child family in the 1980s. However, since the time of the "1.57 Shock" a steady trend towards fewer children has been clearly visible, with the result that interest in and awareness of this phenomenon has been reinforced. Nevertheless, the birth rate has fallen steadily since then to 1.35 in 2000 (*Nihon Keizai Shinbun* 09.08.2001: 46). The proportion of the population under 15 years of age has fallen compared with the proportion of people 65 years and older and, at approximately 15% of the total population in 1998, has

[4] It took Sweden 85 years, Great Britain 46 years, and France 116 years to double their proportion of senior citizens (persons aged 65 years and older) from 7 to 14%. In Japan, however, the proportion was 7.1% in 1970; in 1994 it reached 14.1%. Thus, the proportion of senior citizens doubled within 24 years.

[5] It is widely held that the superstition associated with the year 1966 (it was a *hinoeuma* [fire horse] year according to the Chinese zodiacal chronology) found its expression in the low birth rate.

reached its lowest level to date. The demographic forecast of January 1997 predicted that the total Japanese population will reach its peak in 2007 and will steadily decline thereafter so that for the first time since the Meiji era, the trend will be towards a "society in demographic decline".

Whilst the proportion of payments by the social security system in the national economy constantly increased, after the burst of the "Bubble Economy" in the 1990s, a trend towards low growth became evident. From 1990 until 1999, the average annual growth rate of the GDP in real terms bottomed out at 1.2% (KEIZAI KIKAKUCHŌ 2000: appendix 14). Both the growth rate of wages and salaries as well as corporate earnings stagnated. In view of these circumstances, a sharper awareness of the charges associated with the welfare system among employers and employees was noticed. As a result of falling tax revenues and the implementation of a series of economic measures, public finances had become too dependent on government loans. Drawing up the social security budget became more difficult.

Therefore, adjustments to the social security system are constantly under way. An important example to mention first is dealing with the problem of care for the elderly. In view of the aging of society, in December 1989 a ten-year strategy to promote preventive medicine in old age ("The Gold Plan") was drawn up to expand the infrastructure of services in the field of preventive medicine for the elderly. The aim is to guarantee that one's golden years be healthy, worth living, active, and long. Accordingly, concrete objectives were formulated for home care services and institutional services. In the ten-year period from 1990 to 1999, implementation went ahead according to plan. In the interim period, in 1994, amendments were made to the plan and the objectives scaled up. Since 1995 work has been undertaken to implement the revised "Gold Plan".

In 1994 the expansion of a new care system began. After examination by a consultation committee and a one-year debate in Parliament, in December 1997 the Care Insurance Act (*Kaigo hoken-hō*) was passed. In December 1999 the Guardianship Act for Adults (*Seinen kōken-hō*) was passed to protect the recipients of care insurance services.[6] The revision of the care system and the systematic improvement of infrastructure have been promoted in order to meet the new demand for care which has arisen as a result of the declining number of children and the consequent aging of society. Important targets include an increase in the numbers of service recipients, an improvement in the quality of the services, an increase in home care and standardization of the range of services in health care, the selective expansion of municipal care administrations, an

[6] For details see ARAI (1999).

increased orientation towards recipients of services and finally, support for autonomy and private initiative.

In the field of pensions, the Japanese Diet passed a reform law in 1999, which came into effect in April 2000. The new policy that the government has adopted with regards to the public pension system strives to secure financial sustainability through a number of parametric reform measures, such as the curtailment of earnings-related benefits, an increase in the entitlement age, and changes in the system of indexing benefits. The 1999 reform package will slash current aggregate pension benefits by about 20% by fiscal year 2025 (*Nihon Keizai Shinbun* 22.03.2000: 1). The official reform strategy adopted by the government is designed to offset these benefit cuts in public pension schemes through the promotion of occupational pension plans. The government hopes that changes in the regulatory and financial framework, which came into effect in April 2002, will make the existing defined benefit occupational plans more attractive. Also, in October 2001, Japanese-style 401(k) defined contribution plans were introduced for the first time.

In health care, various adjustments, which are expected to come into effect sometime in the later part of 2002, are likely to increase patients' financial burden. For example, co-payments for members of the Society-Managed Health Insurances are likely to increase from their current 20% to 30% in future. The premiums for the Government-Managed Health Insurance for employees of small firms, and co-payments for wealthy elderly are also likely to be raised. At the same time, the national fee schedule (*shinryō hoshū*), which applies to all patients regardless of which health insurance system they belong to, is about to be lowered by about 2.7%, resulting in an additional burden to health care providers as well (*Nihon Keizai Shinbun* 18.12.2001: 5).

The structural reform of social security has been under way since the second half of the 1990s. However, in the structural deterioration experienced by public finances during the phase of lower economic growth after the collapse of the "Bubble Economy", the question of cost for state benefits, which increase annually by ¥ 3 billion and have exceeded ¥ 60 billion, is still a serious problem, which is likely to necessitate further adjustments in the coming years (Shakai Hoshō Seido Shingikai 1995).

5. Conclusion

I have attempted to gain an overview of the development of the social security system since the Second World War. Generally, until the beginning of the 1970s, the aim was to catch up with Western countries. The

main emphasis was on "poverty relief", on the "prevention of poverty", and on the "expansion of services". Since the end of the 1970s, in order to adjust to changing economic circumstances and ways of life, the emphasis has been on the planning of "fair services and costs" and the "creation of a system that is stable in the long term". At the same time, issues such as the review of the health and pension insurance system, the care insurance system, and the guardianship system for adults will receive constant attention in the coming years.

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Population Aging and Living Arrangements of the Elderly in Japan

Kojima Hiroshi

1. Introduction

The terms for aging (*kōreika*) and hyper-aging (*chō-kōreika*) have been popular in Japan for a couple of decades. After the "1.57 Shock" (the public sensation associated with the media coverage of the then record-low total fertility rate of 1.57 for 1989) in 1990, low fertility has suddenly become a public agenda. The term *shōshika* [trend toward less children] became popular after its first use in the *1992 White Paper on the National Life* (Keizai Kikakuchō 1992) and came to be often used side by side with *kōreika* by scholars, policy-makers, politicians, and business people as well as mass media.

At the same time, the measures to cope with the two interrelated demographic trends have become policy topics particularly because the changes in family structure and functions have made it difficult for families to keep supplying the care of the elderly and young children as they traditionally did without further support from the larger society. The so-called Gold Plan for the elderly and the Angel Plan for children were formulated several years ago. The new law for long-term care insurance was enacted in December 1997 and was implemented in April 2000. More effective support for child rearing has been debated within the government.

Japan's social policy has been criticized for its heavier reliance on the "traditional" family which gave most support for the care of the elderly, young children, and others. Today's intergenerationally extended households are also said to be a family-adaptive strategy in order to cope with the lack of social policy measures for the care of the elderly and young children as well as housing and income maintenance, in the light of higher labor force participation of married women in outside employment (Morgan and Hirosima 1983). However, the Japanese family seems to be overburdened now due to the changes in itself as well as its socio-economic environment.

One of the relatively unknown major changes, which has come to limit the capacity of the family to support the elderly, is the drastic change in the size and composition of sibship among current middle-age genera-

tions (which may be called "sibling configuration transition"), caused by the decline in both fertility and infant or child mortality in the immediate postwar period. The sibling configuration transition should have drastically changed the availability of parents to children for coresidence and support as well as the availability of children to parents because in Japan only one married child is expected to live with the parents and to give them major support. The social policy measures have to be strengthened in response to both the current and previous fertility and mortality decline to provide adequate care for young children and the elderly for the welfare and reproduction of the population.

This article describes the trends in population aging in Japan and its demographic determinants and consequences. It discusses the social policy implications of aging with special reference to the coresidence of elderly parents and adult children, particularly drawing on the results of multinomial logit analysis of the data from the 1989 National Household Survey conducted by the Institute of Population Problems (Jinkō Mondai Kenkyūjo) (currently, National Institute of Population and Social Security Research (Kokuritsu Shakai Hoshō Jinkō Mondai Kenkyūjo)). The first half of the article partly draws on KOJIMA (1995b: 197–203) and the second half partly draws on KOJIMA (1993: 1–5), while the projection figures and the analyzed data set are updated.

2. TRENDS IN POPULATION AGING

Japan's population, which was 84.1 million in 1950, has reached 126.9 million in 2000, making Japan the ninth most populous country in the world. The annual growth rate was about 3% during the immediate postwar period, but decreased to the order of 1% in the mid-1950s, and remained at this level through the mid-1970s. Then, it fell below 1% and has continued to decline further to the level around 0.2%. The slower growth of population is mainly due to the decline in fertility and mortality. Both declined rapidly in the immediate postwar period. Then, fertility stayed around the replacement level and declined further beginning in the mid-1970s. Mortality continued to fall further, particularly in the older age groups.

Table 1: **Trends in the age composition of the Japanese population, 1920–2100 (%)**

Year	Total (in thousands)	0–14	15–64	65+	65–74	75+
Enumerated						
1920	55,963	36.5	58.3	5.3	*3.9*	*1.3*
1930	64,450	36.6	58.7	4.8	*3.4*	*1.4*
1940	73,075	36.1	59.2	4.7	*3.5*	*1.2*
1950	84,115	35.4	59.6	4.9	*3.7*	*1.3*
1960	94,302	30.2	64.1	5.7	*4.0*	*1.7*
1965	99,209	25.7	68.0	6.3	*4.4*	*1.9*
1970	104,665	24.0	68.9	7.1	*4.9*	*2.1*
1975	111,940	24.3	67.7	7.9	*5.4*	*2.5*
1980	117,060	23.5	67.3	9.1	*6.0*	*3.1*
1985	121,049	21.5	68.2	10.3	*6.4*	*3.9*
1990	123,611	18.2	69.5	12.1	*7.2*	*4.8*
1995	125,570	15.8	69.4	14.5	*8.8*	*5.7*
2000	126,926	14.6	67.9	17.3	*10.2*	*7.1*
Projected						
2000	126,926	14.6	68.1	17.4	*10.3*	*7.1*
2005	127,708	13.9	66.2	19.9	*10.9*	*8.9*
2010	127,473	13.4	64.1	22.5	*11.7*	*10.8*
2015	126,266	12.8	61.2	26.0	*13.5*	*12.5*
2020	124,107	12.2	60.0	27.8	*13.6*	*14.2*
2025	121,136	11.6	59.7	28.7	*11.9*	*16.7*
2030	117,580	11.3	59.2	29.6	*11.7*	*17.8*
2040	109,338	11.1	58.0	30.9	*14.9*	*18.4*
2050	100,593	10.8	53.6	35.7	*14.2*	*21.5*
2060	91,593	10.7	53.5	35.8	*12.7*	*23.1*
2070	82,506	11.3	53.5	35.2	*13.2*	*22.0*
2080	74,931	11.9	53.6	34.5	*13.1*	*21.4*
2090	68,966	12.4	54.0	33.6	*12.5*	*21.1*
2100	64,137	13.1	54.3	32.5	*12.3*	*20.2*

Note: The figures are as of October 1 each year and include Okinawa.

Sources: KOKURITSU SHAKAI HOSHŌ JINKŌ MONDAI KENKYŪJO (2000, 2002); KŌREISHA KOYŌ KAIHATSU KYŌKAI (2001).

This led to a sharp decline in the proportion of the child population (aged 0–14) while that of the aged population (aged 65+) continued to rise, as

Table 1 shows. The share of the working-age population (aged 15–64) rose from 59.6% in 1950 to 68.9% in 1970, and has virtually leveled off at around 70% thereafter. On the one hand, the share of the child population, which was 35.4% in 1950, has dropped to 14.6% by 2000. On the other hand, the proportion of the aged population rose rapidly, from 4.9% in 1950 to 10.3% in 1985. The speed of aging has been accelerating since then, and in 2000 the share of the aged population has reached 17.3%. As a consequence, the median age of population increased by 19.3 years from 22.2 in 1950 to 41.5 in 2000 (see Table 2).

As Table 1 shows, the aged population is projected to increase further according to the new series of official population projections, which was published by the National Institute of Population and Social Security Research, Ministry of Health, Labor and Welfare in January 2002. According to the medium variant, the total population will increase continuously from 126.9 million in 2000 to 127.7 million in 2006 and decrease continuously thereafter to 126.9 million in 2013, 100.6 million in 2050, and 64.1 million in 2100. While both the child population and the working-age population will gradually decrease, the aged population will almost continuously increase from 22.0 million in 2000 to 36.5 million in 2043 before starting to gradually decrease. The median age of population will increase from 41.5 years in 2000 to 53.9 years in the late 2050s and the early 2060s and will then continue to decrease to 50.5 years around 2100 (see Table 2).

The population of Japan is expected to experience rapid aging not previously observed in the West. The proportion of the elderly among the total population will rise from 17.3% in 2000 to 28.7% around 2025, which will probably make Japan the most aged country in the world. It is projected to rise further to the highest level of 36.0% around 2054 before starting to decrease. Among the elderly, the proportion of "older old" population (aged 75 and over) is expected to dramatically increase from 7.1% in 2000 to over 16% in 2025. It is projected to reach the highest level of over 20% in the 2050s.

3. Demographic Determinants and Consequences of Aging

3.1 Demographic determinants

As mentioned above, the rapid aging of Japan's population has been led by the rapid decline in both fertility and mortality. After falling below the replacement level at 2.05 in 1974, the total fertility rate (TFR) went into steady decline and reached the record low level of 1.34 in 1999 (although it has slightly increased to 1.36 in 2000). This TFR decline is explained by the respective trends of its two components: the fertility rate among married

women and the proportion married among women. While the former has remained fairly constant until the mid-1990s, the latter has greatly declined.

In other words, the trend toward higher age at marriage and a higher proportion remaining never-married has greatly reduced the incidence of marriage among women in their twenties, and this may be regarded as the primary demographic determinant of the recent TFR decline and therefore of population aging. In fact, in 2000, the proportions never-married among women aged 25–29 and 30–34 (54.0% and 26.6% respectively) have more than doubled compared with those in 1975 (20.9% and 7.7%). It can also be noted that the mean age at first marriage among women rose constantly from 24.7 in 1975 to 27.0 in 2000.

Life expectancy at birth in 2000 has come to be 77.72 years for males and 84.60 years for females, longer than in any other country in the world. It has been lengthened by two years during the last decade. Recently, however, the total number of deaths is on the increase due to population aging which has increased the relative number of older persons with a higher mortality risk. At the same time, age-standardized mortality has been declining in the old age groups.

An examination of life expectancy trends in the light of age-specific death rates shows that it was the mortality decline among infants and children and among youth that made a great contribution to the lengthening during the early 1960s. Since the 1970s, however, mortality decline in the middle and old-age groups have been responsible for most of the lengthening. In recent years, there has been a particularly large mortality decline in the old age groups, which is promoting population aging (see also Lützeler in this volume). Life expectancy at birth is expected to reach around 79 years for males and 86.5 years for females around 2015.

3.2 Demographic consequences

One of the most direct demographic consequences of population aging is the increase in the age dependency ratios and the aged-child ratio (see Table 2), although some demographers regard them as indicators of aging itself. The total dependency ratio is the ratio of the combined child population (aged below 15) and aged population (aged 65+) to the working-age population aged 15–64 (per 100), while the child dependency ratio and the aged dependency ratio represent the ratio of each population group to the working-age population (per 100). As Table 2 reveals, the total dependency ratio, which was 67.7 in 1950, continued to fall until it attained the lowest level of 43.3 in 1991 and 1992. Since then, it has risen to 46.9 in 2000. It is projected that it will continue to rise and reach its first peak of 87.4 in 2054. It will then decline slightly before resuming its rise

to reach another peak of 86.9 at around 2071. It will then continue to decline to 84.0 in 2100.

Table 2: **Trends in mean age and economic dependency ratios, 1920–2100**

Year	Median age	Dependency ratio			Aged/ child	Non-active/ active
		Total	Child	Aged		
Enumerated						
1920	22.2	71.6	62.6	9.0	14.4	105.3
1930	21.8	70.5	62.4	8.1	13.0	117.6
1940	21.9	70.9	62.7	8.2	13.1	125.0
1950	22.2	67.7	59.4	8.3	13.9	133.5
1960	25.6	55.9	47.0	8.9	19.0	114.1
1965	27.4	47.1	37.9	9.2	24.4	106.9
1970	29.0	45.1	34.9	10.3	29.4	99.0
1975	30.6	47.6	35.9	11.7	32.6	110.3
1980	32.5	48.4	34.9	13.5	38.7	107.2
1985	35.2	46.7	31.6	15.1	47.9	103.0
1990	37.7	43.5	26.2	17.3	66.2	93.6
1995	39.7	43.9	23.0	20.9	91.2	88.4
2000	41.5	46.9	21.4	25.5	119.1	87.6
Projected						
2000	41.5	46.9	21.4	25.5	119.1	87.6
2005	42.9	51.0	21.0	30.0	143.2	86.2
2010	44.4	56.1	20.9	35.2	168.3	89.4
2015	46.1	63.4	21.0	42.4	202.3	92.4
2020	48.0	66.7	20.3	46.4	228.9	94.0
2025	49.8	67.5	19.5	48.0	246.5	95.4
2030	51.2	69.0	19.0	50.0	262.7	–
2040	52.9	79.3	19.7	59.6	302.3	–
2050	53.4	86.7	20.1	66.5	330.8	–
2060	53.9	87.0	20.0	66.9	333.7	–
2070	53.4	86.9	21.1	65.8	311.8	–
2080	52.5	86.6	22.2	64.4	290.8	–
2090	51.7	85.3	22.9	62.3	271.7	–
2100	50.5	84.0	24.1	59.9	248.0	–

Note: The figures are as of October 1 each year and include Okinawa.
Sources: KOKURITSU SHAKAI HOSHŌ JINKŌ MONDAI KENKYŪJO (2000, 2002); KŌREISHA KOYŌ KAIHATSU KYŌKAI (1997, 2001).

This fluctuation of the total dependency ratio reflects the fluctuation of both the child dependency ratio and the aged dependency ratio, although the movement of the aged dependency ratio may be considered more important. The child dependency ratio has kept decreasing from 59.4 in 1950 to 21.4 in 2000 and is projected to attain the lowest level of 18.9 around 2031 and to fluctuate mostly around 20 until around 2060 before starting to rise. The aged dependency ratio, which was 8.3 in 1950, has risen to 25.5 in 2000. The aged dependency ratio, which was 8.3 in 1950, rose to 25.5 in 2000. It is projected to increase steadily to 67.4 up until about 2054 before starting its decline to reach 59.9 in 2100.

The aged-child ratio is the ratio of the number of aged persons to the number of children (per 100), which simultaneously takes into account the numbers and changes at both ends of the age distribution. Its change is very dramatic, especially after 1970 when the proportion of the aged surpassed the 10% mark. It was only 13.9 in 1950 but has risen to 119.1 in 2000. It is projected to continue its rise to the highest level of 336.9 in 2055 before starting its decline to 248.0 in 2100.

In contrast to the total dependency ratio, which is a measure of demographic dependency or age composition, the economic dependency ratio is a measure of economic dependency. It is defined as the ratio of the economically inactive population to the active population over all ages (per 100). It was 133.5 in 1950 and decreased to 99.0 in 1970. However, it increased again to 110.3 in 1975. Then, it kept decreasing to 87.6 in 2000. It is projected to continue its decline to 86.2 in 2005 and to resume rising to 95.4 in 2025, which marks the last year in the projection made by the Employment Policy Research Committee (Ministry of Health, Labor and Welfare). It is expected to rise faster between 2005 and 2015 because it is based on previous population projections which assumed a lower speed of population aging than is forecasted now. It is also expected to rise after 2025 because this measure, at least partly, moves in parallel with the total dependency ratio.

Other demographic consequences include the changes in the sex ratio and marital status composition among older people. Since mortality is generally lower among females than males, females outnumber males among the elderly. The sex ratio (males per 100 females) of the aged population was 72.1 in 2000 and it decreased with age. It was 72.5 in 1950, 76.6 in 1960, 78.3 in 1970, 73.2 in 1980, 67.2 in 1990, and 69.8 in 1995. These changes do not seem to be systematic, but the change by age group generally shows a trend toward a lower sex ratio, especially in recent years.

There is a trend toward a higher proportion married among the elderly due to the mortality decline, especially among middle and old ages,

although the level is much higher for males due to their higher mortality and higher age at marriage. The proportion married was 64.6% among older males and 25.1% among older females in 1950, but it has increased to 83.1% and 45.5% respectively in 2000. Conversely, the proportion widowed has declined rapidly among males and "younger old" females (aged 65–74) due to the mortality decline. However, on the one hand, the decline is much slower among "older old" females (aged 75 and over) due to the sex differential in mortality and the larger age difference between spouses. On the other hand, the absolute number of "older old" widows increased rapidly from 0.58 million in 1950 to 3.91 million in 2000, while the male counterpart increased from 0.19 million to 0.63 million. There is a growing concern as to who will take care of those "older old" widows. Many of them have been taken care of in intergenerationally extended households, but the potential availability of kin to take care of them is said to be declining.

4. HOUSEHOLD CONTEXTS OF AGING

4.1 Intergenerational household extension of the elderly

While Japan has many individual demographic features in common with developed societies in the West, including low levels of fertility and mortality, it exhibits different developments in the area of family demography, which it seems to share more with newly industrializing and developing societies in the East. Given that Japan does not lag behind other developed societies in socioeconomic development, this suggests that family patterns do not necessarily change in the same direction with socioeconomic developments. It is even possible that some aspects of socioeconomic and demographic development may facilitate the realization of traditional family patterns that vary from society to society. The rapid change in sibling configuration among adults in Japan, as a result of fertility decline in the past, may be one of those aspects because of the normative pressure on the eldest children to live with older parents and support them.

In many parts of prewar Japan, the intergenerationally extended or stem family household was the normative living arrangement for the older parents and their eldest son. When parents did not have any sons, they often lived with their eldest daughter and son-in-law. Coresidence was generally continuous, or began again when the eldest child married or the parents retired, and normally ended with the death of parents. Living arrangements were closely related to the primogeniture custom which gave priority to males.

Table 3: **Trends in living arrangements of the elderly (aged 65+), 1960–2000 (%)**

Year	Total (in 1000)	Institutional households	Ordinary households				
			Subtotal	Relative extended	Couple only	Non-relative	1-Person
1960	5,398	1.1	93.8	86.8	7.0	0.2	4.3
1965	6,236	–	–	83.8	9.1	0.3	4.6
1970	7,393	2.2	90.3	78.7	11.6	0.2	5.8
1975	8,865	3.0	89.1	74.1	14.9	0.1	6.6
1980	10,647	3.6	87.8	69.8	18.1	0.1	8.3
1985	12,468	4.2	86.1	65.5	20.6	0.1	9.5
1990	14,895	4.3	84.6	60.5	24.1	0.1	10.9
1995	18,261	4.2	83.6	55.9	27.8	0.1	12.1
2000	22,005	4.7	81.4	50.5	30.9	0.2	13.8

Note: The figures are as of October 1 each year and include Okinawa from 1975 onward.

Source: Kokuritsu Shakai Hoshō Jinkō Mondai Kenkyūjo (2000); Sōmushō Tōkeikyoku (2001).

Although there has been a steady decline in the proportion of intergenerationally extended households in the postwar period, the majority of older persons aged 65 and above still live with their adult children (in the extended household), as Table 3 shows. The proportion of older persons in one-person and couple-only households is on the rise, but lower than in the West. The percentage of older persons in institutions is leveling off at a lower level. Moreover, the large majority of "older old" persons still live with a married child in the extended household (other relative households).

4.2 Economic and housing situations of elderly households

The coresidence of elderly parents and their adult children involves various economic and social factors. It may not necessarily represent one-sided help from either generation. Moreover, the motivations may be different between generations. Table 4 reveals the changes in the annual income of "aged households" and its composition. The average annual income has kept growing relatively fast during the past two decades, considering that the nominal wage in 1995 is 2.24 times as high as in 1975. This is mainly caused by the rapid growth in the amount of public pension while the amount of earned income has been relatively stable since the 1980s.

Table 4: **Annual income of aged households and its composition, 1975–1998 (%)**

Year	Total annual income		Earned income	Property income	Public pension	Other social security transfers	Remittance and others
	in ¥ 1,000	in %					
(old def.)							
1975	[1,147]	100.0	56.0	9.7	26.2	–	8.1
1980	[1,981]	100.0	44.2	7.8	40.3	2.2	5.6
1985	[2,393]	100.0	39.6	6.8	47.2	3.9	2.5
1990	[2,898]	100.0	30.4	9.2	54.8	2.1	3.5
1991	[3,053]	100.0	34.2	9.6	52.2	1.6	2.4
(new def.)							
1991	[2,737]	100.0	28.6	9.8	57.1	1.8	2.7
1992	[2,960]	100.0	30.5	8.9	57.0	1.2	2.4
1993	[2,928]	100.0	30.9	7.0	58.9	1.8	1.5
1994	[3,050]	100.0	27.8	7.2	60.5	1.4	3.0
1995	[3,169]	100.0	24.8	8.0	62.7	0.9	3.7
1996	[3,160]	100.0	26.6	6.0	62.5	1.0	3.9
1997	[3,231]	100.0	26.6	6.3	63.6	1.0	2.5
1998	[3,355]	100.0	23.3	8.0	64.5	1.2	3.1

Note: Old definition: "aged households" consisting of only one man aged 65 and above and/or one woman aged 60 and above, allowing for the addition of never-married persons aged under 18. New definition: "aged households" consisting of only one man aged 65 and above and/or one woman aged 65 and above, allowing for the addition of never-married persons aged under 18.

Source: KŌREISHA KOYŌ KAIHATSU KYŌKAI (2001).

The relative share of each income source has changed drastically during the two decades. On the one hand, the proportion of earned income has continued to decline from 56% in 1975 to 23.3% in 1998. On the other hand, public pension represented only 26% in 1975 but has grown rapidly to around one-half by the mid-1980s. Then, it has gradually increased to almost two thirds in 1998. The proportion of property income has hovered around 8% during the two decades while that of remittance and other income decreased from 8% in 1975 to 3% in 1985 and has remained around the same level. This may suggest that the transfer income from non-coresiding kin has become insignificant during the two decades while the transfer income from the government has grown fast.

However, the majority of the elderly lives with their adult children and possibly grandchildren. In such cases, the average household income and the proportion of earned income are much higher, which suggests that there should be much more intergenerational transfer in cash or kind within the same household, although the data are not available. It is also likely that the direction of transfer may not be always from adult children to elderly parents within the same household even at one time. Parents may be actually paying the larger share of the living expenses. They can give in-kind help to their children in terms of housework and child care. They often do not collect any rent from their children living in their house. It may be that a certain level of wealth of either generation is necessary for maintaining a larger house and expenditure, although it is also possible that the intergenerational household extension is a family-adaptive strategy among those who cannot afford separate housing.

Data on housing are available for households with persons aged 65 and above. In 2000, 83.9% of these households lived in owned housing, 9.1% in private rent housing, 0.4% in company housing, 5.8% in public housing, and 0.9% in rented rooms and other accommodations. The housing situation of elderly single-person households seems to be less favorable: 63.4% in owned housing, 22.4% in private rent housing, 0.5% in company housing, 11.3% in public housing, and 2.5% in rented rooms and other accommodation. In contrast, 95.2% of three-generation households are located in owned housing, which may suggest that an owned house (presumably a larger one) is almost a prerequisite for parent-child coresidence (Sōmushō Tōkeikyoku 2001).

5. Intergenerational Household Extension of Married Children with Older Mothers

5.1 Introductory remarks

This section analyzes the effects of wealth and housing (representing feasibility of coresidence) as well as sibling configuration (representing mainly availability of kin for coresidence) and geographic factors (representing availability, feasibility, and desirability) on the intergenerational household extension.

While the proportion of older persons in the extended household has decreased in the 1980s, the proportion of married males aged 20–39 in the extended household seems to have increased slightly (Hirosima 1987). The two trends may seem contradictory, but the prevalence of intergenerationally extended households can differ according to whether the unit of

observation is parents or married children. Similarly, the postwar fertility decline has had different effects on the potential availability of kin to live with for each generation because only one married child is expected to live with the parents. Considering the increasing number of "older old" widows and the decreasing potential source of their support due to the fertility decline, it was considered appropriate to analyze the determinants of married child's coresidence with an older mother.

5.2 Analytical framework

The following empirical analysis is based on an analytical framework for determinants of coresidence of married male household heads with older parents, particularly mother or mother-in-law who are more likely to survive their husbands due to their lower mortality and lower age at marriage. It is a modified version of the framework developed by KOJIMA (1989, 1990). The analysis is restricted to male household heads because female household heads tend to be unmarried, and unmarried heads are much more likely to live alone.

In the analytical framework, coresidence with either the male head's mother or his wife's mother (mother-in-law) is assumed to be determined by three intervening variables: the availability of kin for coresidence, the feasibility of coresidence, and the desirability of coresidence. Each of these three is, in turn, determined by a set of independent variables.

The availability of kin for coresidence is determined by the demographic characteristics of the head and his wife. These include the head's age (hypothesized to have a positive effect on coresidence) and the sibling configuration of the head and his wife represented by the sib size (a negative effect on coresidence with own mother) and the possession of four types of siblings including older brothers (for the wife only), older sisters, younger brothers, and younger sisters (a negative effect on coresidence with own mother). The availability is more strongly affected by the norm about the choice of kin to live with, which may be represented by the eldest-child status meaning the oldest among sons or the oldest daughter without brothers (a positive effect on coresidence with own mother).

The feasibility of coresidence is affected by economic and housing characteristics of the household. The economic situation is represented by monthly spending per person (hypothesized to have a positive effect on coresidence). Housing situation is represented by the number of rooms per person (a positive effect on coresidence) and home ownership (a positive effect). The desirability of coresidence is generally influenced by the norms and values concerning parent-child coresidence, inheritance

rules, and arrangements for home making and for the care of the elderly and young children. These factors indicate the strength of social, economic, and cultural alternatives to coresidence. In this study, they are represented by region and urban versus rural residence: a positive effect of residence in the Tōhoku area (with a higher prevalence of extended family households) and a negative effect of residence in Southern Kantō (Tōkyō Metropolitan Region) as well as Kyūshū (with a lower prevalence) on coresidence are hypothesized. Further, a negative effect of metropolitan/urban residence and a positive effect of rural residence are expected, although in part these variables also represent availability and feasibility. The list and frequency distribution of these independent variables are presented in the Appendix Table at the end of this article.

5.3 Determinants of coresidence

Table 5 shows the results of a multinomial logit analysis related to the data from the 1989 National Household Survey conducted by the then Institute of Population Problems, focusing on the effects of these independent variables on the coresidence of married male household heads with their mother or mother-in-law who are both alive and aged 60 and above, leaving about 700 cases. The dependent variable in this model is trichotomous: coresidence with the head's mother (18.6%), coresidence with the wife's mother (4.5%), and separate residence from either of them (76.9%). For easier interpretation, the results are presented in the form of relative odds instead of the original coefficients. The odds for the reference category of each variable is set at 1.00 and the relative odds for other categories are calculated as the exponentiated coefficients. The results of binomial logit analysis for each type of coresidence are also presented in the Appendix Table.

Table 5: **Determinants of coresidence of married couples with an older mother, Japan 1989**

Independent variables	Restricted model			Extended model		
	H's Mo. vs. Separate	W's Mo. vs. Separate	H's Mo. vs. W's Mo.	H's Mo. vs. Separate	W's Mo. vs. Separate	H's Mo. vs. W's Mo.
Husband's Age						
(15–39)	1.00	1.00	1.00	1.00	1.00	1.00
40–44	3.58**	1.08	3.31#	2.79*	0.76	3.67#
45–49	4.40***	1.26	3.49	3.86**	1.12	3.44
50+	9.13***	2.17	4.21	7.92***	1.23	6.43#
H's Eldest-Son Status						
eldest son	6.76***	0.52	13.06***	9.40***	0.67	14.09***
(non-eldest)	1.00	1.00	1.00	1.00	1.00	1.00
Husband's Sib Size						
1–2	1.12	0.47	2.37	0.93	0.39	2.37
(3–4)	1.00	1.00	1.00	1.00	1.00	1.00
5+	0.60	0.47	1.28	0.88	0.77	1.14
H's Older Sister						
existent	1.37	1.35	1.19	0.86	0.94	0.91
(non-existent)	1.00	1.00	1.00	1.00	1.00	1.00
H's Younger Brother						
existent	0.75	0.62	1.20	0.52#	0.46	1.11
(non-existent)	1.00	1.00	1.00	1.00	1.00	1.00
H's Younger Sister						
existent	0.76	2.11	0.36#	0.56	2.05	0.27#
(non-existent)	1.00	1.00	1.00	1.00	1.00	1.00
W's Eldest-D. Status						
eldest daughter	0.29*	1.12	0.26	0.15**	0.77	0.19
(non-eldest)	1.00	1.00	1.00	1.00	1.00	1.00
Wife's Sib Size						
1–2	0.66	1.56	0.42	0.51	1.26	0.40
(3–4)	1.00	1.00	1.00	1.00	1.00	1.00
5+	1.37	1.36	1.01	1.64	1.67	0.98
Wife's Older Brother						
existent	0.74	0.20#	3.68	0.65	0.15#	4.45
(non-existent)	1.00	1.00	1.00	1.00	1.00	1.00
Wife's Older Sister						
existent	0.80	0.40	1.98	0.73	0.36	2.02
(non-existent)	1.00	1.00	1.00	1.00	1.00	1.00
W's Younger Brother						
existent	0.70	0.10*	7.21#	0.39*	0.06**	6.70#
(non-existent)	1.00	1.00	1.00	1.00	1.00	1.00

Wife's Younger Sister						
existent	0.82	1.06	0.78	0.57	1.04	0.55
(non-existent)	1.00	1.00	1.00	1.00	1.00	1.00
Spending per Person						
high				0.25**	0.37	0.66
(medium)				1.00	1.00	1.00
low				1.23	2.51	0.49
Rooms per Person						
large				4.48**	6.78*	0.66
(medium)				1.00	1.00	1.00
small				1.01	0.13#	7.75
Home Ownership						
non-owner				0.06***	0.62	0.09*
(owner)				1.00	1.00	1.00
Region						
Tōhoku				1.16	3.94	0.29
Southern Kantō				0.33**	0.91	0.36
Kyūshū				0.56	5.07*	0.11*
(others)				1.00	1.00	1.00
Urban-Rural Resid.						
metropolitan				1.46	34.60**	0.04*
large cities				0.84	12.00*	0.07*
(other cities)				1.00	1.00	1.00
rural				2.38*	14.94*	0.16

Note: ***: p<0.001; **: p<0.01; *: p<0.05; # p<0.10 (levels of significance). Reference categories are in parentheses.

Source: Data Tape from the *1989 National Household Survey*, Jinkō Mondai Kenkyū-jo.

The first three columns of Table 5 show the results of a restricted model with demographic variables only. The first column presents the effect of each variable or category on the odds of coresidence with the head's mother, relative to separate residence. The household head is more likely to live with his own mother as he gets older, probably because she becomes older and less healthy. As expected, the head who is an eldest son is almost seven times as likely as non-eldest sons to live with his mother relative to living separately from either mothers. He is less likely to live with his mother when his wife is the eldest daughter (without brothers), as expected.

The second column shows the effect on the odds of coresidence of the household head with his wife's mother, relative to separate residence. He is much less likely to live with her when his wife has either older brothers or younger brothers than otherwise, which is also as expected. A negative

effect is larger for having younger brothers, possibly because they are more likely to be never-married and stay home long after the wife's marriage.

The third column presents the effect on the odds of coresidence with his own mother, relative to coresidence with his wife's mother. He is more likely to live with his own mother compared to living with his mother-in-law when he is aged 40–44, which may or may not be related to the fact that his wife is more likely to be born during the prime years of the postwar baby boom (the late 1940s). He is, as expected, also much more likely to live with his own mother when he is an eldest son or when his wife has younger brothers, while he is less likely when he has younger sisters, which may indicate a new tendency among older parents, i.e., to seek care and support from their own daughter rather than a daughter-in-law and a corresponding tendency among their children's generation.

Columns four to six of Table 5 show the results of an extended model including socioeconomic and geographic variables. The effects of demographic variables are largely similar even after the inclusion of these variables, suggesting that demographic variables have relatively independent effects on coresidence behavior. However, there are also some effects that become significant or larger. The household head's age comes to have a clearly positive effect on the odds of coresidence with his own mother, relative to coresidence with his wife's mother, probably because the head's mother who tends to be older than the wife's mother becomes older. The positive effect of the head's eldest-son status and the negative effect of the wife's eldest-daughter status on the odds of coresidence with the head's mother, relative to separate residence, become much larger, which may be considered natural. Both the head's possession of younger brothers and the wife's possession of younger brothers come to have a significantly negative effect on the odds of coresidence with the head's mother relative to separate residence. The negative effect of the husband's possession of younger brothers is probably caused by their tendency to be never-married and stay home, which should discourage coresidence of the head's couple. The negative effect of the wife's possession of younger brothers, however, is somewhat difficult to interpret. Perhaps this is also related to the above-mentioned new tendency among older parents to seek care and support from their own daughter rather than a daughter-in-law and a corresponding tendency among their children's generation.

The effects of socioeconomic and geographic variables are only partly as expected. A better economic situation seems to discourage coresidence with the wife's mother, relative to separate residence, which is contrary to the hypothesis. Probably the spending per person represents a result rather than a determinant of household structure. A larger housing unit

tends to encourage coresidence with the head's mother and the wife's mother and a smaller one tends to discourage coresidence with the wife's mother as expected, but this may also be due to the reversed causation. Home ownership tends to encourage coresidence with the head's mother relative to both separate residence and coresidence with the wife's mother, as expected.

Contrary to the hypothesis, living in the Tōhoku area does not have any significant effects, and living in Kyūshū encourages coresidence with the wife's mother, which may be related to the traditional custom of inheritance by the eldest daughter found in some areas of this southwestern part of Japan. Living in Southern Kantō, however, tends to discourage coresidence with the head's mother, relative to separate residence, as expected. It also comes as no surprise that living in rural areas encourages both coresidence with the head's mother and coresidence with the wife's mother, relative to separate residence. Unexpectedly, however, living in metropolitan areas and large cities also encourages coresidence with the wife's mother, relative to both separate residence and coresidence with the husband's mother, which may reflect either the housing shortage in these areas or more readily available child care from the wife's own mother when the wife works by commuting long distances. If this is the case, social policy measures related to housing and child care should be strengthened in metropolitan and larger urban areas.

5.4 Determinants of coresidence plans

Table 6 shows the results of an analysis focusing on determinants of the household head's future coresidence plans, using the same sets of independent variables and the same restrictions for case selection. The dependent variable in this analysis is also a trichotomous one: plan to live with the head's mother (31.1%), plan to live with the wife's mother (7.3%), and plan to live separately from either of them (61.6%). Compared with Table 5 showing the results for current coresidence, similarities as well as differences can be detected. The effects of age are similar but less pronounced, possibly because of an uncertainty about the survival of parents and the heads themselves.

Table 6: **Determinants of coresidence plans of married couples with an older mother, Japan 1989**

Independent variables	Restricted model			Extended model		
	H's Mo. vs. Separate	W's Mo. vs. Separate	H's Mo. vs. W's Mo.	H's Mo. vs. Separate	W's Mo. vs. Separate	H's Mo. vs. W's Mo.
Husband's Age						
(15–39)	1.00	1.00	1.00	1.00	1.00	1.00
40–44	1.64	1.91	0.86	1.36	1.71	0.80
45–49	2.42*	1.57	1.54	2.11#	1.38	1.53
50+	3.34**	1.71	1.96	2.65*	0.92	2.89
H's Eldest-Son Status						
eldest son	10.99***	0.44	24.76***	12.51***	0.61	20.38***
(non-eldest)	1.00	1.00	1.00	1.00	1.00	1.00
Husband's Sib Size						
1–2	1.22	1.10	1.12	1.07	0.78	1.38
(3–4)	1.00	1.00	1.00	1.00	1.00	1.00
5+	0.52#	0.55	0.94	0.47*	0.74	0.64
H's Older Sister						
existent	1.82*	2.04	0.89	1.76#	1.61	1.09
(non-existent)	1.00	1.00	1.00	1.00	1.00	1.00
H's Younger Brother						
existent	0.67	0.54	1.24	0.68	0.42#	1.62
(non-existent)	1.00	1.00	1.00	1.00	1.00	1.00
H's Younger Sister						
existent	0.59#	1.48	0.40#	0.54	1.21	0.45
(non-existent)	1.00	1.00	1.00	1.00	1.00	1.00
W's Eldest-D. Status						
eldest daughter	0.45	1.63	0.28	0.28*	1.10	0.26
(non-eldest)	1.00	1.00	1.00	1.00	1.00	1.00
Wife's Sib Size						
1–2	0.49#	1.35	0.37	0.52	1.04	0.51
(3–4)	1.00	1.00	1.00	1.00	1.00	1.00
5+	1.76#	1.51	1.17	1.98#	1.38	1.44
Wife's Older Brother						
existent	0.84	0.25*	3.38#	0.85	0.21*	4.12#
(non-existent)	1.00	1.00	1.00	1.00	1.00	1.00
Wife's Older Sister						
existent	0.74	0.66	1.13	0.84	0.63	1.33
(non-existent)	1.00	1.00	1.00	1.00	1.00	1.00
W's Younger Brother						
existent	0.68	0.23*	2.96	0.61	0.20*	3.10
(non-existent)	1.00	1.00	1.00	1.00	1.00	1.00

Wife's Younger Sister						
existent	0.86	0.78	1.10	0.76	0.69	1.10
(non-existent)	1.00	1.00	1.00	1.00	1.00	1.00
Spending per Person						
high				0.76	0.60	1.26
(medium)				1.00	1.00	1.00
low				3.29**	3.22#	1.02
Rooms per Person						
large				2.91*	9.07**	0.32
(medium)				1.00	1.00	1.00
small				2.06#	0.57	3.63
Home Ownership						
non-owner				0.23***	0.34	0.66
(owner)				1.00	1.00	1.00
Region						
Tōhoku				0.71	1.84	0.39
Southern Kantō				0.71	1.96	0.36#
Kyūshū				0.74	3.94#	0.19*
(others)				1.00	1.00	1.00
Urban-Rural Resid.						
metropolitan				1.56	5.05*	0.31
large cities				2.34**	6.40**	0.36
(other cities)				1.00	1.00	1.00
rural				2.55*	2.34	1.09

Note: ***: p<0.001; **: p<0.01; *: p<0.05; # p<0.10 (levels of significance). Reference categories are in parentheses.

Source: Data Tape from the *1989 National Household Survey,* Jinkō Mondai Kenkyūjo.

The effects of eldest-son status seem to be more pronounced. Presumably, those eldest sons who are currently living separately from their mothers have plans to live with her in the future. Further, significant effects of sib size become apparent: the household head from a larger family is less likely to plan to live with his mother, and a wife from a larger family is more likely to plan to live with his mother as expected from the results for current coresidence. Obviously, there are some household heads who postpone living with their mothers. On the one hand, the head's possession of older sisters comes to have a positive effect and that of younger sisters comes to have a negative effect on the odds of planning to live with his mother, relative to planning to live separately, of which the latter may also be an indication of the new tendency mentioned above. On the other hand, the head's possession of younger brothers comes to have a negative effect on the odds of planning to live with the wife's mother, relative to planning to live separately, which is somewhat difficult to interpret.

The effects of socioeconomic and geographic variables on coresidence plans are largely similar to those on current coresidence. However, there are two notable exceptions. A smaller number of rooms per person comes to have a positive effect on planning to live with the head's mother, relative to planning to live separately, which may suggest that some heads living in a small housing unit either plan to move to a larger house for coresidence in the future or to the parents' house. Living in large cities comes to have the same effect, which may be explained in the same way. Anyway, the results suggest the difficulties in finding a suitable housing unit for intergenerational household extension, especially in large cites. Therefore, social policy interventions regarding housing in large cities are to be anticipated.

6. Policy Implications and Conclusion

The effects of the household head's eldest-son status and the wife's eldest-daughter status as well as the possession of brothers on current and future coresidence suggest that the primogeniture custom is still alive in contemporary Japan: The eldest children are more likely than the non-eldest to live with their parents, possibly for old-age support in exchange for a larger share of inheritance. The sib size of either spouse does not have any significant effects on current coresidence, possibly because its effect is potential as shown by its significant effects on coresidence plans. A negative effect of the head's possession of younger sisters on the odds of coresidence with his mother relative to the wife's mother suggests that crowding in terms of gender roles in the household discourages the coresidence of her sister-in-law on the one hand. But, on the other hand, it may be an indication of a new tendency for older mothers to seek care and support from their own daughter rather than a daughter-in-law particularly because the negative effect is clearer for coresidence plans.

The positive effects of the eldest-child status on the odds of current and future coresidence with own parents are much larger than the effects of most other sibling configuration variables in terms of the absolute size of coefficients. The effects of the wife's possession of younger brothers is also large. If these tendencies will remain stable, fertility decline, which has caused population aging as well as the sibling configuration transition, may not necessarily decrease the potential availability of old-age care and support by adult children to parents through coresidence, since it will increase the proportion of eldest children in younger generations while it will decrease the average sib size.

However, if the observed trend among older parents to seek care and support from their own daughter rather than a daughter-in-law and a corresponding tendency among their children's generation becomes predominant, it can lead to intragenerational and intergenerational conflicts in some cases and a lack of care and support for the elderly in others. On the one hand, when eldest sons are no longer designated as the primary care-takers or inheritors of their parents, children may compete for the care of rich parents in exchange for a larger share of inheritance resulting in conflicts between children and parents with different preferences. On the other hand, there may be competition arising among children to avoid caring for poor parents without assets to inherit. In either case, social policy interventions may be called for. However, all these social policy measures, including those supporting child rearing, should be integrated into one comprehensive family policy for intergenerational support and societal reproduction.

In addition, some Western demographers including HÖHN (1988) suggest that the impact of indirect policies on fertility, i.e., social policies, is much stronger than that of population policies designed explicitly to affect fertility. If this is the case, a comprehensive family policy for intergenerational support and societal reproduction may have favorable effects even on fertility, thus easing demographic and other constraints imposed on the family.

A comprehensive family policy should be based on a group of principles. They include intergenerational solidarity and gender equity which may be universal as underlying principles (KOJIMA 1994, 1995b), but their surface representation as policy measures may be modified by the specific demographic, social, economic, and cultural contexts found in each society. Modifications fit for Japan may have policy relevance to other countries in East or Southeast Asia and possibly those in the West.

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Appendix Table: **Frequency distributions and determinants of coresidence with each mother**

Independent variables	FREQUENCIES (%)	H's Mother vs. Other Types	W's Mother vs. Other Types
Husband's Age			
(15–39)	23.9	1.00	1.00
40–44	29.9	3.40**	0.90
45–49	20.8	4.83***	1.26
50+	25.4	9.33***	1.88
H's Eldest-Son Status			
eldest son	50.9	9.37***	0.37*
(non-eldest)	49.1	1.00	1.00
Husband's Sib Size			
1–2	22.7	1.17	0.92
(3–4)	42.5	1.00	1.00
5+	34.8	0.65	0.57
H's Older Sister			
existent	48.1	1.03	1.69
(non-existent)	51.9	1.00	1.00
H's Younger Brother			
existent	48.1	0.59	0.84
(non-existent)	51.9	1.00	1.00
H's Younger Sister			
existent	46.3	0.63	1.36
(non-existent)	53.7	1.00	1.00
W's Eldest-D. Status			
eldest daughter	14.0	0.16**	3.15
(non-eldest)	86.0	1.00	1.00
Wife's Sib Size			
1–2	25.4	0.34*	0.96
(3–4)	45.1	1.00	1.00
5+	29.5	0.61	1.29
Wife's Older Brother			
existent	42.8	0.69	0.39
(non-existent)	57.2	1.00	1.00
Wife's Older Sister			
existent	46.2	0.71	0.66
(non-existent)	53.8	1.00	1.00
W's Younger Brother			
existent	49.0	0.47*	0.38
(non-existent)	51.0	1.00	1.00

Wife's Younger Sister			
existent	41.6	0.55#	0.91
(non-existent)	58.4	1.00	1.00
Spending per Person			
high	16.9	0.26**	0.48
(medium)	70.1	1.00	1.00
low	13.0	1.13	1.43
Rooms per Person			
large	12.2	4.07***	3.33*
(medium)	69.5	1.00	1.00
small	18.3	1.11	0.24
Home Ownership			
non-owner	23.1	0.06***	0.71
(owner)	76.9	1.00	1.00
Region			
Tōhoku	7.7	2.40#	6.06**
Southern Kantō	28.7	0.31**	0.76
Kyūshū	11.4	0.57	2.93#
(others)	52.2	1.00	1.00
Urban-Rural Resid.			
metropolitan	14.4	1.48	11.09**
large cities	35.2	0.66	3.37#
(other cities)	30.7	1.00	1.00
rural	19.7	2.21*	4.26*

Note: ***: p<0.001; **: p<0.01; *: p<0.05; # p<0.10 (levels of significance). Reference categories are in parentheses.

Source: Data Tape from the *1989 National Household Survey*, Jinkō Mondai Kenkyūjo.

The Aging Process in Germany and Implications for a Needs-Oriented Social Policy

Karin Veith

1. Introduction

The implications of aging reach far beyond the increase in the absolute number and proportion of elderly people living within a society. The aging population is highly relevant to the functioning of the German social security system, which provides the main financial basis for a needs-oriented social policy. It calls for further improvements in social policy and must take into consideration the quantitative and qualitative dimensions of aging, as well as the level of old-age welfare a society is aiming for and is able to afford.

Thus, in order to properly analyze the topic of this article, three different aspects have to be considered:

I. What are the quantitative and qualitative proportions of aging in Germany?
II. What resources do elderly people have at their disposal to organize their lives? What do they need?
III. What consequences for social policy can be deduced from this? What is necessary, and where are the limits?

Before starting with the analysis, it may be helpful for the non-German reader to briefly outline the so-called pillars of the German social security system which are relevant for the topic. These are a) the public pension scheme, b) health and accident insurances, c) long-term care insurance, and d) payments according to the *Bundessozialhilfegesetz* or BSHG (Federal Social Assistance Act).

The amount of benefits from the *pension scheme* depends on the income level as well as on the number of years spent in gainful employment. Married women – apart from their own pension scheme – receive payments depending on their husbands' contributions. The pensions of the elderly are currently being financed by the contributions made by the employed population, and are based on the assumption that future generations in employment will provide enough contributions for their own pensions ("pay-as-you-go system"). From this, it becomes clear that the proportion between the number of people employed and the number of

retirees is very important, and, thus, must be taken into consideration by social policy-makers.

Health and accident insurance as well as the recently implemented *long-term care insurance* are financed by the entire economically active population. While the percentage of incomes (wages or pensions) paid to long-term care insurance is fixed by law at 1.7%, the percentage paid for health insurance differs; it is partly dependent on the insurance company's offer and partly determined by the composition of the insured. However, benefits from long-term care insurance have an upper limit. Those not able to pay the remaining sum are automatically covered by special security supplements under the BSHG which are provided by municipal authorities.

2. The Quantitative and Qualitative Proportions of Aging in Germany

The German *Bundesforschungsanstalt für Landeskunde und Raumordnung* (BfLR) (Federal Research Institute for Regional Geography and Regional Planning)[1] regularly collects regionalized data and calculates ratios which are considered important for the assessment of future needs in social infrastructure as well as for the amount of funds necessary to finance the pillars of the security system, especially the public pension scheme. For instance, the share of the population aged 60 years and older is an important indicator when estimating the ratio of people who are entitled to benefits from the public pension scheme. The proportion of the "older elderly" population aged 80 years and over helps to estimate the ratio of people who may potentially need help by family members, friends, and/or professional caregivers. The proportion of the female population aged between 45 and 75 years provides us with clues about the ratio of people who usually take care of elderly people. Finally, the percentage of the population aged 20 to 60 years shows the ratio of people who are economically active, and, thus, the main contributors to the funds of the social security system.

At least with regard to the period from 1995 to 2010, population trends do not follow spectacular courses. However, it becomes obvious that the proportion of elderly people aged 60 and older is rising more or less constantly from around 21 to 25%. On the one hand, Germany's constant-

[1] Since January 1998, the institute forms a section of the newly created *Bundesamt für Bauwesen und Raumordnung* (Federal Office for Building and Regional Planning).

ly low birth rate can be cited as the main cause for this. There was, on the other hand, a short-term decline in the proportion of people aged 80 and over at the end of the 1990s which was brought about by the "baby bust" during the First World War as well as the casualties incurred by the Second World War. Thus, the share of the "older elderly" will not exceed 5% until 2010. The data also show that disparities between regions of different levels of urbanization are diminishing. While in the 1990s it was still the core cities of conurbations which displayed the largest extent of population aging in Germany, in 2010 only slight differences will remain. This is due to the fact that, on the one hand, regional differences in fertility, still markedly higher in rural areas, are on the decline. On the other hand, however, working-age immigrants, who tend to find jobs and accommodation in cities, lessen the relative increase of elderly people in urbanized regions.

In contrast to the proportion of people who potentially need help and care, the share of people in the "care-giving age group" of 45–75 years will remain quite stable at around 35 to 40% of the total population. It should be stressed, however, that it is not only the number or proportion of people which influences the availability of caregivers. Wealth and social values also strongly affect quality and quantity of help and care that the younger generation provides to the older generation. To date, caring for the elderly is nearly exclusively done by women, but, as rising female employment participation rates show, many women may no longer be willing to put aside their own careers and perform full-time care services for their aged relatives (Veith and Bucher 1994: 223). Taking this into account, it can be assumed that the ratio between the availability of caregivers and the potential number of people who need help and care will deteriorate. Nevertheless, about 80% of all support given is still provided in private households.

Even more problematic is the fact that the proportion of the population which is at the age of contributing to the social security system is on a slow but constant decline. This signifies that the financial burden per capita will rise if the social security system's structure is not altered or if the benefits are not reduced. During recent years this demographic trend was further aggravated by high levels of unemployment, and experts expect this trend to continue in the future.

Proportional data, however, do not always give a correct impression about trends in absolute numbers. Table 1 shows the change in the absolute number of people aged 65 and over in need of care and/or support as outlined in the above-mentioned regions for the years 2000 and 2010, respectively. For calculating these figures, projection results on demographic change were multiplied with the results of a survey on the

proportion of people who need help and care by age groups. As a result, a tremendous increase in absolute numbers can be seen. This clearly shows that there will be an enormous additional need for services and material infrastructure designed for the elderly. In particular, the municipal authorities who are mainly responsible for the provision of social infrastructure will have to raise enormous funds to satisfy this demand.

Table 1: **Change in the absolute number of people aged 65 years and over in need of care and support, 1991–2010**

People aged 65+ in need of	Type of region	1991	2000	2010	1991–2000 (in%)	2000–2010 (in%)
care and support	1	779,265	865,239	983,445	11	14
	2	1,073,037	1,267,301	1,588,482	18	25
	3	461,225	535,584	659,292	16	23
care	1	276,468	318,967	361,099	15	13
	2	277,755	455,464	574,758	21	26
	3	162,088	192,019	239,299	18	25
support	1	502,797	546,272	622,346	9	14
	2	695,282	811,837	1,013,724	17	25
	3	299,137	343,565	419,993	15	22

Note: 1 = core cities; 2 = other urbanized areas; 3 = rural areas.
Source: BMFuS 1993; internal BfLR data and population projections 1991–2010/ROP; own calculations.

With regard to regional differences, the following further conclusions can be drawn (see VEITH and BUCHER 1994: 216, 219, 222): Overall, the increase in the number of disabled elderly will be higher in rural than in urban areas. Within the latter group, a process of local deconcentration of elderly people is expected, i.e., the absolute numbers of aged citizens will increase mainly in suburban "other urbanized areas" and not in core cities. In all areas, the potential availability of private persons nursing the elderly increases at a slower rate than the number of elderly people needing care and support. However, on closer examination it appears that while this ratio is most unfavorable in core cities at the moment, in 2010 it will be rural areas that are worse off. The ratio of people in employment to those in retirement will also change and its consequences have to be considered with regard to the funding of the German social security system.

3. The Material Situation of the Aged and their Needs

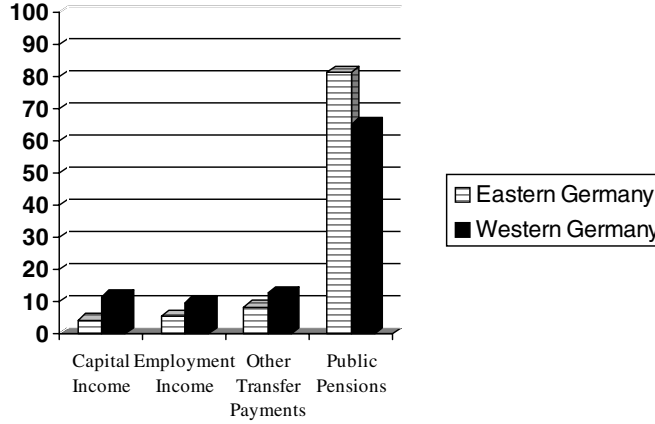
In order to understand how elderly people organize their lives, it is crucial to know what resources they possess and what their requirements are. Income and property are of fundamental importance, but the quality of housing, social contacts, the capacity to master their own lives, and the availability of social services must be considered, too.

3.1 The economic situation

When we view the economic situation of aged people, it is useful to distinguish between different types of income, i.e., public pension and occupational pension benefits, capital income, rental earnings, and benefits from long-term care insurance.

As a whole, the level of public pension benefits depends on the level of wages earned in the past and the amount of time spent in gainful employment of a person's life. As a result of the economic prosperity enjoyed throughout the 1960s, 1970s, and partly the 1980s in Germany, nearly all those who retired during the last 20 years are in a financially comfortable situation.

Figure 1: **Income structure of two-person pensioner households, 1993 (%)**



Source: BMFSFuJ (2001: 194).

From the mid-1980s to the mid-1990s, the gap between the income of employees and those of retired people has shrunk, though only to a slight degree. With regard to one-person households, the pensioners' income rose from 85 to 87% of the employees' income, whereas the corresponding figures for two-person households are 74% and 78%, respectively (*iwd* 1994: 3). As Figure 1 indicates, during the mid-1990s, 65.2% of the household income of a two-person pensioner household in western Germany was covered by public pensions, 11.7% by capital income, 9.9% by income from continued employment, and 12.9% stemmed from other kinds of transfer payments (BMFSFuJ 2001: 194).

In general, regional variations in the economic situation of retired people are not very distinct, while marital status and gender have a greater discriminatory power.

In East Germany, public pension income constitutes an even larger share of the overall household income of the elderly. One reason for this is that – corresponding to a somewhat higher status of women in former East German society – most women were in continuous employment and therefore now have their own, well-doted pensions.

Projections for East Germany suggest that the proportion of capital income will become more important in the future. There are several reasons for this: Given the fact that the ratio between the generations has taken an unfavorable direction, a general reduction of benefits from the public pension scheme is unavoidable. Furthermore, rising unemployment and a growing number of jobs in the informal sector will promote a polarization of pensioners' income levels. Elderly people from low-income groups and/or elderly people who are divorced and do not have capital incomes at their disposal, will become increasingly disadvantaged. From a regional point of view, the situation for the elderly will deteriorate in regions or municipalities with high levels of unemployment. The situation will not change for aged people in need of help and care who can afford it, but for those who depend on long-term care insurance and on municipal BSHG benefits, a future reduction in income levels seems highly probable.

3.2 Housing conditions

Research results tell us that people want to live by themselves for as long as possible. To be the owner of one's own apartment and/or to enjoy good housing conditions are factors which enhance the possibility of realizing this desire. The following Table 2 gives a general idea of the housing situation for the whole population and for the population aged 60 years and older.

Table 2: **Projected change in the housing situation of all households and elderly households, basic indicators 1993–2010**

Indicator	Region	All households		Elderly households	
		1993	2010	1993	2010
sqm dwelling space/person	West	37.8	42.3	50.1	59.0
	East	29.5	39.4	40.5	44.5
sqm dwelling space	West	88.1	93.9	80.8	91.5
	East	70.1	84.3	61.2	68.7
facilities (bathroom/toilet/central heating) in %	West	81.7	–	77.0	–
	East	54.1	–	41.6	–
rent level (in DM)	West	652	–	545	–
	East	333	–	283	–
rent proportion (% of income)	West	21.1	–	23.0	–
	East	12.7	–	15.9	–
proportion of owner-occupiers	West	41.8	45.0	43.8	52.5
	East	26.1	34.2	24.0	30.0

Source: Statistisches Bundesamt 1993; Bucher, Kocks and Siedhoff 1996.

By comparing elderly households with all households, it becomes evident that in general – apart from the facilities within apartments – the aged are much better off. They enjoy more space, pay less rent, and a large proportion owns the apartments or houses they live in. A partial explanation for is that elderly people tend to remain in the home where they raised their children. Several reasons can be cited here: They are accustomed to their apartment, a new one would be more expensive, and very often it would be necessary to leave the area, which would mean that they would lose their existing social contacts (Bucher, Kocks and Siedhoff 1996).

A comparison between elderly households in the eastern and western part of Germany further reveals that the situation – except for rent levels – is more favorable in the West. By 2010, the overall situation is expected to improve, but the gap between the two parts of the country will broaden further.

When we evaluate the housing situation of people who require care, it is advisable to focus on the quality of their housing conditions. Quality has a considerable impact on how long a person can live in his/her own apartment, how much help is required, and how expensive this additional help may cost. Survey results, which relate to the period immediately after reunification, reveal clear differences between the western and eastern parts of Germany regarding the standard of facilities (BMFuS 1993: 146). However, during the 1990s the housing situation of elderly people living in eastern Germany has improved markedly. The percentage of

people aged 65 years and older who live in apartments with their own bathroom, toilet as well as central heating has risen from 74% (1988) to 94% (1998) in western Germany, and from 33% (1990) to 85% (1998) in eastern Germany (BMFSFUJ 2001: 245–246).

It is important to bear in mind that home help services and day-care centers can only work efficiently, and thus be financed adequately, if the quality of housing is sufficient. In general, the situation is quite good in the western part of Germany. In the former eastern part, the situation has undergone rapid changes, but further improvements are needed, especially in rural areas.

3.3 The social network, care network, and social infrastructure

Apart from the economic and housing situation, social contacts are very important for coping with everyday life, especially when care and help is required. Today, alongside advances made in medical technology and increases in life expectancy, the number of elderly who are bedridden has risen considerably. Thus, more elderly people than ever before require help that continues over an extended period of time and which is highly intensive. On the other hand, many of them have no other choice but to live alone. This applies especially to elderly females. Data show that in 1993 more than 50% of women aged 65 years and older lived in one-person households, in contrast to only about 15% of aged men. It is expected that this huge difference will continue to exist at least until 2010 (see BMFUS 1994). One main reason for this is the lower life expectancy of males combined with the lower age at which females marry.

The average size of households, however, is not necessarily an adequate indicator for the level of integration into social networks. First of all, it gives no information on the spatial distance to family members and friends. Moreover, it provides no indication of how many social contacts people have and how intense these relationships are. Survey results show that most elderly people in Germany actually want to live by themselves and not with their children. They are accustomed to their independence and are not willing to relinquish it. To be sure, most elderly people remain in close contact with their children, and they are given their support when they require it. When we examine the age group of elderly people aged 80 years and older, at the outset of the 1990s a total of 67% of them were still cared for by their children or children-in-law (BMFUS 1993: 129). Nevertheless, it has been determined that the pattern of private care networks is changing as a result of regional mobility. Very often care networks, which play an important role for the dependent elderly population, are supplemented by professional caregivers (SCHUBERT 1994: 236). The tradi-

tional attitudes that employing professional help is something shameful or that elderly people are not accustomed to using care services no longer apply. Today, professional care services are not only socially accepted, but elderly people also better understand how to use them. In general, professional help is available and the qualitative levels of long-term nursing care or institutional care, home help services and day-care centers are not poor. However, further efforts will be necessary to improve supply levels, especially in rural areas.

In addition, there are signs for a further polarization in the quality of social services. The financial basis for social services is provided by payments from health insurance, long-term care insurance, and by the users themselves as well as from subsidies from the municipalities and the German *Länder* [federal states]. Depending on the economic situation of the users, the quality level of social services received might become quite variable. Moreover, the economic situation of the *Länder* and the municipalities might become unbalanced, leading to regionally different levels of services for the aged.

4. The Consequences for Social Policy – Demands and Limits

It has already been pointed out that elderly people wish to live by themselves for as long as possible. Presently, most of them are in a very good position to do so because of sufficient resources. Economic and housing situations are both quite satisfactory. Moreover, the possibility to organize everyday life with the help of professional elderly-oriented services has increased; it is no longer a stigma not to be cared for by relatives or children. Finally, the level of social services – long-term nursing care or institutional care, home help services and day-care centers – is both quantitatively and qualitatively of a high standard. In sum, the financial situation, housing conditions, and facilities are all favorable for elderly people to continue living at home. Future trends, however, point towards a growing polarization in the economic situation of both private households and the (local) public sector. Thus, the situation will not remain favorable for everybody.

In short this means the following: The changing ratio between the employed and the older, dependent generations as well as the expected developments on the labor market – continued high unemployment and a growing informal sector – will induce a reduction not only in public pensions, but also in the amount of funds available for long-term care insurance and health insurance. Hence, fewer resources will be left for professional care services per person.

Regarding the public sector, recent changes in the economic system (i.e., the process of economic transformation and globalization) will broaden the gap between rich and poor regions. Since the level of elderly-oriented social infrastructure largely depends on the wealth at the municipal level, the "place of residence" might become an increasingly important factor for the elderly who can no longer live by themselves. On the whole, however, a reduction in infrastructure levels is to be expected in all regions.

During the next 10 to 20 years, the situation will still be favorable for most elderly people due to the long-lasting period of economic prosperity up until the 1980s (LANG 1994). In addition to public pensions, quite often they receive benefits from occupational pension schemes, capital income, and rental earnings. Many are thus able to compensate for cuts made in the social security system and the reduction of subsidies from the public sector. Those, however, who depend solely on the public pension scheme will experience a marked deterioration in their quality of life.

Social policy must keep in mind the demographic and economic developments which I have outlined in this article: 1) the changing ratio between the employed population currently aged between 20 to 60 years and the dependent elderly and 2) a growing polarization in the economic situation of both private households and the public sector. It is my contention that, on the one hand, social policy will have no choice but to reduce the qualitative level of social services. By doing this, fair solutions have to be found. On the other hand, social policy will have to concentrate support on the real poor and on those regions, which will probably decline as a result of economic transformation and globalization processes. As a result, the existing German practice of sharing the financial burdens of the different *Länder* and municipalities will have to be reconsidered and adjusted to the new economic situation.

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3. Long-Term Care and Pension Insurance Systems: A Comparison

The Politics of Japan's Long-Term Care Insurance System

Paul Talcott

1. Introduction: The New Long-Term Care Insurance System

In December 1997, the Japanese Diet approved the Long-Term Care Insurance Law, setting in motion what was hoped to be an integration of medical care, nursing care, and welfare services for the elderly. By April 2001, the system had operated for twelve months, and the results were promising, but not yet as complete as intended. Significant barriers to implementation of the original program goals, particularly the division between welfare service organizations, local governments, and medical care providers, and the division of responsibility between local governments and the central government, had not been resolved as much as hoped. Some users could not find enough service providers to use all the services they had been authorized to use. Nevertheless, the new system succeeded in three areas: it created a unified system for home care and facility care for all people over 40 years old with diseases associated with aging, it financed the system with a mix of premiums and public subsidy, it gave more discretion to users in selecting services than in previous programs.

Given the record budget deficits and enormous debt of the central government in the late 1990s, the introduction of such large, new program without budget caps in an era of administrative restructuring and fiscal restraint came as something of a surprise.[1] Under the circumstances, it represented a victory of sorts for Ministry of Health and Welfare[2] planners who had been working on the predecessors of the program since as early as 1989. Final decisions about the shape of the program depended also on coordination between several different configurations of ruling coalitions, particularly the Liberal Democratic/Social Democratic/Sakigake coalition in 1997 when the Long-Term Care Insurance Law passed the Diet, and the Liberal Democratic/Kōmei/Liberal coalition just before

[1] Local government budgets had previously set an upper ceiling on spending for long-term care for the elderly (Ikegami 1997: 1311).

[2] On January 6, 2001, the ministry was merged with the Ministry of Labor in the new Ministry of Health, Labor and Welfare (*Kōsei Rōdōshō*).

implementation in December 1999. Eventually the political benefits of the program outweighed the fiscal costs, but political influence at the last moment threatens to make the system much more expensive than anticipated.

This article discusses Japan's long-term care insurance (LTCI) system (*kaigo hoken*), beginning with the issues it was designed to address and the population (primarily the elderly) whom it is intended to benefit.[3] After outlining the laws establishing the system, and the political process by which original plans shifted at the last minute, it turns to the kinds of benefits and services available, as well as subsidies for service providers. Next it looks at the users, what they pay, and how many users fit in each category of benefits by the end of 2000. Then it turns to financing issues, including where the money goes, and where it comes from. Finally, it addresses recent reforms of the system, and the likely direction for subsequent policy development. At each stage, the system is characterized as an appeal for votes from the elderly, rather than as a compromise to deal with the problems of the aging society.

2. Profile of Japan's Elderly Population[4]

The problems of how to care for the elderly in Japan's rapidly aging society have been raised since throughout the postwar era of Japan's health policy, even as early as 1955 when the Ministry of Health and Welfare was developing plans for universal health insurance (Kokumin Kenkō Hoken 50-nen Shi Henshū Iinkai 1995: 50). Japan's population is aging more rapidly than that of any other country. Although it is not entirely clear that the aging society brings only problems – issues of crowding, high land prices, and unemployment may be somewhat alleviated, particularly in crowded urban areas[5] – the problems of financing existing levels of health care and welfare services without either redesigning systems or developing new sources of funding, or both, cannot be easily ignored.

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[3] For an analysis of expectations about the system after its initial trial period but before implementation, see Ikegami and Campbell (2000: 26–39).

[4] Portions of this section are drawn from Paul Talcott: "Background Paper on Health Care for the Elderly in the United States and Japan", in: Calhoun, Michael (ed.): *The Silver Market: New Opportunities in a Graying Japan and the United States*. New York: Japan Society (forthcoming).

[5] The advantages of a declining population, such as cheaper land and more leisure time, are emphasized by Fujimasa and Furukawa (2000).

2.1 Growing share of elderly and the "older elderly" in Japan's population

Between 1970 and 1994, the proportion of people 65 years old and older rose from 7% to 14% of Japan's population (Kokuritsu Shakai Hoshō Jinkō Mondai Kenkyūjo 1999).[6] In the year 2000, the share of the elderly population is estimated to be 17.34%. The "older elderly" in Japan (people 75 years old or older) are increasing at a faster rate. Between 1980 and 1998 the proportion of these people rose from 3.1% to 6.4% of the population. By 2000 the ratio to the total population was projected to rise to 7.1%. By 2025, the "older elderly" will outnumber the "younger elderly" (between 65 and 74 years old) by 15.6% to 11.8%, and will rise to 18.8% of the population by 2050 (Sōmuchō Chōkan Kanbō 2000: 2).[7] Unless immigration or employment opportunities for women and the elderly expand dramatically, the working age population supporting the elderly in Japan will shrink, just as the number of "older elderly" will reach an unprecedented level. As the next section and discussion of expected system users will make clear, the "older elderly" are the ultimate target of the long-term care insurance system.

2.2 Health status and long-term care[8]

When the long-term care insurance system was designed, the initial number of elderly in the system was estimated to be around 2.8 million, with roughly half of these requiring full-time care due to being completely bedridden. By 2010, numbers are expected to rise to 3.9 million, but the number of bedridden elderly will be reduced to less than half of the total. Based on population data presented above, these figures represent about 15% of the population over 64 in both years. For long-term care, the "older elderly" are the largest group. Of the population requiring long-term care, 85% are 75 years of age and older. Of the people under 80 years old, only 20% are expected to require care (Sōmuchō Chōkan Kanbō 2000: 133). By contrast, far fewer people under 65 years old are expected to require long-term care for diseases associated with aging. Estimates made in 1996 for the fifteen designated diseases associated with aging eligible for LTCI payments were only 140,000 people nationwide.[9]

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[6] Other figures for Japan in this section are also drawn from these projections.

[7] Original data are from Sōmuchō (for 1980: National Census; for 1998: official population projections) and from Kokuritsu Shakai Hoshō Jinkō Mondai Kenkyūjo (projections for 2000 and beyond).

[8] For a comprehensive look at the social aspects of caring for the elderly, see Long (2000).

[9] Sum of estimated cases in analysis of Miura Kōji (2000: 384), former director of the Long-term Care Insurance Planning Section, Ministry of Health and Welfare.

In Japan, the seven most frequent conditions for inpatient treatment for the elderly were cerebrovascular conditions, cancer, heart disease (other than hypertension), fractures, schizophrenia, diabetes, and hypertension. For outpatient treatment, the number of visits is highest for hypertension, osteoporosis, cerebrovascular conditions, heart disease (other than hypertension), arthritis, cataracts, and diabetes (Kōseishō 1999). Medical facilities have developed under the medical insurance system to provide both inpatient and outpatient care, but medical treatment is not the only component of the system. The medical system, particularly hospitals, but also clinics with beds, have long provided long-term institutional care at a much lower cost to the elderly than welfare facilities for the elderly owned by local governments. Part of the reason for developing the long-term care insurance system was to reduce use of the medical system for long-term hospitalization, a process called "social hospitalization" (*shakaiteki nyūin*) by the Ministry of Health and Welfare. The cost of this kind of long-term hospitalization was estimated to reach ¥ 1 trillion by 1995, or nearly one-eighth of all medical spending for the elderly (Watanabe 1997: 20–21).

In surveys about their future health status, the elderly in Japan, particularly those living without younger family members (as an elderly couple or by themselves), are quite apprehensive. A *Yomiuri Shinbun* (28.09.2000: 2) survey in September 2000 found that 70% of the elderly had some fear about their future situation, and 54% were worried about their own health or that of their spouse. Yet the elderly also had a certain level of satisfaction with the health care system in general. A 1994 poll of all citizens showed that people 60 and older had the highest level of satisfaction with the way the health care system helped protect them from high medical costs. People 60 years or older were also the most satisfied in general with the health care system (Kōseishō 1995: 10). Some changes in costs for the elderly in the new LTCI system may reduce satisfaction with the costs of care. Home nursing care users in particular, have found the new system to be less satisfactory than the medical insurance system. Under the old system of medical insurance, these visits were basically free after a certain per-month co-payment (¥ 2,200 per month in 1999), but with LTCI, users have to pay 10% of the charges for each visit. Although it is difficult to assess overall satisfaction of users of the new system, since national surveys of satisfaction with the system will not be conducted until June 2001 by the Ministry of Health, Labor and Welfare, a survey of local governments in March 2001 found that 48% of localities felt that the burden for families had increased under the new system (*Yomiuri Shinbun* 03.04.2001: 18). At the same time that dissatisfaction may be rising among the elderly, it is

important to remember that the prior cost was quite low for many services including long-term hospitalization. Still, the costs for low-income elderly and those in remote areas can be expected to rise under the new system.

Although problems with quality, access to advanced technology, and high costs for low-income elderly remain serious, the elderly in Japan find themselves in a decent position relative to younger generations. This reflects the universality of coverage and high public support for public insurance for the elderly. High costs are more of a problem for middle-aged people than for the elderly in Japan: people between 45 and 55 years old pay much larger insurance contributions than do the elderly, because pay is tied tightly to both age and seniority, and insurance contributions for most working people are based on income.

2.3 Elderly income and housing

The social burden of paying for medical care and welfare services for the elderly arises in part because incomes fall after retirement, and health costs are likely to rise. Housing is also an important component in the costs of caring for the elderly. The increased reliance on facilities in the long-term care insurance system reflects shifts in both the life expectancy of the elderly and also the larger number of elderly living independently. Many elderly in Japan live with their children, although not as many as is commonly thought. Despite the common image of multi-generation housing, fully half of the six million elderly households in Japan consist of elderly living alone or as a married couple (*Nikkei Net* 17.05.2001).

Median household income for people aged 65 or older is not that different from that of the active labor force: ¥ 2.07 million per person, or ¥ 3.23 million per household. Total household income is much lower than the figure for all households, which was ¥ 6.57 million, but since non-elderly households are larger (2.95 people compared to 1.56 for elderly households) the average income per household member is nearly the same: ¥ 2.23 million per person (Kōseishō Daijin Kanbō Tōkei Jōhōbu 1999). 64% of income for the elderly came from public pensions, and an average of 27% from other labor-based income. Returns on financial assets provided only 6% of income for the elderly, reflecting interest rates below 1% on fixed-term savings. The relative affluence of the elderly in Japan, on average, has produced calls by the most recent blue-ribbon commission of experts consulted by the Prime Minister on the future of the social security system to rethink the current policy of not collecting premiums for the health services system for the elderly (*Nikkei Net*

25.03.2001). Still, 60% of the elderly rely entirely on pensions and other public support for their income.[10]

Changing family situations also created a sense of urgency for developing a long-term care insurance system. By 2000, the number of households headed by people 65 years or older was estimated to be 10,956,000. By 2002, only 25% of elderly households are estimated to include children; 30% were living alone, and 33% were living as a married couple without children or other relatives (Sōmuchō Chōkan Kanbō 2000: 33).[11] This means that fewer caregivers are available in the family. What has not changed much since 1970 is the percentage of the population over 65 who lived in some institutional setting: 4.5 in 1970, 4.5 in 2000. Of these, 37% were in special welfare facilities for the elderly, 22% were in health facilities for the elderly, and 41% were in ordinary hospitals (Sōmuchō Chōkan Kanbō 2000: 90).[12] Part of the goal of the LTCI system is to reduce reliance on facility-based care, but with multi-generational families becoming less prevalent, the emphasis is on self-reliance as much as on daughters (or sons) as caregivers.

3. Laws and Structure of System Operation

Preparation for the LTCI system began as a bundle of subsidies for facilities and services for the elderly to be provided by local governments and non-governmental organizations. The subsidy component to build new services began life as the Gold Plan in 1989,[13] while the benefits and financing components began to be deliberated by a working group within the Ministry of Health and Welfare excluding non-bureaucrats, in 1994. Final approval came from an advisory council on social security and a new advisory council to review policies for the elderly, the Old Age Health and Welfare Advisory Council (Rōjin Hoken Fukushi Shingikai). But by the time participation broadened to include political parties, the main outlines of the system had become fixed, in part through informal consultations, but in part according to options drawn up by bureaucrats

[10] Results of a survey by the Ministry of Health, Labor and Welfare, reported in *Nikkei Net* (17.05.2001).

[11] Original data are from Kokuritsu Shakai Hoshō Jinkō Mondai Kenkyūjo (1998): *Nihon no setaisū no shōrai suikei (zenkoku suikei)* [The Future Shape of the Number of Households in Japan (Projections for All Japan)].

[12] Original data from Ministry of Health and Welfare.

[13] The origins of the Gold Plan are analyzed in detail in Campbell (1992: chapter 9).

alone.[14] The political process that followed is summarized in this section, and is remarkable for the level of intervention by politicians after the basic outlines seemed to have already been fixed in place. In an era of shifting coalitions, competing reform programs, and intense factional conflict within the Liberal Democratic Party (LDP), long-term care insurance has become one of the tools for appealing to supporters, particularly the elderly.

3.1 Kaigo hoken *Law*[15]

The Japanese Diet established the long-term care insurance system when the Upper House passed the Long-Term Care Insurance Law (*Kaigo hoken-hō*) on December 9, 1997. Beneficiaries of the system were defined in Article 9 to be people 65 years old and older (Type 1) or older than 40 but younger than 65 years old (Type 2). As a social insurance system, Type 1 and Type 2 beneficiaries both pay insurance contributions. Article 3 placed responsibility for operation of the system with local governments: cities, towns, villages, and the wards of Tōkyō.

3.2 Implementation laws and ordinances

As with many laws in Japan, the statutory basis for the LTCI system and its implementation were stipulated in a basic law and an implementation law. The implementation law (*Kaigo hoken shikō-hō*) set out the scope of matters to be stipulated without further review by the Ministry of Health and Welfare in ordinances (*shōrei*). These ordinances established eligibility criteria, placed the funding for the system in the special budget accounts (*tokubetsu kaikei*), set up an oversight committee, and set out other details of system operation. Final regulations for implementation (*Kaigo hoken shikō-rei*) issued on March 31, 1999, and eligibility criteria were further established by ministry ordinance on April 30, 1999.

Although the long-term care insurance system was met with some complaints about such matters as the disparities in availability of service, insufficient payments for services, the principle of taking insurance contributions from pensions, and rising costs, even the citizen groups formed as watchdogs early in the process of developing the system expressed

[14] The definitive study of the steps before LTCI was developed into legislation is Nihon Ishikai Sōgō Seisaku Kenkyū Kikō (1997).

[15] A useful summary of the implications of these laws, along with the text of important provisions, can be found in the *Shakai hoken techō* [Handbook of Social Insurance] (2000).

satisfaction with how smoothly the system was introduced.[16] In the aftermath of implementing the system in April 2000, as before, partisan politics has not played too much of a role in the development of the long-term care insurance system, at least not in terms of one party advocating policies entirely different from another. Even issues on which coalition partners could not agree were pushed off into the future in the form of expected reforms of all social security systems by 2005.

At the same time, partisan disagreement over benefits did occur when the system was being planned, and over funding when implementation was being debated (Ikegami and Campbell 2000: 30–31). Complicating the introduction of the LTCI was the condition that coalition governments have changed three times since the passage of the original LTCI bill in December 1997. Only one of the parties remains in its original form: the Liberal Democratic Party. The coalition partners at the time of initial long-term care insurance legislations, have either disappeared (the Shintō Sakigake [Pioneer] Party) or been reduced significantly through defections to other parties (the Social Democratic Party of Japan; SDPJ). The next coalition government after passage of the long-term care insurance bill formed in October 1998, and along with the Liberal Democratic Party (LDP) which had been in power alone until 1993, and in various coalitions since June 1994, included the Kōmei Party and the Liberal Party, both of which had been part of the opposition Shinshin [New Frontier] Party until its dissolution in December 1997. The Liberal Party left the coalition in April 2000, just after implementation of the long-term care insurance system began, but some of its members resigned and formed a new party, the Conservative Party (Hoshutō) which remained in the coalition.

At each stage, influence on legislation at late stages by politicians reflected not so much long-held policy differences between the different coalition partners, but rather the impending elections for the Upper House in July 1998 and for the Lower House in September 2000, and the changing tactics of the Liberal Democratic Party to reach out to elderly voters. Finally, it was not only coalition governments but also the opposition which had some role in formulating long-term care insurance. In April 1997, at the same time as health insurance reforms were discussed by the ruling coalition and the newly-formed Democratic Party (Minshutō), a four-party agreement was also reached about the content of the Long-Term Care Insurance Law, before the bill was introduced into the Diet.

[16] See the evaluation of the new system by the founder of the "Ten Thousand Citizens' Committee to Realize a Public Long-term Care System ", Ikeda Shozō, in *Banbū* (June 2000: 39–41).

3.3 Delays in passage of Kaigo hoken *Law between introduction in November 1996 and passage in December 1997*

Coalition politics slowed the introduction of the Long-Term Care Insurance Law, but politics within the LDP also played a role in the delay. In spring 1996, when the LDP in coalition with the Social Democratic Party and the Sakigake Party first discussed introducing the long-term care insurance bill into the Diet, disagreement between the LDP and its coalition partners led to the bill's introduction being delayed. The Social Democrats and Sakigake urged quick introduction, and Prime Minister Hashimoto Ryūtarō initially agreed, but Cabinet Secretary Kajiyama Seiroku pointed out that there was no possibility to introduce the bill in the regular session which ended in June, citing voices within the LDP who were not yet satisfied with the vague commitment to new spending without first determining the actual level of burden the public was expected to bear. This illustrates the process of policy-making even within the coalition: first the LDP needed to complete its internal policy review, and only then it would consult with its minor coalition partners.

The first time the LTCI bill was introduced into the Lower House was in November 1996. Unfortunately just after its introduction, a period of scandal paralyzed the Ministry of Health and Welfare: the vice-minister was found to have accepted gifts from a nursing home contractor who received subsidies designed to speed the facilities to be used in the long-term care insurance system, and legislative coordination became problematic under the circumstances. After the LDP/SDPJ/Sakigake coalition initially agreed in April with the Democratic Party to pass the law only after all necessary revision had been made, deliberation continued during the regular Diet Session in spring 1997.

The final review of the bill by the Lower House Committee on Welfare finished in May 1997. Minister of Health and Welfare Koizumi Jun'ichirō (who became Prime Minister in April 2001) delayed introduction of the long-term care insurance bill due to the hotly-debated Organ Transplantation Law that also had to clear the same committee in the regular Diet Session in spring 1997 (*Nikkei Shinbun* 01.04.1997: 2). By this time the LDP and its coalition partners had agreed on the form of the initial law, which would leave much of the details of implementation to the implementation law (discussed below). The Democratic Party, formed in January 1997, opposed strongly a clause that would allow certain local governments that had difficulty developing services for homehelpers to delay implementation of the system, and delay collecting premiums, for a period of up to five years, and even longer if a Cabinet order (not requiring parliamentary approval) could be obtained. The Democratic Party also hoped

to include citizen participation on local government commissions charged with planning and operating local administration of the system. In addition, the Shinshin Party opposed the social insurance system entirely, as well as co-payments for long-term care services. Even the LDP coalition partner, the Social Democrats, looked favorably on revisions to the burden on users. Another complication for the Long-Term Care Insurance Law in June 1997 was the subsequent plan to introduce a bill revising the health insurance system immediately after the LTCI Law, and any delays to the LTCI bill near the June 18 finish of the Diet Session would complicate efforts to raise new revenue to finance the health insurance system (*Nikkei Shinbun* 04.05.1997: 23). Timing mattered as much as the contents of the legislation. The health insurance bill was scheduled to go into discussion in the Upper House Social Affairs Committee on May 23. As a result, on May 22, 1997, the Lower House passed the LTCI bill, with minor revisions (*Nikkei Shinbun* 27.05.1997: 5). Agreement on the health insurance system reforms could not be reached in time for the end of the regular Diet Session, and thus action on the LTCI bill in the Upper House was delayed until the fall (*Asahi Shinbun* 03.12.1997: 1). Final approval came in December 1997 after minor revisions in the Upper House.

3.4 Changes to the LTCI system after passage of the law

The most important changes to the LTCI system came without formal revision of the law or the implementation law. Rather, they came as budget items in a supplementary budget in November 1999 (Gekkan Kaigo Hoken Henshūbu 2000: 18). Once again, the internal politics of the LDP as much as coalition politics brought the impetus for change. The most sweeping changes came with the new partnership between the Liberal Democratic, Kōmei, and Liberal parties that formed a coalition in November 1998. Just before the system was due to be implemented, the LDP, with an eye on upcoming elections proposed the suspension of insurance contributions for the elderly for six months, and a further twelve months of only 50% of the planned contribution for the elderly. They also added a new kind of benefit discarded during the first round of deliberations: cash payments to caregivers under certain, limited circumstances. In late October 1999, the coalition agreed to the proposal, with additional provisions suggested by Kōmei, such as reducing co-payments for low-income seniors for homehelpers.

To finance the suspended premiums, the coalition decided to rely on new public debt. Estimated cost of the suspended premiums for people 65 years old and older reached ¥ 400 billion for the first six months, and a total of ¥ 1.6 trillion for the eighteen month period, which represents over

one-third of all premium revenue anticipated in that period (*Asahi Shinbun* 29.10.1999: 2). The motive for suspending premiums was best captured by an anonymous Liberal Party official: "If we hold a general election right after imposing a new tax on people, it will only help the Communist Party" (*Asahi Shinbun* 30.10.1999: 2). LDP Policy Affairs Council Chairman Kamei Shizuka explained the deal by referring to the lack of an absolute majority of the LDP alone (*Asahi Shinbun* 28.10.1999: 1). New coalition partners brought new dimensions to policies planned by previous coalitions. Other issues, such as another generation of the Gold Plan, a "Super Gold Plan", were easier to agree to, since all parties were interested in expanding the facilities available to use under the new insurance, as well as the subsidies to build them (*Asahi Shinbun* 29.10. 1999: 2).

The new shift was also not without controversy even within the LDP. Deputy Policy Affairs Chief Sakurai Shin and other members of the Social Policy Committee of the LDP criticized Kamei's plans as risking public criticism for increasing social security costs (*Japan Times Online* 27.10.1999). The Minister of Health and Welfare, Niwa Yūya, expressed sharp opposition in public to plans to add cash benefits as an option instead of purely services (*Asahi Shinbun* 23.10.1999: 6). Even though he had served in party office as Assistant Chairman of the powerful Policy Affairs Research Committee in July, which had originally proposed a three-year period of reduced premiums, his position was more protective of the consensus in the ministry (*Asahi Shinbun* 26.10.1999: 2). Niwa's objections demonstrate how electoral concerns did not characterize all political leaders in health care policy. Nevertheless, electoral strategy did dominate the final LDP push for additional benefits on the eve of implementation.[17] Subsidies for the reduced burden on the elderly came through supplementary budget, financed by new debt.

This reliance on public debt to pay for growing health care costs fits into an overall pattern of spending in the hopes of restarting the economy. Since the bubble burst, revenues had stagnated, and by 1999, debt issuance financed 40% of total government spending. At the same time, tax revenue actually fell as a result of tax cut packages (*Asahi Shinbun* 09.11.1999: 13).[18] Coalition leaders brought about expensive policies not only to refloat the economy but also to win votes particularly from elderly voters, regardless of the potential cost for future generations. In long-term care insurance, therefore, the subsidies created a reliance on debt for

[17] On the dominance of electoral factors in other health care reforms, see Talcott (2001).

[18] The ratio of debt to revenue was calculated by Ministry of Finance.

current expenditures on health care, with purposes somewhat different from public spending designed to restart the economy by increasing demand.

3.5 Structure of system operation

Cities, towns, villages, and the metropolitan wards of Tōkyō administer the long-term care insurance system. This paragraph will refer to them as local governments.

Since local governments have varying sizes and administrative capacities, the law also allows new wide-area multi-governmental cooperation organizations (*kōiki rengō*) to administer the system for a number of local governments. And as in the community-based National Health Insurance system (*kokumin kenkō hoken*), payment processing is handled not by the local government but rather by the prefectural association for processing long-term care insurance payments.

Services can be provided by municipal governments directly, by service providers operated by non-profit organizations, or by private sector businesses. In the old welfare system for the elderly, services had to be provided directly by government service providers, and not all local governments could provide all services. Although voluntary non-profit groups do provide some services, especially in suburban areas, most of the non-profit organizations providing long-term care services are run by long-standing social welfare program organizations (*shakai fukushi jigyōdan*), as well as medical corporations (*iryō hōjin*) and other forms of medical service providers who create new divisions to provide services authorized by the long-term care insurance system.

Private sector businesses include special corporations such as Comsn set up entirely to provide long-term care after the insurance system was announced, new divisions of existing care providers, and new entrants into both medical care and personal care, such as Secom, a home-security business, and Nichii Gakken. These companies face strong competition from local government services that provided all services under the old system of welfare for the elderly. Many of these users continue to want to have the same provider, making it difficult for private enterprise to gain as much market share as hoped, or even to hire as many workers as expected (*Banbū* June 2000: 32). Moreover, existing social welfare providers also have access to public subsidies and long-standing contracts with cities to operate public facilities.[19] Other familiar public corporations,

[19] In Okayama one such social welfare group has several former city officials on its board, indicating the level of political connection built into the old system

such as JA, the National Federation of Agricultural Cooperatives, are hoping to turn their local presence and "brand image" into new sources of revenue for the future (*Nikkei Net* 05.03.2001).

The success of private sector providers in long-term care thus hinges on both further deregulation in the health care sector and also changes in the relationships between local governments and care providers for the elderly.

The prospects are not certain for the private sector. The Japan Federation of Employers (Keidanren) has identified long-term care as one of the sectors in which industry requests for regulatory reform have not been reflected in changes in the laws and regulations (*Nikkei Net* 10.04.2001). Existing non-profit organizations providing facility and home-based care may apply for subsidies designed to promote the availability of services. Existing residential care facilities have an even greater advantage if they are organized as social welfare corporations (*shakai fukushi hōjin)* since revenue from the long-term care insurance is not taxable for them. At the same time, private companies may have an advantage in providing home care services, or at least an additional incentive, since even non-profit organizations providing home care such as household chore assistance must pay corporate tax on revenue from the long-term care insurance system. The rationale for this decision by the Ministry of Finance was that private companies should not be at a cost disadvantage in providing long-term care services. The Ministry of Health and Welfare had argued unsuccessfully to make registered non-profit organizations exempt from taxes in order to promote more services, particularly in areas not likely to be profitable for companies, such as remote or sparsely populated areas (*Asahi Shinbun* 20.04.2000: 2). The capital-raising capacity of private businesses stands in sharp contrast to that of local non-profit organizations for home care services, but many barriers to entry in the residential care industry remain.

4. Eligibility, Benefits, and User Contributions

Eligibility for long-term care insurance system benefits is determined in two parts. The first is by age, and the second is by health status. It introduces a higher degree of risk selection into the insurance system than one purely based on occupation category or age alone. Even after eligibility for benefits is established, however, the beneficiary must apply to a

of welfare for the elderly that complicates entry by private companies (*Asahi Shinbun* (20.04.2000, Ōsaka Morning Edition, Okayama Section): A).

local government committee to certify the level of need. The local government first uses a specially-designed computer software package to assess the level of need for care of the applicant. A committee composed of five appointed members then conducts a second review, in which it may overrule the recommendation of the software, but in principle, the system is supposed to be based primarily on the objective, software-based assessment.[20]

4.1 Types of beneficiaries (65 years of age and older, aged 40 to 65)

The two types of beneficiaries for services are the elderly 65 years old and older (Type 1) and those between 40 and 65 years old (Type 2) who have diseases associated with aging. The most frequent conditions of the fifteen officially designated diseases include: strokes (62,000 people), complications from diabetes (22,000 people), chronic rheumatoid arthritis (11,000 people), Parkinson's disease (9,000 people), and early-stage Alzheimer's disease, projected at about 6,000 people.[21]

The original design might have included other disabled people in the plans, since the kinds of services provided (and the service providers) are quite similar for home care. Despite the initial hopes of some groups advocating for the disabled, such as the "Ten Thousand Citizens Committee to Realize a Public Long-term Care System" (Kaigo no Shakaika o Susumeru Ichimannin Shimin Iinkai), however, the system became fixed as one designed to support independent living among those with diseases of aging only (*Nikkei Shinbun* 12.05.1997: 7).[22]

4.2 Types of benefits (facilities, services)

Unlike the German system, Japanese long-term care insurance was not initially designed to provide a choice between cash benefits or in-kind benefits. This point was controversial in the beginning. At the final stages of implementation, Liberal Democratic Party leaders insisted that some benefits be given to families who took care of severely impaired family

[20] At the same time, the problem of running an insurance system in which eligibility and usage are not easily forecast may lead to early reforms, including re-introducing some element of central supervision over eligibility determination (see Doi 2000: 132).

[21] The numbers of patients are estimated based on ministry data by Miura (2000: 384).

[22] The leader of this group, Higuchi Keiko, was also on the Advisory Council that reviewed initial Ministry of Health and Welfare outlines of the long-term care insurance system (see Ikegami and Campbell 2000).

members but did not use any benefits from the LTCI system. A one-time payment of ¥ 100,000 was authorized at the discretion of local authorities, not as an official benefit, but as an "honorarium" (*irōkin*), a category of payments to families that already had a legal basis for local governments. Each would be free to institute this system or not. The additional cost for the national budget was estimated to be ¥ 130 million, a small fraction of the overall budget (*Shakai Hoken Junpō* 2040, 11.11.1999: 19).[23] In fiscal year 2000, 74% of local governments were found to use the system. Moreover, 69% of localities also gave an additional payment of ¥ 10,000 per month to caregivers taking care of the elderly at home, due to the lack of availability of respite care facilities in many communities (*Yomiuri Shinbun* 03.04.2001: 18). The amount of money is nowhere near that in the German system, which in the early stages was designed to pay families cash in amounts up to one-half of the equivalent in-kind benefits.

For Japan, in-kind benefits are the main part of the system. The particular mix of services are chosen and contracted for by the individual seeking care, or their family on their behalf as appropriate, working with a specially-licensed care manager or their family physicians. Care managers work in the private sector on a part-time basis, and in urban areas workloads can be quite heavy, with a fixed payment for case management not based on the volume of work, such as changing care plans frequently (*Japan Times Online* 29.03.2001). In some areas, new non-profit organizations, such as the Setagaya Welfare Support Center in Tōkyō, are developing to support families in discussions with care managers, but these efforts are limited to local initiative (*Yomiuri Shinbun* 26.03.2001: 11). Moreover, care managers and physicians sometimes come into conflict. Managers are faced with time pressure and demands of client families, while the type of care recommended by physicians because of their expertise may be quite different (*Nikkei Net* 23.03.2001).

Care managers build a menu of options in consultation with families for twelve kinds of home care benefits and three kinds of facility care, shown below. Services are then contracted with the service providers. Under the previous welfare system for the elderly, local governments would make the decisions. Contracts are intended to make the obligation of providers and users, and the cost of services, more transparent.

Home care benefits
- homehelp service
- bathing service

[23] This point is discussed in more detail in section 8 on changes to the implementation law.

– home nursing visits
– home treatment management and guidance (by doctors)
– day service (at day care center)
– outpatient rehabilitation (at medical facility)
– respite care
– group therapy for senile dementia
– nursing care services in for-profit nursing homes
– leasing and/or purchase of care-related furniture and implements
– home renovations (small-scale standardized improvements)
– support for home care

Facility care benefits
– long-term care welfare facilities (special nursing homes for the elderly)
– long-term care health facilities (geriatric health care facilities)
– long-term care medical facilities, acute-care beds, beds for treatment of senile dementia, designated long-term care hospitals[24]

The list demonstrates how long-term care for the elderly under the LTCI system incorporates the previous institutions set up under the 1963 Welfare Law for the Elderly (*Rōjin fukushi-hō*) and the medical insurance system. In this way it is more of an additional layer of insurance on top of existing welfare and medical infrastructures, rather than a pure blend of welfare and medical care. Facility care can be based in either medical or welfare facilities. Medical care facilities, including hospital beds for long-term hospitalizations, are usually parts of medical corporations or private foundations operating hospitals for inpatient and outpatient care in addition to specialized facilities for geriatric care. Welfare facilities were previously the option preferred by local governments for long-term residency under the 1963 Welfare Law for the Elderly, and are usually operated by local governments or social welfare organizations. Even under the old law, the costs of living in such welfare facilities were subsidized by local governments, but only under a system of administrative discretion (*sochi seido*). Under both the old and new systems, the costs of living in private for-profit elderly homes are not directly subsidized, except for long-term care services for residents living there. For facility-based care, a monthly fee is paid by the long-term care insurance system, and a certain co-

[24] Based on tables in NATIONAL FEDERATION OF HEALTH INSURANCE SOCIETIES (2000: 72) and *Nichii News* (05.07.1998): Kaigo hoken seido no gaiyō [Outline of the Long-term Care Insurance System]. Online at http://www.med.or.jp/nichinews/n100705f.html (as of April 20, 2001).

payment is paid by the families or the resident, as are charges for food, diapers, and other consumables. The amount of co-payment depends on the level of care, but the charges for food, diapers, etc. are fixed by the facility for all residents.

For home services, user fees are set as a flat 10% of the benefits used. Additional services can be purchased if the user pays the entire cost. Additionally, some services, such as housecleaning, are supposed to be paid for entirely by the user. The budget amount for benefits is set at the same time as eligibility according to Table 1 below, regardless of whether care is in facilities or at home.

Table 1: **Amount of benefits per month and level of care**

Degree of need	Type of needs	Benefit amount (¥/month)
needs support	some assistance in daily life	61,500
care level 1	some long-term care	165,800
care level 2	small degree of long-term care	194,800
care level 3	medium degree of long-term care	267,500
care level 4	large degree of long-term care	306,000
care level 5	highest degree of long-term care	358,000

Source: National Federation of Health Insurance Societies (2000).

4.3 User contributions

People 65 years old and older, or Type 1 beneficiaries, must pay insurance contributions from pensions for the long-term care insurance system.[25] People 40 years and older but younger than 65 years old, or Type 2 beneficiaries, must pay contributions assessed by their local government, in the same way that pension contributions for the public pension system are collected. While the per-capita component of premiums for Type 2 beneficiaries are fixed nationwide, premiums for Type 1 beneficiaries is set according to the expected level of system usage forecast for each local area, adjusted for the reported income of each individual (*Shakai Hoken Junpō* 2071, 21.08.2000: 7). In fiscal year 2000, for the Type 1 beneficiaries, the contribution rate ranged from a low of ¥ 1,533 in Ōiso-mura, Ibaraki Prefecture to a high of ¥ 4,499 in Atsuden-mura, Hokkaidō Prefecture, with a national average of ¥ 2,796 (*Banbū* June 2000: 22–23). Due to a last-minute initiative by the Liberal Democratic Party in November 1999, however, the elderly paid no premiums from April 2000 to October 2000,

[25] Long-Term Care Insurance Law, Article 7, Section 1, part 7.

half premiums from November 2000 to October 2001, and pay full premiums only since October 2001. Once contributions began, local governments deducted contributions directly from pensions for Type 1 users, and sent invoices to the homes of Type 2 residents.

Type 2 users only pay a percentage of their income, just under 1%. Minister of Health, Labor and Welfare Sakaguchi Chikara of the Kōmei Party announced that the per-capita contribution rates for fiscal year 2001 would be ¥ 2,700 per month (*Shūkan Shakai Hoshō* 29.01.2001: 44). There is a cap on combined premiums for health insurance and long-term care insurance, but this amount can be adjusted without legislative action.

For elderly users, some local governments decided to reduce or eliminate premiums for elderly beyond the original six-month free period and twelve-month half-premium period. The Ministry of Health, Labor and Welfare responded with strict instructions not to do so.[26] 78 local governments ignored repeated reminders not to subsidize premiums. It is a small group of localities that can afford to subsidize premiums, but sufficient to demonstrate that consensus on the idea of long-term care insurance as social insurance is not complete, and that at least some local politicians like to use the new system as a way to extend patronage to their residents, to mitigate the delay in building long-term care services, or both.

5. Facility Construction Under the Gold Plan 21

Services under the LTCI are encouraged with subsidies through the Gold Plan 21, the latest version of subsidies that began in 1989. As with the original Gold Plan, the Gold Plan 21 established numerical targets for building new facilities, targeting the number of facilities, or the total personnel of a given type, or the aggregate capacity of all facilities nationwide. Allocation of subsidies requires application and approval at the prefectural level as well as at the national level. Personnel at the prefectural level are appointed on short-term duty from the Ministry of Health, Labor and Welfare, and give a certain level of national coordination to a program that appears to be decentralized to some extent.

In fiscal year 2000, ¥ 230 billion was allocated for investment in infrastructure projects related to LTCI.[27] Public subsidies cover up to three-

[26] Materials from the Meeting of Section Heads responsible for Long-term Care Insurance, February 14, 2001.

[27] Ministry of Health and Welfare F.Y. 2000 Budget, Appendix 1 to Materials for National Meeting of Section Heads Responsible for Long-term Care Insurance, November 16, 2000.

quarters of the construction cost for these facilities. Targets for the Gold Plan 21 for 2004 are listed below:

Table 2: **Gold Plan 21 targets**

TYPE	TARGET
homehelper services	350,000 people
visiting nurse stations	9,900 stations
respite care facilities	26,000 facilities
temporary stay facilities	96,000 people
long-term care welfare facilities for the elderly	360,000 people
long-term care health facilities for the elderly	297,000 people
group homes for dementia	3,200 homes
"care houses" for assisted living	105,000 people
welfare centers for the elderly	1,800 centers

Each of these facilities can be used only after certification of need for assistance or care, as described in the following section. The goals of each type of facility include new facilities created after the LTCI system began, such as the care houses designed to support independent living, to a new source of funding for a much older kind of facility, such as the Welfare Facilities for the Elderly, formerly known as the Special Nursing Home for the Elderly (*tokubetsu yōryō fukushi shisetsu*) operated by local governments for the bedridden elderly.

Other systems, such as the homehelper system, was developed earlier but only allocated through the previous system of local administrative discretion (*sochi seido*) in which benefits depended on individual evaluations of eligibility at the local level under the Welfare Law for the Elderly of 1963. The former system began as an aid to low-income elderly, but soon expanded to be available to even middle-class elderly, although with a lower priority for entering facilities. Under the old system, the level of cost-sharing by the user was determined by the local government on a case-by-case system. The number of homehelpers was dramatically expanded after the introduction of the long-term care insurance system, and entry into facilities became available after a more objective determination of eligibility than under the established welfare system.

In contrast to the welfare system, the health insurance system for the elderly had also provided some services, but on a universal availability basis and at much lower cost than the new LTCI system. The home-visit nursing stations, for example, provided visiting nurses for elderly 70 years of age and older as part of all medical services, which were provided for a nominal monthly co-payment for all medical service. By contrast, with the

long-term care insurance system, first a care plan must be developed, then eligibility certified by the local government, and after services are delivered, a co-payment of 10% must be paid, with no monthly ceiling.

6. Current Data on Long-Term Care Insurance Usage

The first national census of long-term care providers and users is not scheduled to take place until June 2001 by the Ministry of Health, Labor and Welfare. No national statistics have yet been reported to the public, in part because the initial payments under the system to providers were made on the basis of estimated usage and subject to later corrections (*Shakai Hoken Junpō* 2071, 21.08.2000: 3). Even local governments are only beginning to survey usage and user satisfaction. However, some preliminary data have been reported in the advisory councils related to long-term care insurance reporting to the Ministry of Health and Welfare, and the picture of the system resulting from initial reports is one of rapid implementation nationwide.

As shown in Table 3, Type 2 users are mostly enrolled either in community-based National Health Insurance (*kokumin kenkō hoken*) or Small and Medium Enterprise Health Insurance (*seifu kanshō hoken*, directly administered by the government). Total expenditures on Type 2 beneficiaries are projected to reach ¥ 29,000 per person, for a total of ¥ 1.25 trillion.

Table 3: **Fiscal year 2000 Type 2 beneficiaries and long-term care premiums**

Health insurance system	Number of Type 2 beneficiaries	Total long-term care spending (billion ¥)
Small and medium enterprise (government-operated)	13,573,725	393
Large employers	10,850,773	314
Sailors	117,794	0.34
Public employees	3,472,606	100
Community-based health insurance	15,175,711	439
Total	43,190,075	1248

Source: Data compiled by Shakai Hoken Shiharai Kikin (Social Insurance Payment Fund), reprinted in *Shakai Hoken Junpō* 2060 (11.05.2000: 37).

One reason that premiums for Type 2 users are made through existing insurance systems is that employers must split the cost of the insurance premiums with employees. The amount is just under 1%, depending on

employment status. Although it may appear similar to the practice in the medical insurance system, this measure was vigorously opposed, particularly by the Central Committee of Small and Medium Enterprises (Zenkoku Chūshō Kigyō Dantai Chūōkai), the Japan Federation of Employers (Nikkeiren), and the Japan Chamber of Commerce (Nihon Shōkō Kaigijo) (*Nikkei Shinbun* 25.04.1997: 5). For community-based health insurance and the sole proprietors, farmers, and retirees (under 65) enrolled in it, the government pays one-half of the premiums. By contrast, the Democratic Party supported a tax-based system, similar to that favored by many employers (*Nikkei Shinbun* 26.04.1997: 5). In the end, premiums followed instead the social insurance model of premiums for people between 40 and 64 years old.

Table 4: **Type 1 beneficiaries by level of care and facility type**

Level of care						
Requires support	1	2	3	4	5	Total
320,809	670,271	466,664	352,238	364,870	322,931	2,497,783

Home-based care							
Requires support	1	2	3	4	5	Unclassified	Total
212,229	401,175	248,135	158,531	127,627	110,201	39,024	1,296,922

Facility care				
Welfare facility	Geriatric health facility	Hospital bed (long-term care type)	Unclassified	Total
283,513	220,293	102,135	17,984	623,925

Note: Level of care and home/facility care are based on data from December 2000, while the type of facility or home care is based on data from October 2000.

Source: Kōsei Rōdōshō Hokenkyoku Kaigo Hokenka (2001).

According to the Ministry of Health, Labor and Welfare, the number of Type 1 (65 years of age and older) beneficiaries reached nearly 2.5 million by December 2000, or just under 11% of the eligible population. Detailed figures are presented in Table 4. Of the recipients, fewer than one-half were found to require Level 3 of care or higher. The number of people in facilities was 623,925 people, just under one-fourth of the people requir-

ing care. Only 20% of these were in long-term hospital beds, and 40% each were in medical or welfare facilities for the elderly. At the same time, nearly 500,000 people at Level 3 or higher were being cared for at home (Kōsei Rōdōshō Hokenkyoku Kaigo Hokenka 2001). Details are presented only for Type 1 users. More detailed data on usage by Type 2 users (aged 40 to 65) and by facility type should become available after June 2001 when the first comprehensive surveys are planned to be conducted by the ministry.

Although a vast amount of services were provided in the first year of full operation, the system did not reach all of its goals. A *Nikkei Shinbun* survey of local governments found that people used an average of only 74% of the services planned in their care plans in 2000 (*Nikkei Net* 11.03.2000). The reasons for under-use included the lack of availability of services, another reason for the continued popularity of cash benefits in many communities.

7. Budget and Financing

One of the primary goals of the new long-term care insurance system is to reduce spending for the elderly under the old-age health insurance system by replacing costly medical care with more appropriate facility-based and home-based care. Based on the budget reduction for fiscal year 2000 in the old-age health insurance system of 11.1%, the long-term care insurance system has not yet fully achieved this goal, since in April 2000 spending had decreased only by 7.7% (*Shakai Hoken Junpō* 2071, 21.08.2000: 7). Nevertheless, it is still too early to pass final judgment, and the initial reduction, although smaller than expected, suggests that care is beginning to shift into the new system as planned.

Resources for funding long-term care come from individual contributions from the elderly (Type 1 users), people older than 40 but less than 65 years old (Type 2 users), and general revenues. The ratio is 17%: 33%: 50% for the three funding sources. Subsidies from general revenues not only cover part of the cost of services, but also part of the costs of constructing and operating facilities, and of operating costs for public bodies as well including local governments and insurance claims processing public corporations. These general subsidies, however, are split between the central government (50%), the prefectural government (25%), and the local government (25%). Since expenditures for long-term care are not capped, local and prefectural governments are likely to bring pressure for national subsidies to localities facing higher-than-expected costs, a concern ex-

pressed by Akamatsu Yoshinori, mayor of Kagoshima City, in the initial meeting of the Minister's Expert Commission on Social Security Reform in January 2000.[28] Moreover, Type 2 users pay 33% of the costs, but receive only 5% of the benefits of the system.[29] Therefore, some observers are critical that the system is a hidden tax increase on the non-elderly.[30] Future reforms could therefore find support for an increase in general-revenue subsidies for the system, but there is little indication that the Ministry of Finance or the Ministry of Health, Labor and Welfare have any intention of raising national subsidies for the operating costs of the system.

7.1 Facilities

In addition to public subsidy of fees for long-term care insurance, there are significant public subsidies for facility construction to provide services under the long-term care insurance system. These are budgeted through the Ministry of Health, Labor and Welfare directly, and additional loans for long-term care insurance facility construction are available through the Welfare and Medical Program Organization (WAM, Shakai Fukushi Iryō Jigyōdan). Amounts from the ministry budget are financed through general taxation; WAM and other loan programs are financed by loans from the postal savings system. Neither subsidies nor loans to facilities are financed by contributions to the long-term care insurance system. This means that in the public health insurance system, capital costs are not covered by reimbursements under the insurance system. Since reimbursements are calculated without reference to construction costs, public money subsidizes facility owners only at the stage of construction. In this way, facility construction relies on political relationships to license grantors, since a facility cannot recover construction costs entirely through operating revenue that is disbursed as a benefit. The approval of facilities thus becomes a scarce resource allocated by administrators. In the health and welfare administration system, prefectural governments (or major cities) must approve construction plans. These ad-

[28] *Shakai hoshō seido no arikata ni tsuite kangaeru yūshikisha no kaigi gijiroku* [Minutes of the 1st Meeting of the Prime Minister's Expert Commission on Social Security Reform], January 18, 2000. Currently (as of August, 2002) online at http://www.kantei.go.jp/jp/syakaihosyou/dai1/1gijiroku.html.

[29] *Zenkoku kōsei kankei buchō kaigi shiryō* [Materials for the National Meeting of Division Heads responsible for Health and Welfare Administration], January 1, 1997.

[30] A representative criticism of inter-generational unfairness can be found in Itō (2000).

ministrations are usually run by central government Ministry of Health, Labor and Welfare career employees on assignment. This suggests a continued incentive for political concerns to outweigh fiscal restraint in the future, particularly if the services become popular.

Political problems are not the only way the LTCI system may be used for different purposes than simply handling the problems of caring for the elderly. The structure of central control of personnel in charge of licensing contributed to a scandal in 1996 involving former vice-minister Okamitsu Nobuharu. Koyama Hiroshi, real-estate developer in Saitama Prefecture seeking to build nursing homes, provided a condominium and a car to Okamitsu. Koyama also gave money to Chatani Shigeru, a Ministry of Health and Welfare employee who had been temporarily assigned to Saitama Prefecture in charge of approving license and subsidies for long-term care facilities.[31] At the same time, few examples of this kind of behavior have been reported after 1996, and it seems that the negative example, and strict rules enforced on ministry and local government personnel regarding gifts from the private sector, succeeded in discouraging other such attempts to influence the allocation of subsidies. Another avenue for contract troubles comes when subsidies go through social welfare organizations rather than directly through the local government. New instructions issued in 2001 clarify that no "rebates" (kickbacks) are to be taken from contractors building long-term care insurance facilities, in light of several unspecified incidents reported to the ministry.[32] While the administration of subsidies contains the possibility for abuse, incidents seem to be isolated.

By the time long-term care insurance came into full effect in April 2000, many facilities were built by medical corporations that already operated hospitals and/or clinics. One of the reasons cited for the heavy participation by doctors is the predisposition of the ministry to restrain health care spending, which means that doctors expect that the only way to expand revenue is to provide services under the new long-term care

[31] Despite his explanation that the gifts were no more than tokens of friendship, Okamitsu received a sentence of two years in prison. He was the first vice-minister ever to be sentenced and serve time in prison rather than have the sentence suspended. Chatani was also convicted and sentenced to eighteen months in prison but his sentence was suspended. Both had to repay the amounts received from Koyama.

[32] *Zenkoku kaigo hoken tantō kachō kaigi shiryō* [Materials for the Meeting of Section Heads Responsible for Long-term Care Insurance], February 14, 2001. No details of the incidents were published, but their existence was mentioned as an area for caution.

insurance system (Ikegami 1997: 1311). The third category of facilities, hospital beds for long-term care (*ryōyō-gata byōshōgun*) represent administrative efforts to designate beds in certain hospitals with many long-term inpatients for lower payments.

7.2 Services

Contributions to the long-term insurance system (*kaigo hokenryō)* finance the provision of services. Since long-term care insurance spending depends in part on unpredictable demand for services, the amount budgeted for long-term care is adjusted over the year in supplementary budgets as needed. Usage for a fiscal year is estimated and budgeted under the social security section of the special budget accounts. Actual spending, however, is determined in principle by the person seeking long-term care (or their families) in cooperation with the care manager, under the budget amount set by the process of certification of need for care. The spending so far has been less than budgeted in some cases, but the overall amount of spending is on track with expectations. The new tool of monthly benefit budgets resembles a prospective payment system, and may serve to contain the growth of spending better than entitlement-based medical care in which decisions by (mostly) private physicians determine the level of spending. On the other hand, amounts were set to provide a similar amount of services as under the old system, at a cost to the user not out of line with previous out-of-pocket expenses, at least for facility-based care. It remains to be seen whether the new mechanism will be politically feasible.

7.3 Administration

The national government budget for long-term care insurance also subsidizes local government administrative costs, and public corporations which process insurance claims for LTCI (as well as ordinary health insurance). For local governments that are too small to have an effective administrative structure for long-term care insurance, the Ministry of Health and Welfare promoted the development of wide-area multi-governmental cooperation organizations (*kōiki rengō*) to administer the system on behalf of several localities. By May 2001, 58 such alliances had formed nationwide. The restructuring of local government administration was not limited to cooperation on the issue of long-term care insurance. Each local government also has a section responsible for administering the system of health care for the elderly (*rōjin hoken fukushi*), and by the end of 2002, the ministry intends to have each locality draw up plans

to eliminate overlaps and redundancies in personnel between these two sections.[33] These measures concerning local governments are implemented without Diet action, since ministry ordinances are authorized in the implementation law.

In return for compliance with strict oversight and reorganization plans, localities are being given even higher subsidies than first anticipated. By February 2001, an *additional* ¥ 100 billion ($ 0.8 billion at then-current exchange rates) was proposed to smooth implementation at the local level, half for new programs, and half for facilities and salaries for additional officials to administer the system at the local level.[34] This pattern in policy, in which central officials set the direction and provide incentives and penalties for compliance and non-compliance, has come under criticism as not fully involving local communities in planning their own futures. The opposite criticism was also heard from the beginning, however, that without standardization, people nationwide would pay the same premiums, but depend entirely on the discretion of local governments, just as in the previous old-age welfare system.

8. Changes in Long-Term Care Insurance Legislation under Discussion

Reform measures that will not require amending the laws are underway in the area of certification of need for care and the fee schedule for long-term care. The Ministry of Health and Welfare created an expert committee, the Certification of Need for Long-Term Care Discussion Group (Yō-Kaigo Nintei Kentōkai) to report back after surveys in November 2000 and February/March 2001, and possibly to develop a model program to introduce a revised certification system in several localities in fiscal year 2001 (*Shakai Hoken Junpō* 2071, 21.08.2000: 4). For the fee schedule, increases are planned for April 2003. After a study of the operating costs of long-term care providers, the Social Security Advisory Council, which reports to the Minister of Health, Labor and Welfare, will debate increases in certain service areas. Many care providers are complaining that they cannot provide high-quality service at the current level of insurance

[33] Materials regarding wide-area cooperation organizations, presented in the National Meeting of Section Heads Responsible for Long-term Care Insurance, February 14, 2001.

[34] Materials regarding fiscal measures in 2001 for local government LTCI programs, presented at the National Meeting of Section Heads Responsible for Long-term Care Insurance, February 14, 2001.

reimbursements (*Nikkei Net* 02.04.2001). In addition, the Subcommittee on Long-Term Care Fees of the Health Insurance and Welfare Advisory Council (Iryō Hoken Fukushi Shingikai Kaigo Kyūfuhi Bukai) set guidelines for the revision to the fee schedule in an interim report on October 26, 2000. This kind of revision in fees in advisory councils with representatives from business, labor, care providers, and government experts is the same style used for the regular health insurance system. For determining price increases in the fee schedule for the regular health insurance system, however, surveys could not be successfully conducted because of resistance from private hospitals and clinics about the methods and use of information in the surveys. For this reason, the long-term care cost survey could also become politicized.

Assuming the present course of social insurance and consumption-tax funding continues, there are likely to be only increases in the premiums for long-term care insurance, rather than any whole-scale system revisions in the near future. Initial indications of the next direction for reform of the whole social security system, in the form of the Prime Minister's Commission on Social Security report in March 2001, are that no major changes will be made to system financing (*Nikkei Net* 08.03.2001). Under the Japan Medical Association's (JMA) new plan for Structural Reform of Health Care in Japan, the long-term care insurance system for people 75 years of age and older will be integrated into a new health insurance system for the elderly, but no earlier than 2007. The JMA plan would also have a separate LTCI system for people under 75 years old administered separately.[35] But with a full-scale reform (*bappon kaisei*) of health insurance slated for 2002, the prospects of rapid change in the long-term care insurance field are limited, and it is not certain how comprehensive any health-related reforms will be given the challenge of satisfying the powerful groups as well as ordinary citizens in a period of slow government revenue growth.

9. Conclusion

The basic goals of Japan's long-term care insurance system have been achieved: a social insurance system provides financing (along with public subsidies) for a menu of services to care for the elderly (and younger people with diseases associated with aging) at a level appropriate for their need for care through a mixture of public and private providers at

[35] A simplified version of the JMA plan is on their website (in Japanese) at http://www.med.or.jp/nichikara/koso_p.pdf (as of June, 2001).

prices fixed by the Ministry of Health, Labor and Welfare. In each of these areas, there is also room for improvement. The early expectation of some critics that the system would be unavailable or unused seems to be partially fulfilled: a *Yomiuri Shinbun* (01.04.2001: 1) survey found that 80% of localities did not spend their whole budget, due to underuse of services. This echoes the *Nikkei Net* (11.03.2000) finding that 74% of users did not use all the services planned in their care plan. Moreover, private enterprises seeking to provide residential and home care services have not seen as much regulation as they would like, and major companies have dramatically scaled back their operations in light of lower-than-anticipated demand, or over-investment in too many locations at once. Finally, there is some criticism of the process of determining levels of care, particularly for home-bound elderly, that the system does not provide enough services to really free families from the heavy burden of care.[36]

These elements of dissatisfaction may provide material for politicians to make new appeals to elderly voters as they have in the past. At the same time, the higher burdens on younger voters may give opposition politicians grounds to complain that the system has been shifted away from its original purposes for political reasons, at great cost to voters under 65. So far, this kind of confrontation over generational politics has not surfaced as a campaign issue. Alienating older voters is a risky strategy, since they tend to vote in much greater numbers than younger voters.[37] The deep fiscal crisis of the Japanese state in 2001 may place limits on the extent to which new benefits can be extended to the elderly, particularly after Finance Minister Shiokawa Masajūrō's commitment to a ¥ 30 trillion ceiling for new public debt in fiscal year 2002.[38] At the same time, the deep local control over the program may give Diet members and their constituencies an incentive to increase spending if it proves popular. While the Ministry of Health, Labor and Welfare tends to supply personnel to run prefectural government sections responsible for administering and licensing, local governments have their own balances, and unless the ministry is able to place personnel directly in charge of wide-area cooperation organizations, there may be incentives to expand spending wider than anticipated. The system that was designed to overcome so-called "provider-induced demand" (excessive use of resources by revenue-seek-

[36] For a well-documented critique of the system operation and benefits, see NIKI (2000).

[37] This argument is elaborated further in TALCOTT (1999: chapter 6).

[38] Finance Minister Shiokawa Masajūrō announced the ¥ 30 trillion debt ceiling in connection with Prime Minister Koizumi's reform plans (*Nikkei Net* 24.05.2001).

ing physicians) may face instead problems of "political-induced demand" (excessive use of resources by vote-seeking politicians).

Final judgment on the course of future reforms will depend on electoral calculations of the Liberal Democratic Party, both in terms of the timing of the next Lower House election, and in the nature of public spending decisions. If the past is any indication, it can be expected to cost more, not because of negligence, but out of conscious decisions to use the system. This pattern is evident in recent health insurance reforms as well as the long-term care insurance system. Record public debt levels, reaching 115% of GDP by 1999 for central and local government debt combined, may make the system less difficult to expand, but part of the reason the debt grew large was due to a pattern of political intervention without regard to financial consequences. If this tendency to use the system to reward supporters and appeal to voters does not change, the LTCI system may provide better services or cost less for the elderly, but at the same time end up being worse for the nation as taxes, debt, or both must be raised to pay for improvements. The fate of the long-term care insurance system, like so many other issues confronting Japan in 2001, rests in the hands of political leaders.

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Six Years of Long-Term Care Insurance in Germany: An Overview

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1. Introduction

In Germany financial security for dependent persons has been a topic of much discussion for almost thirty years. However, it was only seven years ago – in 1995 – that it became a main social-political issue or a significant aim of the government. The main reasons for the growing importance of ensuring financial security for persons in need of care are of course the well-known demographic developments. Worth mentioning first is the significant increase in a) the absolute number of elderly people, b) the proportion of elderly people within the whole population, and c) the absolute number and proportion of people aged 80 years or older within the population 65 years or older. In this context it must be kept in mind that very old age is closely related to the need for care; while the risk of becoming dependent on long-term care averages 3.5% for people aged between 60 and 80 years, this percentage increases to 30% for those aged 80 years or older. An important trend which contributes to the aging of the German population is the fact that fertility rates remain far below the replacement level (Deutscher Bundestag 1998).

In addition, shifts in the family structure (e.g., the number of persons living alone is rapidly increasing, people are marrying later, marriages do not last as long as they used to and are often childless) and an increase in the number of women participating in the labor force are aspects which challenge the availability of care and support given to the elderly by family members. Against this background problems connected to the provision of long-term care for an increasing number of elderly people have become a major concern for Germany and led to the introduction of the Long-term Care Insurance (LTC-Insurance) in 1995 as the fifth pillar of the social security system (the other four pillars are health, unemployment, pension, and accident insurance).

Before the LTC-Insurance came into force there was no real social security that dealt with the risk of long-term care. For example, older persons who lived in a nursing home had to finance the cost of care by themselves. If the individual had no financial resources he/she had to rely on private family support or resort to the means-tested social assis-

tance scheme to cover the cost of residential care in institutions (BÄCKER *et al*. 2000). Keeping in mind that residential care is very expensive in Germany – the average cost amounts to approximately 3,000 Euro per month for a person who needs intensive support and care – this meant that more than 75% of elderly people living in nursing homes were dependent on social assistance in order to be able to cover the cost of care shortly *before* the introduction of the LTC-Insurance (KRUG and REH 1991).

Within the socio-political discussion concerning the necessity of introducing the LTC-Insurance a second "cost factor" was important, which is connected to the one just mentioned: the financial burden on local authorities due to their expenditure for long-term care for an increasing number of elderly people. Although the cost of care had to be financed by those concerned in the first place, the local authorities still had to pay huge amounts of social assistance benefits, because in Germany they are the carriers of the social assistance provisions. These costs – which to a great extent reflect the expenditure for residential care – increased from 1.5 billion Euro in 1975 to nearly 9 billion Euro in 1995 – the year the LTC-Insurance came into force. Therefore, local authorities badly needed relief to ease the financial burden of long-term care and increasingly applied pressure to find ways to cover the cost of residential care (ROTHGANG 1997a, 1997b).

2. THE LTC-INSURANCE: SOME GENERAL INFORMATION

The LTC-Insurance has the following *aims*:

- To reduce demands placed not only upon the personal finances of people in need of care and their families, but also upon local authorities' social assistance budgets;
- to generally improve the life situation of care recipients and caregivers;
- to promote home or family care instead of residential care by improving the quality of life of care recipients *and* caregivers;
- to promote preventative health care and rehabilitation measures for persons with care needs;
- to control the public cost of care;
- to promote the implementation of a highly qualified professional care system (EISEN and SLOAN 1996; ROTHGANG 1997a, 1997b).

The German LTC-Insurance scheme *includes* all people employed in Germany as well as pensioners and non-employed family members. It is based on the principle "LTC-Insurance follows health insurance". The

LTC-Insurance is similar to health insurance which can be either mandatory (social) or private (voluntary). It is a *statutory scheme* which combines two branches: a social care insurance scheme and a private care insurance plan. Currently, approximately 92% of the German population is covered by the mandatory scheme and 7% by the private LTC-Insurance. In all, about 82 million Germans are insured.

The LTC-Insurance is almost entirely *financed* as a "*pay-as-you-go-system*" by equal contributions from employers and employees, including the self-employed and pensioners. Non-employed spouses and children are also covered without having to pay contributions. The strong opposition from employers who refused to pay greater ancilliary labor costs was compensated by a reduction in the cost of paid vacation leave: one of Germany's public holidays was abolished and thus employees lost out on the equivalent of one day's paid vacation leave. By "dealing" with the problem in this way they enabled a greater part of the cost to be shifted to employees, a novel aspect in the history of the German social insurance system.

The *rate of contribution* amounts to 1.7% of the individual gross earnings or the qualifying pension. In sharp contrast to the traditions of the social insurance system in Germany, the contributions are *limited* by law to 1.7%. As a result, the benefits of the insurance are also restricted to a certain amount or, in other words, these amounts are neither indexed to prices or income, nor is there any provision for regular increases.

In this context it should be mentioned that the social insurance model was the only model that could rely on a vast majority of votes in the *Bundestag* (German Parliament). At an earlier stage of the discussion, though, other possibilities were taken into consideration such as:

- case-mix reimbursement;
- capitation financing;
- a market model financed completely private – encouraged, for example, by tax reliefs – and run by private insurance companies; or
- a transfer model, administered and financed by the state.

Important reasons, however, led to the preference of the social insurance model, which may be considered as a compromise between a transfer model and a market model (Naegele 1992). These reasons are:

1. The German tradition of organizing social security is regarded as successful by the vast majority of German citizens.
2. The need for care is regarded as a general social risk comparable to other social risks which are covered by the remaining four pillars of the German social security system.

3. Within the social insurance model it was possible to *organize* the LTC-Insurance as its own branch under one roof with the statutory health insurance. In other words: the carriers of the health insurance – the insurance funds – are now the carriers of the LTC-Insurance as well. This in turn means that the implemention of new institutions was not necessary.
4. It was obvious that a model financed by taxes had no chance of success because of the existing financial burden accompanying German unification. In addition, those who were in favor of a social insurance model also believed that the adaptation of provisions would be easier within the social insurance model than within a model financed by taxes.
5. By using the social insurance model, those already in need of long-term care could be included right away.

In the past, and in accordance with constitutional law in Germany, the provision of all public and social services and facilities was a task carried out by the local authorities which – following the *principle of subsidiarity* – worked closely together with welfare organizations. However, in order to realize the aims of the LTC-Insurance and to safeguard the provision of long-term care, three aspects have been changed in this system.

- First, the LTC-Insurance funds now *enter into contracts* with the providers of home and institutional long-term care facilities and other organizations providing services and benefits. Through so-called supply contracts, these long-term care facilities are integrated into public benefit systems with legally defined rights and obligations. The providers of services and institutions are obliged to provide nursing care for the insured and in return, are eligible for remuneration from the LTC-Insurance funds.
- Second, the LTC-Insurance law explicitly encourages *privately run providers* who work on a profit basis to enter the market – provided they guarantee qualified care. As a result, three groups of providers are now operating within the care market:
  - Local authorities;
  - welfare organizations;
  - privately-run providers as new participants in the market.

  Whereas the last group mainly operates in the home care sector, the local authorities and the big welfare organizations dominate the market for residential care, day and night care as well as short-term care.
- The third aspect refers to the *responsibility the LTC-Insurance concedes to the 16 German Federal States* with regard to the efficiency, quantity, and economy of the "caring infrastructure". To realize this task most of the

federal states implemented their own laws which – although they may differ from state to state – grant care services and facilities, including the cost of investment they might incur. The provision of the LTC-Insurance can be regarded as an incentive for the professional care providers to enlarge and to improve their services and facilities. To better understand the importance of this goal, a look into the past is helpful. Before the implemention of the LTC-Insurance there was a great discrepancy between the need for professional care and the quantity of professional home care services and facilities that were available to satisfy this need. Only one-third of those concerned could draw upon adequate care services and facilities or, in other words, two-thirds were without any kind of professional support or were completely dependent on the help of family members or on other informal caregivers. Therefore, an improvement of the "caring infrastructure" was unavoidable.

Persons – no matter whether they live in their private homes or in institutions – *qualify for benefits* from the LTC-Insurance for more than six months if he/she has – regardless of age – a physical or mental illness or disability which makes him/her dependent on the help of others in performing "activities of daily life" (in the areas of personal hygiene, nutrition, and/or mobility). In addition, individuals must also require assistance a few times a week with "instrumental activities of daily life" (grocery shopping, cooking, cleaning, dishwashing, changing and washing bedlinen and personal clothing, heating the home).

In order to determine the extent of benefits and services, the beneficiary will be assigned to one of *three care levels* according to the severity of care requirements and the resulting extent of help needed.

- *Care level I* is accorded to persons in *considerable need* of long-term care. They would require assistance at least once a day for two activities at the minimum in the areas of personal hygiene, nutrition, or mobility. They would also require assistance several times a week in carrying out household chores. Individuals must need at least 90 minutes of assistance, from which personal care must take up at least 45 minutes.
- *Care level II* is accorded to persons in *severe need* of long-term care. They require assistance at least three times a day with personal hygiene, nutrition, or mobility. They must need at least three hours of assistance, from which personal care must take up at least two hours.
- *Care level III* is accorded to persons in *extreme need* of care. They need help all the time in performing at least two activities of daily life. They

must need at least five hours of assistance, from which personal care must take up at least four hours.

The assignments are based on a professional assessment. If a person applies for care benefits, a qualified nurse or a physician (from the medical division of the health insurance fund) will visit the applicant at home to determine whether and to what extent he/she will require long-term care.

The benefits of the LTC-Insurance which are designed to assist people who need care can be described as follows (see Table 1):

1. Benefits for *home care:* Depending on his/her care level the care recipient may be entitled to the following benefits for home care: *Benefits in kind* of the value of 384 Euro per month for persons with care level I, 921 Euro for persons with care level II, and 1,432 Euro for persons with care level III. In exceptional cases benefits in kind to the value of 1,921 Euro can be paid. *Benefits in cash* amount to 205 Euro per month for persons with care level I, 410 Euro for persons with care level II, and 665 Euro for persons with care level III. The care recipient can use this money to "buy" informal help. It is possible to combine benefits in kind and benefits in cash in order to get a highly individualized care program.
2. *Additional* benefits of the LTC-Insurance for home care are:
   - payment of day or night care up to 1,400 Euro per month;
   - payment of short-term care (up to four weeks per year) up to 1,400 Euro;
   - stand-in care (up to four weeks per year) up to 1,400 Euro;
   - subsidization of the improvement of housing according to the special needs of the care recipient up to 2,500 Euro;
   - subsidization of certain technical care aids and appliances (e.g., wheel chairs);
   - contributions to the pension fund on behalf of the carer in case he/she gives up paid work in order to care for a dependent person;
   - free nursing care courses.
3. Benefits for *residential care*: Regarding institutional care, the LTC-Insurance only covers the cost of nursing care. The monthly care rate is paid directly to the nursing home. The amount depends on the care level of the beneficiary. The present care rates for persons with care level I are up to 1,023 Euro per month, care level II up to 1,279 Euro, and care level III up to 1,432 Euro. To avert hardship the benefits in care level III can be increased up to 1,688 Euro. Accommodation and food still has to be paid for by the care recipient or – if

he/she has no financial resources – by close relatives or the social assistance fund.

Table 1: **Benefits of the LTC-Insurance (per month in Euro)**

	Home care		Residential care
	benefits in *kind*	benefits in *cash*	benefits in *kind up to*
care level I	384	205	1,023
care level II	921	410	1,279
care level III	1,432 *(in exceptional cases 1,921)*	665	1,432 *(in exceptional cases 1,688)*

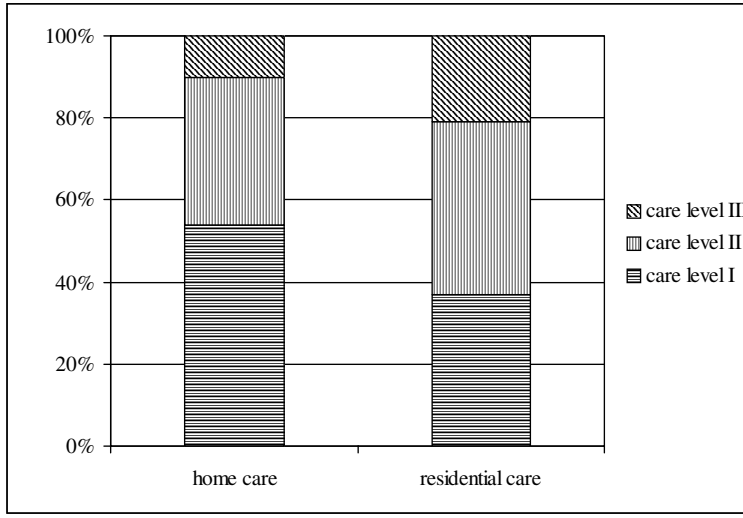
Although the list of benefits provided by the LTC-Insurance seems to be impressive, the risk of being in need of care is *not* covered completely – the LTC-Insurance is a so-called "Teilkaskoversicherung" (part-comprehensive cover). In contrast to the statutory health insurance – which in principle does not know a limitation of benefits – the benefits of the LTC-Insurance *are limited*. Therefore, it can be assumed that the social risks which might be linked to care are recognized as less important than those social risks which might be linked to illness.

3. Some Important Data

Let us examine data on how many individuals receive benefits from the LTC-Insurance and how they are distributed with regard to the different levels of care. At the end of the year 2000, about 1.4 million persons living in private homes and about 553,000 persons (2.5% of the whole German population) living in institutions received benefits from the LTC-Insurance.

With regard to home care 54% of individuals entitled to benefits were assessed as being in considerable need of care (care level I), 36% were assessed as being in severe need of care (care level II), and only about 10% were assessed as being in extreme need of care (care level III). With respect to institutional care we obtain the following figures: care level I = 37%, care level II = 42%, care level III = 21% (see Figure 1).

Figure 1: **Proportion of persons receiving home or institutional care by care level in % (2000)**

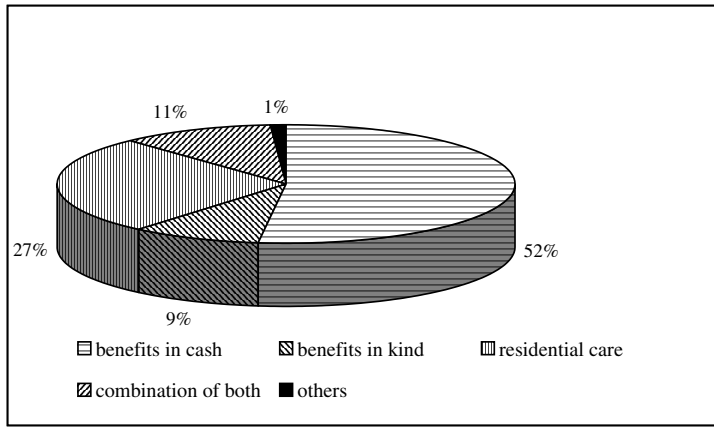


Source: Based on http://www.bmgesundheit.de/themen/pflege/finanz/pflegestufen. Downloaded June 28, 2001.

An interesting question refers to the *distribution* of benefits that are offered by the LTC-Insurance. Data from the LTC-Insurance fund reveal that of those who receive provisions for *home care* the vast majority decided to take benefits in cash. Shortly after the introduction of the LTC-Insurance 80% instead of 50% – as predicted by the German Ministry of Social Affairs – did so as compared to 20% who chose benefits in kind (EVERS 1997). In the meantime, however, more people have decided to take benefits in kind or a combination of both. Currently, we estimate a ratio of about 70% receiving benefits in cash, 20% receiving benefits in kind and about 10% receiving a combination of both. In general, it seems that those who are assessed as "care level III" show a higher willingness to take benefits in kind or a combination of benefits in kind and in cash. In this context, it has to be kept in mind that benefits in cash are "cheaper" for the LTC-Insurance fund than benefits in kind.

When we look at it from a different perspective we see the proportion of different benefits – for home care as well as for residential care (see Figure 2).

Figure 2: **Distribution of benefits of the LTC-Insurance in % (2000)**

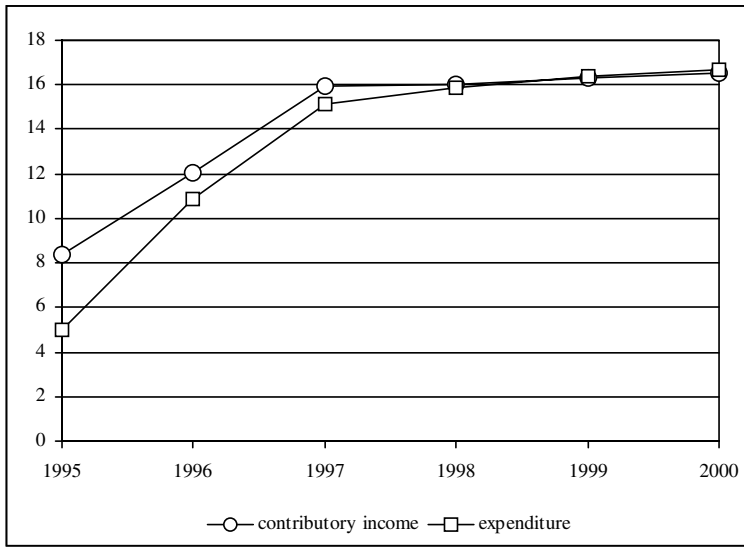


Source: Eildienst Landeskreistag Nordrhein-Westfalen, May 2001.

With regard to the distribution of expenditure for the different benefits of the LTC-Insurance we see that benefits in cash amount to 25%, benefits in kind to 13%, residential care to 46%, social security for caregivers to 6%, and other benefits to 10% of all costs. Thus, it is important to note that although residential care covers only about 27% of all benefits of the LTC-Insurance, it still amounts to 46% of all costs. This fact is due to the high cost of residential care as mentioned earlier.

Since the LTC-Insurance has been introduced in 1995, we can observe the following development of contributory income and expenditure. From 1996 until 1998 contributory income was higher than expenditure, however, as Figure 3 shows, after this period expenditure exceeds contributory income. For the year 2000 contributory income amounted to 16.55 billion Euro, whereas the overall expenditure was 16.68 billion Euro.

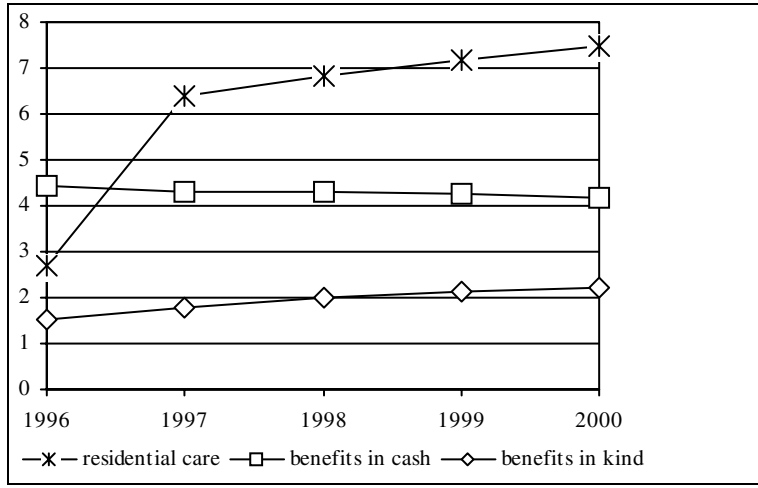
Figure 3: **Contributory income vs. expenditure from 1995 until 2000 (in billion Euro)**



Source: http://www.bmgesundheit.de/themen/pflege/finanz/dv-ergebnisse. Downloaded June 28, 2001.

The main reason for this development is that expenditure for residential care and for benefits in kind have increased, whereas the expenditure for benefits in cash slightly decreased (see Figure 4). In 1997 the LTC-Insurance fund spent 6.41 billion Euro for residential care, whereas in the year 2000 it spent 7.48 billion Euro, which equals an increase of 16.5%. The responsible factors for this shift towards professional care, which will become even stronger in the future, were mentioned earlier.

Figure 4: **Expenditure from 1996 until 2000 for different kinds of benefits (in billion Euro)**



Source: http://www.bmgesundheit.de/themen/pflege/finanz/dv-ergebnisse. Downloaded June 28, 2001.

4. Evaluation of the LTC-Insurance

After six years the *success* of the LTC-Insurance can be described with regard to the following main aspects:

First, the number of individuals in need of care who are depending on social assistance has declined by 20% to 33%. This particularly refers to persons who receive residential care. In consequence, local authorities are less burdened and there has been a remarkable reduction in costs of local social welfare funds. However – as already mentioned –, in some cases the provisions of the LTC-Insurance do not cover all expenditure related to care, particularly residential care. It is estimated that about 40 to 50% of those who live in nursing homes still receive social assistance benefits (Bundesministerium für Arbeit und Sozialordnung 1998).

Second, data show that between 66% and 75% of those entitled to benefits of the LTC-Insurance are satisfied with the provisions (Runde *et al.* 1996; Bundesministerium für Arbeit und Sozialordnung 1998; Klie 1998). It can also be observed that there has been a change in the self-definition and self-esteem of persons in need of care; from a recipient

of social insurance provisions to a "client" on the "care market" (Igl 1999).

Third, the number of care services has increased substantially, leading to the introduction of competition and plurality on the "care market". Over the past nine years the number of nursing homes has doubled from around 4,300 (in 1992) to 8,600 today, and the number of home care agencies has risen from an estimated 4,000 (in 1992) to almost 13,000 today. In consequence, those in need of care and their families now have better access to professional support. This is not only true for the different kinds of home care services available but also for day/night and short-term care facilities.

Fourth, at least up to now (see below), it can be observed that the number of persons entering nursing homes is declining, or in other words, more persons receive care within the community for a longer period of time. This development is seen as a result of the financial incentives, i.e., the benefits in cash, that the LTC-Insurance provides for home care. However, the implications of this development for the quality of life of the care recipients and caregivers is yet to be examined. Although it can be assumed that the growing number of professional home care services have many positive effects for caring families, some of these effects might be offset by the fact that persons in need of intensive care might not always receive the kind of support they need (Bundesministerium für Arbeit und Sozialordnung 1998).

Although the introduction of the LTC-Insurance was a step in the right direction, experience with this new scheme has also revealed some *deficits*:

First, according to all available predictions the number of elderly living and being cared for in institutions will increase. In addition, it is also expected that the number of persons in need of intensive care (care level III) will rise more rapidly than the number of persons with lower care levels. By the year 2050, forecasts assume that nearly 3.9 million (Rückert 2001) or even 4.7 million (Deutsches Institut für Wirtschaftsforschung 2000) individuals will receive benefits from the LTC-Insurance – or, in other words – up to 2.5 times more people than today, with an above-average increase after 2020. All these changes challenge the financial resources of the LTC-Insurance (Rothgang 2001). As we have already seen, expenditure already exceeds contributory income (see Figure 3).

Second, since the introduction of LTC-Insurance, the definition of "dependency" has come under much criticism. It was seen and continues to be regarded as too narrow and too much oriented toward physical limitations. Therefore, not all persons in need of care are covered by the

LTC-Insurance. Certain groups of disabled persons – for example, people with dementia or younger disabled persons who can perform most "activities of daily life" but still need supervision and/or some support – are not covered by the insurance or, in other words, they do not "fit" into the categories of defined "dependency". Therefore, the problem of financing the care for these persons remains unsolved and is currently subject to much discussion (Borosch and Naegele 1998).

Third, there has been some criticism that the quality of care provided is suffering since the LTC-Insurance came into force. The reasons for this assumption are that care is provided under time pressure and that the "care market" is confusing for people in need of care or for their relatives. In addition, quality control measures are seen as being underdeveloped. The same applies for effective forms of user involvement, user empowerment, and consumer protection (Schnabel and Schönberg 2000).

Fourth, a further weak point is the organization of the LTC-Insurance which legally confirms the separation between illness and needing care within the German social security system. This is contradictory to the fact that being needy of care – in general – is a consequence of chronical illness and not of decreptitude. Therefore, logically and systematically long-term care should have been covered by the health insurance.

5. Recent Developments

In September 2000 the "Parliamentary Enquete Commission on Demographical Change" carried out an expert meeting in order to evaluate the effects of LTC-Insurance. In general, the arguments were repeated that have been mentioned above. However, the following proposals were made to overcome the deficits already listed:

- In order to guarantee the financial stability of the LTC-Insurance, *a rise in contribution levels* is regarded as unavoidable already shortly after the year 2005. The respective predictions range from 2.6 to 3% in 2030 and from 3 to 4% in 2040 (Rothgang 2001). Thus, a controversial debate on how to financially secure the LTC-Insurance in the future has begun. The proposals range from raising contributions to reducing the benefits to implementing a new (or additional) financial basis, following a capital-stock system. All experts – apart from those representing the employers side – also agreed on the proposal to adjust benefits in line with the cost of care in order to avoid its slow devaluation. At least the provisions for those with care level III should be adjusted and raised substantially.

- Many experts referred to the fact that there are still gaps that must be filled by the LTC-Insurance. This particularly refers to a *broader concept and definition of dependency* which should at least cover dependency caused by dementia. The experts regarded it as very important to make the benefits of the LTC-Insurance available to persons suffering from this illness, too. In the meantime, the German government reacted to this proposal, and at the end of 2001 a bill was formulated. There are plans to improve the situation of informal care providers of dementia patients by offering them special counseling and by financing a number of days in day care centers. These plans are regarded as a first step toward tackling the problem on a broader scale.
- Currently, the German Federal Government is preparing two laws which explicitly aim at a) the improvement and the broadening of quality assurance, and b) the user-participation in developing quality management in the care sector. To develop the quality of care, the so-called "*Quality Assurance Law" (Pflegequalitätssicherungsgesetz)* comprises a range of tasks which primarily refer to internal quality assurance and control (e.g., to improve existing quality control instruments). In terms of user participation, the law not only demands the involvement of user organizations but also of organizations which look after the interests of professionals in the caring sector when quality measures and respective guidelines will be developed in home and institutional care.

Other important proposals to improve LTC-Insurance can be found in a recently published report of the of the "Parliamentary Enquete Commission on Demographical Change". Apart from other aspects, the Commission proposes facilitation of a better cooperation between health insurance and LTC-Insurance, further development of the care infrastructure, a stronger differentiation of the three existing care levels, and an increased flexibility with regard to the provision of different benefits of LTC-Insurance according to the individual needs of beneficiaries (DEUTSCHER BUNDESTAG 2002).

In conclusion, it remains to be seen whether all these suggestions will be realized in the near future. If this indeed happens, the German LTC-Insurance will be a highly appropriate socio-political measure to ensure quality and equality of care and, thus, can be a model for other countries.

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Long-Term Care Insurance in Germany: The Role of the Federal States

Iris Knüver and Matthias Merfert

1. Basic Characteristics of the German Long-Term Care Insurance Law

After almost twenty years of discussion over how the risk of "requiring long-term care" can be covered in socio-political terms, the long-term care insurance scheme was put into force in Germany in 1995, thus acting as the fifth "pillar" of the social security system.[1]

The SGB XI, that is, the *Gesetz zur sozialen Absicherung des Risikos der Pflegebedürftigkeit* [Law on Social Insurance Against the Risk of Requiring Long-Term Care] (abbreviated as *Pflegeversicherungsgesetz* or "Long-Term Care Insurance Law") is a federal law, in which basic guidelines and intentions are stipulated. The detailed structure of the long-term care insurance scheme is partly the responsibility of the German federal states, which have each passed state care laws. Therefore, in order to make the picture on the German long-term care insurance system complete, it might be appropriate to include these state laws in the analysis. In this article, an outline of the most relevant state law regulations, with special attention on the state care law of North Rhine-Westphalia, will be given. Before doing this, however, it might be useful to briefly consider the most basic characteristics of the new Long-Term Care Insurance Law:

First, it is important to keep in mind that the Long-Term Care Insurance Law is not designed to guarantee the person in need full care services if that need should arise. It serves only to supplement the assistance provided by relatives or neighbors with home care and, in the event of long-term institutional care, covers the costs of care services (depending on the level of need), but does not pay for board and lodging.[2] Basically, home care is given priority over institutionalized care (§3, clause 1 SGB XI). Further, the importance of prevention and rehabilitation is explicitly stressed (§5 SGB XI).

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[1] For more details see Bäcker *et al.* (2000: 93–107 and 332–399) and Gerhard Naegele's and Monika Reichert's article in this volume.

[2] For more details see Rückert (1999).

Second, for the first time within social legislation in Germany, the attempt has been made to set up free-market instruments in order to gain control of the costs of providing care, which have been rising consistently and will continue to rise, given the forecasts of a steady increase in the numbers of those in need of care. Thus, with §11, par. 2 SGB XI, on the one hand, priority is given to non-profit and private institutions over public institutions. On the other hand, with regard to financing, drastic changes are being forced on public institutions and on voluntary welfare organizations.

With the introduction of the principle of competition into the long-term care sector, the suppliers of services are obliged to provide their services in an economically efficient manner. In this context, it is very important for users to be ensured that there will be no deterioration in services as a result of this principle, but rather that quality standards in long-term care are maintained. Legislation provides this in the form of §80 SGB XI and sees to it that the principles and standards for quality of care, quality assurance, and quality control procedure are fixed at the federal level. They are binding on the long-term care insurance schemes, as well as on their associations and the authorized long-term care facilities. In this way, an attempt is being made to fix quality assurance as an instrument of consumer protection.

2. The Participants in the Process of Care

Those directly involved in long-term care are explicitly mentioned in the law, and the division of responsibilities among them is stipulated in it. As an important principle, long-term care is defined in §8 SGB XI as being a task for the whole society which is performed by "the federal states, local authorities, long-term care facilities, and long-term care insurance schemes [which are working] closely together, including the involvement of the medical service, in order to guarantee efficient, regionally divided, local, and well-coordinated long-term care for people at home and in nursing homes". The care facilities are obliged to take the generally acknowledged level of medical care as a performance standard when providing for those people they are looking after (§11 SGB XI).

A considerable degree of responsibility is attributed to the newly created long-term care insurance schemes, which, as the financial carriers of long-term care insurance, are affiliated to the health insurance schemes. In §12, par. 1 SGB XI, they are endowed with the task of providing care for those insured. They work to this end "[…] closely together with all those involved in nursing, health, or social care work and work

toward eliminating faults in the provision of nursing care". In order to attain this target, the long-term care insurance schemes must form regional and local associations.

The federal states are given the responsibility in §9 SGB XI of "providing an efficient, numerically appropriate, and economically effective care system". As already mentioned, they have also been included, together with the other participants, in the duty of providing long-term care as part of the "task for the whole society" (§8 SGB XI). This very vague description of their responsibilities leads to there being different structural options for the states, as stipulated in their relevant laws, and makes it necessary to coordinate the work of those involved in providing care services. The state long-term care committee is a statutory coordination and advisory body which is stipulated at the state level in accordance with §92 SGB XI: "A state long-term care committee is formed by those involved for each state or for parts of the state in accordance with par. 2 and serves to advise on questions concerning the financing and operation of long-term care facilities"; and "the state long-term care committee comprises an equal number of representatives from the long-term care facilities and long-term care insurance schemes, including a representative of the medical service of the health insurance scheme as well as a representative of the responsible state authority. The committee also consists of a representative from each of the supra-local social security institutions, the registered association of private health insurance, and the local health organizations in the state" (§92, par. 2 SGB XI). The state governments are authorized through by-laws to regulate other matters relating to the composition of the state long-term care committee.

Some critics, however, argue that the significance of the state long-term care committee is limited in two ways. First, the committees are not in a position to control the structure of care even to a small extent, a fact which is particularly applicable to the larger federal states, and second, the committees, in accordance with §92, par. 1, clause 3 SGB XI, only give recommendations which are not binding to any significant degree. Accordingly, the importance of the state long-term care committees depends on the relevant state regulations. In 11 of the 16 federal states, the state long-term care committee is mentioned in the state law on long-term care, in each case in connection with the drawing up of state plans. The degree of participation ranges from those which just have a "listening-in" function, through those which participate, to those who commit themselves to an advisory function (see Eifert and Rothgang 1997).

At the local level, other possible coordinating bodies are represented by working groups or so-called long-term care conferences, which will be described in greater detail below. These are in a better position than

the state long-term care committees to look at the special needs that arise at the local level, and to exercise a small degree of control in respect of the care infrastructure. However, the local authorities are only mentioned explicitly in §8 SGB XI. While other areas of responsibility have been created for other participants elsewhere in the law, the local authorities still have no standard responsibilities of their own. The fact that they at least – albeit very late – found their way into the text of the law, might ensure the traditionally high importance of local authorities in the long-term care sector and should also lend them more weight with regard to future long-term care policies. The SGB XI has led to a reduction in the responsibility of local long-term care policies, which was unavoidable as a result of the appearance of new participants in the long-term care process. Nevertheless, local authorities still play a significant part in long-term care policies: under Article 28 of the *Grundgesetz* [Federal Constitution], they are given the responsibility for providing public services to local communities, whose fundamental responsibilities – including care-related issues – are delegated to the respective local administrative bodies.

With §9 SGB XI, the states were given decision-making powers as to what level of responsibility should be passed on to the local authorities, and the states did indeed use these powers to set up quite different regulations. The state of North Rhine-Westphalia, for example, endows its local authorities with comparatively wide-ranging responsibilities, in order that they can continue working from the basis of existing and proven structures (see Borosch and Naegele 1997). In §2 of this state's Long-Term Care Law (PfG NW; see Ministerium für Arbeit, Gesundheit und Soziales des Landes Nordrhein-Westfalen 1996), the local authorities are handed over the responsibility of safeguarding long-term care: "The districts and urban municipalities are obliged to ensure a range of care services in accordance with this law, which meet local requirements, and take the wide range of financial carriers into account".

3. Long-Term Care Conferences

In order to put the unclear responsibilities of the local authorities into concrete terms in the SGB XI, proposals were made at the "Federal Conference on Quality Assurance for those Requiring Long-term Care" to organize conferences on the subject of long-term care at the local level. Possible tasks for these long-term care conferences were found in the following fields (see Rosendahl and Zängl 1997):

– regular exchange of information and extensive communication on the implementation of the SGB XI,
– planning and further development of care services and linking them up with the other benefits given to retired and disabled people,
– stipulation of quality standards and development of quality assurance instruments,
– influence over the drafting of contracts and the contents of long-term care agreements, and
– advice and training of facilities and long-term care staff or individuals providing long-term care.

The state of North Rhine-Westphalia has taken up these proposals in §5 of its state Long-Term Care Law: In order to fulfill the responsibility of society in accordance with §8 SGB XI and to carry out the tasks stipulated in the PfG NW and in §§8 and 9 of SGB XI, the districts and urban municipalities are obliged to set up conferences on nursing care as coordinating bodies and to take over their management (§5 PfG NW). The tasks of the long-term care conferences include cooperation in ensuring the structure of the care services – including the relevant complementary benefits – and in improving their quality.

These tasks are fixed in concrete terms in the respective rules of procedure of the long-term care conferences at the local level. Four partial goals were set at the meetings of the model project "The Implementation of Long-term Care Insurance Services at the Local Level in North Rhine-Westphalia", which was established in scientific cooperation with the Research Institute for Gerontology: (1) information and transparency, (2) networking, (3) infrastructure planning of long-term care services, and (4) quality assurance.

In accordance with §5, par. 3 of PfG NW, long-term care conferences, in addition to members sent from the district or urban municipality, are made up of representatives of the long-term care facilities, long-term care insurance schemes and the medical service of the health insurance scheme, the local old-age pensioners' representative groups, and the association of local self-help groups for disabled or chronically ill people. There is also the possibility for other institutions connected with long-term care to be included.

The decisions of the long-term care conferences take the form of recommendations. The original idea of using the conference to set up a body whose decisions were binding on all participants could not be put into practice and was therefore modified. The recommendatory character has the advantage of maintaining the autonomy of the participants and easing the problem of proportional representation of the participants (see

Rosendahl and Zängl 1997). The status of the long-term care conferences is reflected – among other things – by the fact that, in accordance with §6 PfG NW, the districts and urban municipalities participate in drawing up the so-called long-term care requirement plans.

Beside the state law on long-term care in North Rhine-Westphalia, provisions have been made in the regulatory statutes of three other federal states for committees in the form of conferences or working groups that coordinate care issues at the local level in order to set up necessary structures for offering a range of services. In the city-state of Hamburg, a long-term care conference can be set up with the aim of ensuring and further promoting the quality of long-term care services. The state of Lower Saxony, too, allows the organization of one or more conferences on long-term care under the provisions of a regulatory statute. However, both state laws do not put the local authorities under any obligation to do so.

By contrast, in the state of Rhineland-Palatinate – as in North Rhine-Westphalia – the setting up of conferences on long-term care at a local level is compulsory. Here, they are called "working groups" that are formed by the district councils and local authorities and are aimed at securing and improving the infrastructure. In addition to North Rhine-Westphalia, Lower Saxony, Hamburg, and Rhineland-Palatinate, three other federal states (Hesse, Saarland, and Saxony-Anhalt) refer in their respective state laws explicitly to coordination at the local level (see Eifert and Rothgang 1997).

4. Requirement Planning

All states make provisions in their laws for more or less detailed assessment and planning of requirements. Moreover, almost all states limit their financial support to those facilities which are recognized as suitable to the needs of the market. The planning of requirements always covers care in nursing homes, in most cases part-time care in such homes and often outpatient care, at least to some extent (see Eifert and Rothgang 1998). Following the establishment of conferences, the planning of requirements is another task the local authorities are assigned to. The purpose is to contribute toward upholding the structure of the care services and thus meeting the requirements stipulated in §9 SGB XI. In the state of North Rhine-Westphalia, the responsibility of drawing up the local requirement plans is passed on to the local authorities (§6 PfG NW).

At the same time, it appears to be a problem that the Long-Term Care Insurance Law emphasizes both market orientation and the need to plan

the structure of long-term care services in order to secure a minimum quality standard. The local authorities' means of control are limited from the outset by this contradiction. They are supposed to intervene in the care sector in order to regulate it, but access to the long-term care market is tied in §72 SGB XI to long-term care agreements, which are concluded between the investors of long-term care facilities and the long-term care insurance schemes. Basically, facilities have a right to be approved for a long-term care agreement, provided they fulfill the legal requirements.

In §2, par. 1 of the regulation governing long-term care requirement plans by local authorities, the "districts and urban municipalities […] shall take into account the planning aids published by the Ministry for Labor, Health and Social Affairs […] when assessing the requirements", in accordance with the state long-term care laws. The planning guidelines are to replace the margins of interpretation which hitherto existed in order to facilitate (1) a region-specific assessment of demand, (2) an assessment of demand appropriate for groups specifically targeted, and (3) a uniform calculation procedure (see Frerichs 1996).

In other federal states like Bavaria, there are no uniform planning guidelines. As a result, the local authorities are forced to draw up their own criteria for the planning of requirements (see Eifert and Rothgang 1998).

5. Advisory Services and Other Functions of the Local Authorities

The Long-Term Care Insurance Law provides advisory services for people requiring long-term care, for those who are at risk of requiring care, and for their relatives. According to §7 SGB XI, "the long-term care insurance schemes […] must support the self-reliance of those insured by providing information and advice on how to lead a healthy life, prevent the need for long-term care in old age, and by encouraging the participation in measures to promote health" as well as "informing and advising the insured parties and their relatives regarding issues connected with the need for long-term care, particularly the services of the long-term care insurance schemes as well as services and benefits from other financial carriers".

The confusion surrounding the long-term care market makes it almost impossible for those concerned to get complete information in order to find out the best combination of services and how best to use them. For the purpose of providing information on services available on the long-term care market, the state of North Rhine-Westphalia demands that "those requiring care, those at risk of requiring care, and their relatives

are advised independently of the supporting authority and informed of the necessary assistance in connection with home care, part-time or full-time institutionalized care, and other complementary benefits […]. The advice is to be given in cooperation with the local authorities, long-term care insurance schemes, and others involved in providing care. Within the scope of the conferences on long-term care, these parties advise each other on a suitable procedure as well as on the form of assistance when selecting a suitable offer of assistance" (§4 PfG NW).

In order to fulfill the contract for advisory service, it is not necessary for the local authorities to set up new advisory services. It is sufficient to point to the various providers at the local long-term care conferences. In this way, those requiring care, those at risk of requiring care, and their relatives can be advised by the local authorities, and existing services can be extended or the advisory services performed in cooperation with welfare organizations. These services can also be delegated to a consumer's advice center, something which is already being practiced. As far as the financial support of these advice centers is concerned, there is some criticism that the financial carriers of the advice centers are sometimes also providers of services. Thus, it is not always ensured that the advice provided is independent of the investors' interests.

In addition to the above-mentioned areas, the local authorities have two other functions with regard to the long-term care insurance scheme: First, the local authorities are affected by the introduction of long-term care insurance as providers of care services. As has already been pointed out, the introduction of long-term care insurance led to a series of changes for the providers of services. The aim now is to generate an economic approach in the way the facilities are run. One way of achieving this goal is to move away from the principle of full cost coverage and toward performance-related, previously agreed remuneration. The other way is to introduce the mechanisms of a free-market economy. Second, the local authorities are affected in their capacity as social security institutions. As such, they are relieved in part of the costs of care, but remain responsible for providing assistance with care and supplementary social security benefits (see Igl 1995).

6. Conclusion

In sum, it can be said that the implementation of the Long-Term Care Insurance Law has brought about a fundamental change in long-term care in Germany. With the orientation toward market structures and the reduction in responsibilities that state authorities hitherto held, both the

general situation of long-term care and the division of responsibilities among those involved in care were fundamentally reorganized.

Those requiring care are now entitled to receive assistance from the social long-term care insurance scheme, allowing them to live in their home environment for as long as possible. The range of responsibilities of the local authorities, on the other hand, which up to now was quite substantial, has been determined by the respective federal state long-term care laws and is therefore not uniform throughout Germany. In the state of North Rhine-Westphalia, local authorities are responsible for an extensive range of tasks in social planning. By saving on welfare costs, some of the load is now taken off the local authorities, which, due to their commitments to financing long-term care in accordance with the Federal Social Assistance Law, see their ability to act increasingly threatened.

To conclude, it can be said that both from the point of view of those concerned and of the changed financing structure, a positive approach has been made by ensuring against the risk of "requiring long-term care" within the scope of a social security scheme. However, it must be emphasized that with the change in the organizational structure of the long-term care sector, transitional problems have arisen and, even more important, enormous adjustments have had to be made on the part of all those concerned. Furthermore, questions still remain unanswered in important areas (e.g., problems in the quality of care and in social care in hospitals and nursing homes).

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Long-Term Care Insurance in Germany and Japan: A Comparative Comment

Thomas Klie

The following remarks will comment on long-term care insurance in Germany and Japan in three steps. First, I would like to point out what the Japanese and German efforts to offer social insurance against the risk of needing long-term care have in common. As a second step, I wish to draw attention to what I perceive as substantial differences between the two systems. Finally, I will pose a few questions which appear to be of considerable importance for future discussions in both Germany and Japan.

1. Similarities in Long-Term Care Insurance in Germany and Japan

Both Germany and Japan are confronted with demographic aging – in Japan at the proverbial Shinkansen [bullet train] speed, in Germany somewhat more slowly. This means that fundamental changes in the system of social security and its financing are becoming necessary. In Germany, the system of care for the elderly is in special need of reorganization.

In addition to the demographic challenge, developments that may be subsumed under the fashionable term of "modernization" are constantly reshaping both societies. As a consequence, traditional forms of private solidarity – which constitute the basis of social security for those who need care in both countries – are under pressure and will not be maintained for much longer in their current form. Nevertheless, social security will have to rely on private solidarity which up to this day remains the central pillar when care is necessary.

Strenuous efforts in each country to rationalize its cost-intensive health care system in connection with the critical situation of public finances can be witnessed. In both countries, the health care system, hospitals in particular, has taken part in the provision of long-term care. In Japan, this process is exemplified by the recent expansion of geriatric rehabilitation facilities, even though patients were often not specifically rehabilitated in the strict medical sense.

In both countries, social security for those who need care has been taken up as a national task that is not supposed to be dealt with at the welfare level. Taking into account their lifelong contribution to society, the elderly are thought to be entitled to social security when they require care, without becoming dependent on social assistance. Reliance on social assistance is ill-regarded socially in both countries, an recipients are stigmatized. In Germany, long-term care insurance was introduced partly in order to provide noticeable relief to local authorities, who are heavily in debt, not the least due to their assistance-providing function.

Every model of long-term care insurance that has been developed so far envisages only partially funded care when it is needed. Protection when care is needed is generally based on a combination of funds. In the Japanese model, there are even more participants than in the German one. In both cases, the range of possible aids and services is broad – ranging from home care to fully integrated institutional care. This is done with the aim to build a need-oriented infrastructure of help nationwide; in Germany, responsibility for this infrastructure is divided between the federal government, regional governments, *Pflegekassen* [long-term care funds], and local authorities. While responsibilities for planning are more clearly defined in Japan in accordance with a more traditional concept of planning, they still lie with authorities on various levels.

Both countries make use of market forces to encourage the expansion of services and facilities available as well as to guarantee choice for those in need of care and their relatives. As a result of such an economy of demand rather than a policy of public subsidies, both countries hope for improvements in the development of their infrastructure, especially with regard to home care. In Germany, a narrow regulatory framework for institutions and services offers strict criteria for each type of institution, resulting by and large in the future disappearance of many of the currently numerous kinds of homes, for example the *Altenheim* [home for the elderly]. In both countries, it is not a free, but a heavily regulated market.

These similarities show that problem-solving strategies are comparable despite cultural differences. They also show that there are global influences: the Japanese, for example, have collected information about the different systems of social security for long-term care across Europe. What they have learned from the European discussion, or rather, what conclusions they have drawn, is evident from the differences between the German and the Japanese model.

2. Differences Between the German and the Japanese Model of Long-Term Care Insurance

Even though the Japanese use the term "long-term care insurance", it is not an insurance proper according to the German understanding of statutory social insurance. On top of insurance premiums, the Japanese government allocates tax funds for the financing of long-term care insurance. The prefectures as well as local authorities retain some freedom to act, but also carry certain responsibilities for contributions of their own, including a financial one. Concerning future developments in Germany, the question is how the model of a statutory social insurance system can be developed in the context of a changed age structure, in order to guarantee the funding of health care and social security in the future. Long-term care insurance in Germany was implemented at a time when the ability to finance, for example, the public pension scheme, was becoming the subject of intense debate. In addition, some do not consider the need for long-term care as a typical social risk in the model of social security. That is because the concept of social insurance is based on the protection against risks inherent in the work environment and assumes the equal division of contributions between employer and employee. As the labor market is being globalized, high marginal costs of labor are regarded as a disadvantage in the face of international competition. In Germany in particular, this leads to an unprecedented tightening of expenses in care insurance, exemplified by the introduction of the principle of stable contributions.

While in Germany the *Pflegekassen* – organized partly on a national, partly on a regional scale – support long-term care insurance, in Japan local authorities must fulfill this function. In Germany, local authorities were to be largely relieved of the cost of social assistance for those in need of long-term care, but they have also lost some control in securing long-term care provision. In Japan, in contrast, local authorities play a central role in this area. Local authorities are entrusted not only to implement care insurance but also to finance additional and more extensive institutions and services, this process being subject to discussion of social policy measures at the local level. This reflects regional demographic and cultural differences as well as the importance of local policies in support of private solidarity vis-à-vis those in need of long-term care.

In Japan, the group of people entitled to receive benefits was deliberately defined differently from Germany. Thus, one difference can be seen in the entrance level, which is lower in Japan. Not only those in need of physical long-term care, but also those who simply need help at home are entitled to receive benefits in certain cases. In determining the criteria for

the need for care, the special needs of elderly people with senile dementia were also taken into consideration. In Germany, recognition of the need for care of those with senile dementia constitutes a special problem (Klie 1998: LPK-SGB XI, § 14, Rz 7).

In Germany, the health care system on the one hand, and that of long-term care insurance on the other, are kept strictly separate. While health insurance remains responsible for acute medical care, the care for the chronically ill lies in the hands of long-term care insurance. The principle of "rehabilitation before care" is almost invalidated due to this division of financing depending on the particular case, which is impeding the integration of medical and long-term care (Igl 1995: 289). In Japan, attempts are being made to integrate geriatric rehabilitation and acute medical care into the long-term care insurance system – although not without resistance from the medical sector. The best solution is still open to discussion between policy and care experts.

While the Japanese model assumes that services and institutions support those who require care and their relatives in securing care, the German long-term care insurance leaves a choice between financial aid and service provision – cash or care. Experience with long-term care insurance reveals that people in need of care and their relatives are far more inclined to financial support, than to aid in the form of services. In Germany, around 80% of people receiving care at home choose financial aid, while only 20% prefer service provision. As far as we know, the cash benefits have little influence on care behavior. Those receiving care and their relatives use care payments according to their own cultural predisposition concerning care; it does not lead to alterations in care arrangements (Evers 1997; Blinkert and Klie 1998). Traditional motives for providing care to relatives are supplemented by modern expectations of reciprocity. Cash benefits are especially relevant for those households in which a somewhat "traditional" way of life is pursued, i.e., being married, having more than one child, and showing low mobility during the life cycle. In such cases the benefits of long-term care insurance lead to a high degree of satisfaction of those requiring care. With regard to disabled people with unstable social relationships, satisfaction with the benefits of long-term care insurance decreases perceptibly (Blinkert and Klie 1998).

In Germany, assessment of care need is undertaken by the Medical Services Authorities of the health insurer, which serve as an expert committee of the *Pflegekassen*. Assessment in Japan, by contrast, is integrated into a model of care management, for which local authorities are responsible. Its explicit aim is to guarantee coordination between the different services and care-providers. In Germany, such a consistent model of care

management in the context of implementing long-term care insurance is lacking.

3. Common Problems for the Future Development of Long-Term Care Insurance

Finally, I would like to pose a few questions which are of concern to both long-term care insurance systems. First, there is the question of the relationship between care organized in a private context and professional care as provided by specialized services and institutions (Braun and Schmidt 1997). The differences in the organization and conceptualization of care in the private and professional contexts must not be underestimated. It is a great challenge for professionals to utilize their skills for care that is otherwise organized on a private basis and, in the process, to culturally develop it further in order, for example, to prevent stress situations and possibly violent behavior as a consequence, without giving orders to the families in question (BMFSFJ 1996). In both countries, long-term care insurance is a modernization project that can be regarded as no less important than the introduction of public education for children. The reservations concerning public interventions into private life – education and nursing care – are presumably different in both countries due to different cultural backgrounds.

Related to the problem of privately organized care in relation to care that is professionally controlled and provided is the central question of the relationship between cash and service benefits (Evers 1997). Due to the limited resources provided by long-term care insurance, the contribution, which services and institutions can offer with the help of long-term care insurance toward securing the care needed, remains small. It is important to further develop the infrastructure, including services and institutions, for securing the provision of care. However, doing this is still largely a task which can only be solved adequately by a combination of various contributions from private solidarity networks, market forces, and social benefits guaranteed by the state. Cash benefits offer the option of more flexible care arrangements, which can fall back on the specific resources of each network but also of a society that is turning service-oriented. I think that in Germany, as in the Netherlands, the normative predominance of service provision will disappear in the medium-term in favor of the promotion of supervised cash benefits.

In the context of securing long-term care provision, we may consider whether a care profession independent of medicine will emerge, which would not be characterized by the medical paradigm of ill-health but

develop a health-oriented concept of care and support for those in need of care. The German long-term care insurance was developed in the context of, and influenced by, the health insurance system. Consequently, the concept of the need for care is defined predominantly according to medical criteria. Long-term care insurance still has a long way to go before it can offer its own concept of need for care, rooted in a science of care. Only the diagnosis of the need for care caused by ill-health justifies the receipt of benefits from the care insurance. Securing long-term care when required offers a major challenge for the largely hospital-oriented provision of care. Despite a number of cautions and criticisms concerning the model of long-term care insurance from the point of view of a science of care, it is clear that professional care gains considerably in importance through the care insurance system, since care professionals assume equal responsibility together with medical practitioners, both in establishing a need for care and in tasks such as care advice and examination. In order to be able to fulfill these functions adequately, the care profession is subject to major demands concerning its qualification (Klie and Steppe 1996; Entzian and Klie 1996). In both countries, the science of care as an independent science is still in its beginnings. At least in Germany, it is receiving a great boost through long-term care insurance.

As a third question, I would like to discuss the fair distribution of the limited resources available for securing long-term care in social terms. This raises the issue of inverse redistribution which is linked to that of care insurance. The beneficiaries of long-term care insurance in a clinical context, for example, are those with a net income of around 1,530 Euro per month. They are the only ones to remain without welfare payments, while those earning less are still dependent on social assistance (Rothgang 1997: 191–219). On the international scale, procedures of assessment and classification are sought to help ensure that (1) different backgrounds and forms of care need are considered on equal terms, (2) those services which people in care wish to receive are also recognized, and (3) the time required by family helpers and professional personnel for the various care tasks can be measured in a suitable manner (Équippe de Recherche Operationelle en Santée 1996). This task has just been taken up, especially with regard to private care. By and large, home care is still a black box – at least from a scientific point of view.

The fourth and last question to be raised is that of the future role of local authorities. It is at the local level where help is provided, social culture gains or loses cohesion, and new as well as traditional social networks can successfully be supported and created. In Japan in particular, local differences appear to be noticeable and are taken into account in the model for long-term care insurance. The model of the German care

insurance is a unified one and theoretically covers the Federal Republic of Germany with a uniform pattern of institutions and services without leaving room for contributions at a local level. It is doubtful whether this model is a suitable one in the context of limited benefits from care insurance and the central role of local networks, since it removes the issue of need for care from those responsible for social policies. From the point of view of demand, however, securing the provision for care at a local level ought to be integrated into a concept of local provision for the elderly and the disabled (Klie and Spiegelberg 1998).

4. Summary

Both the initial situations and the models for the introduction of long-term care insurance in Germany and Japan offer numerous similarities. It is also possible to discover striking differences. The definition of the need for care, the role of local authorities in the implementation of care insurance, and the availability or non-availability of the choice between cash benefits and services in the private context are examples for this. It is the comparison of the models in these two countries that allows us to pose questions central to the development of a future care insurance, which can be summarized under the following headings:

- the relationship between care organized in the context of private life and professional care;
- the emancipation of securing care provision from the medical sphere;
- the fair distribution of scarce public resources for the welfare state; and
- the role of local authorities in a future "welfare mix".

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How Policies Differ: Long-Term-Care Insurance in Japan and Germany[1]

John Creighton Campbell

1. Introduction

Facing the 1990 general election in Japan, Hashimoto Ryūtarō, the LDP top leader most identified with health and welfare policy, committed his governing party to a new expansive policy for frail older people. Facing the 1990 federal elections in Germany, Norbert Blüm, the CDU top leader most identified with health and welfare policy, committed his governing party to a new expansive policy for frail older people.

Ten years later, Japan and Germany are the only countries in the world with "pure", large-scale, public long-term-care insurance (LTCI) systems.[2] The obvious first question is "why?" Actually there are two questions here:

1. Why did these two countries start big new entitlement programs at a time of widespread calls for constraining or cutting back the welfare state?
2. Why did both opt for the social insurance model?

Even more intriguing than these two similarities are some differences in the two programs:

3. Why does the German system apply to disabled people of all ages, and the Japanese program just older people?[3]

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[1] This is a revised version of a paper presented at a panel on "Japan's Welfare Policies in Comparative Perspective", chaired by Gregory Kasza, at the Second International Convention of Asia Scholars in Berlin in August, 2001. My thanks to Gregory Kasza, Ikegami Naoki, and Ruth Campbell for their comments.

[2] *Pflegeversicherung* was enacted in 1994 and started in 1995 in Germany, with a three-month period of contributions before benefits started. *Kaigo hoken* was originally scheduled to be enacted in 1995 but was passed in late 1997; examinations started in 1999 and both contributions and benefits started in 2000. As for other countries, Israel has a small LTCI program; Austria and the Netherlands have substantial LTC programs that have some insurance aspects; the Scandinavian countries have very substantial provisions for LTC without insurance – i.e., tax-financed directly provided services.

[3] That is, only those 65+, with the minor exception that people aged 40–64 who have an "aging-related disease" are included.

4. Why is the Japanese program bigger – in the proportion of elderly people covered, and in the size of benefits – than the German program?
5. Why is the German program "capped" to prevent expansion, at both the micro and macro level, while the Japanese program is more open-ended?
6. Why does Germany offer a cash allowance to encourage "informal" caregiving by family members while Japan provides only formal services?

From a comparative public policy perspective, I would suggest that this is a plausible list of the most significant questions about LTCI in Germany and Japan.[4] Most of them are genuine puzzles, counterintuitive in one way or another. I will try to explain all of them sufficiently but briefly. That is, I will try to mention all the key factors, but provide only enough detail to make the argument clear.[5]

My conceptual framework is an adaptation of a longitudinal model I developed years ago, as an attempt to explain how policies change over time. Here I use it as a "cross-sectional" model, to explain differences between countries.[6] This framework aims at choosing among four *types* of explanation, that ascribe differences in policy across nations to:

A. Differences in their basic policy problems.
B. Differences in politics – what groups with what interests have power.
C. Differences in structural or policy legacies that limit the possibilities ("historical institutionalism", more or less).

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[4] There are some other differences: e.g., Japan has "care managers" to help users select, contract, and monitor services, while Germany leaves it to families. However, I think these six are the most important.

[5] In emphasizing comparative explanations I do not attempt to cover the details of the two programs or their decision-making processes, how well they have been working, and whether or not they are good public policy. Other accounts of the Japanese system in English include Paul Talcott's article in this volume, Eto (2000), and Campbell and Ikegami (forthcoming). For Germany, see Cuellar and Wiener (2000), Alber (1996), Goetting *et al.* (1994), or Naegele and Reichert in this volume.

[6] See Campbell (1992), esp. chaps. 2 and 11. The longitudinal model posits four ideal-type explanations of change: cognitive, a rational response to a change in the environment without energetic conflict; political, a product of conflict among actors with different interests; inertial, some sort of "automatic" continuation of past patterns with no new ideas or energy applied; and artifactual, a "garbage can" caused by accidents of timing, random bursts of energy, or other unconnected factors.

D. Differences in the timing or sequencing of events or other "artifactual" (or even "accidental") differences.

It will be recognized that the first three types of explanation are those most often used in comparative public policy research. The last one, drawn from the "garbage can" school in organization theory, is more unusual but is important to include as in effect a "null hypothesis" (which often cannot be convincingly rejected once proposed) (March and Olsen 1976).

2. Why Did These Two Countries Start Big New Entitlement Programs?

The explanations were quite similar for both, and fall into two of our four types. The first reason is two social trends. One trend was population aging. In 1990, 15% of the German population was aged 65+; note that the only markedly older countries in the world (i.e., by at least a percentage point) were in Scandinavia and already had substantial LTC systems. Japan was relatively young in 1990, at 12% aged 65+, but everyone knew that the population was aging at the most rapid pace in the history of the world. The 65+ population would hit 17% in 2000, 25% in 2020, and 30% in 2050 (National Institute of Population and Social Security Research 1999).

Although many of these old people can get along fine on their own so long as they have adequate incomes and medical care, a substantial proportion become impaired by physical or mental disabilities to the extent they need assistance from others to lead anything like a decent life.[7] That assistance could be provided in institutions (hospitals, nursing homes, various sorts of "assisted living facilities"), or while the older person is living in the community. The point that the number of frail elderly who needed assistance was growing rapidly was widely remarked by the media in both countries.

The other social trend was a perceived decline in the main source of assistance for the frail elderly, which in all nations is the family and, more particularly, wives, daughters, and daughters-in-law. This trend was more obvious in Japan, where uniquely among the advanced nations a

[7] Definitions vary but certainly 8–12% of those aged 65+ are effected. Some claim that medical advances are producing a "compression of morbidity" that will reduce the proportions of disabled people, but this argument is controversial and the effect if any is likely to be greatly offset by population increases particularly among the oldest age groups.

majority of the elderly lived in the same household with an adult child. That the *dōkyoritsu* [living-together rate] was declining steadily was always cited by those who argued (approvingly or not) that the traditional Japanese family is falling apart.[8] Germany lacked a statistic quite so convenient for pointing with alarm, but in both countries it was thought that women's attitudes were changing. They were more likely to go to work, or even if they stayed home, less likely to be content with the burdens of caring for an aging relative.

Another reason was operational problems with existing systems of providing long-term care (beyond the common criticisms that they were unfair or inadequate).[9] Nearly all the advanced nations have found that their policies for old-age care are biased toward putting people in institutions rather than providing services at home, which is generally seen as both more humane and cheaper. Germany and Japan were rather extreme on this dimension, since in both countries community-based care was quite inadequate as of 1990 and it was relatively easy to gain admittance to an institution at public expense – nursing homes in Germany, hospitals in Japan, where "social hospitalization" (*shakaiteki nyūin*) of people who were not particularly impaired was widely seen as a problem.

But those are somewhat abstract problems. It was immediate fiscal pressures that were most important. In Germany, the majority of people in nursing homes had to pay for it by going on public assistance. That money comes out of local government budgets, and was rapidly increasing to the point of putting many municipalities in the red. In Japan, the special "health insurance for the elderly" program was cross-subsidized by regular employees' health insurance, and its rapidly rising expenditures, largely due to "social hospitalization", were becoming more and more oppressive.

Rising needs and declining social resources on the one hand, and fiscal pressures on the other, are good Type A explanations for why long-term care for the elderly was seen as a serious problem in both Germany and Japan as of the late 1980s. However, problems do not directly cause policy: social ills and administrative difficulties can continue and even get worse over long periods without the government taking any effective action. Many problems never rise to the policy agenda of issues that get serious discussion in and around the government.

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[8] The ratio has been falling by about 1% a year – e.g., those 65+ living with a child was 69% in 1980, 50% in 1998 (Kōseishō 2000).

[9] Heclo (1974) observes that difficulties with previously enacted programs is a major engine of social policy change.

Here a Type B explanation comes into play. Long-term care got on the agenda in Germany and Japan by the same route. The issue was picked up by a political "issue entrepreneur" in the context of an election campaign (KINGDON 1984). In Germany, the entrepreneur was Norbert Blüm, then Minister of Social Affairs and long-time leader of the progressive or labor wing of the ruling Christian-Democratic Party. An election was coming up in December 1990, in the difficult political environment of pending reunification as well as lackluster economic performance. Blüm thought the CDU needed a positive-sounding issue, particularly one that would hold on to its traditional high support rate among the elderly.

In Japan, the entrepreneur was Hashimoto Ryūtarō, long-time "boss" of the *sharōzoku* or the "tribe" of LDP Dietmen who specialize in health, welfare, and labor issues. Hashimoto was enough of a power in LDP factional politics to be a contender for party president and Prime Minister (which he achieved in 1996), and he already had experience as Minister of Finance and most recently as LDP Secretary-General. He had resigned that post to take responsibility for the LDP's biggest electoral debacle in its history (until then), its sharp defeat in the July 1989 election for the Upper House.

The most potent issue for the opposition Socialists in 1989 had been the new consumption tax, which had been justified by the government as needed to meet the burdens of the aging society. The Socialists claimed that this was just a pretext, since there were no concrete plans to spend the money on old people. After the defeat, with a general election impending early in 1990, Hashimoto got busy and cobbled together just such a concrete plan. It was called the "Gold Plan" or the "Ten-Year Strategy for Health and Welfare of the Elderly".[10] The Gold Plan was approved by the Cabinet in December 1989, and was featured in LDP campaign materials and brought up repeatedly in the televised debates before the election (which, for whatever reason, was something of a victory for the LDP).

The Gold Plan preamble began with concern for the rapidly aging society, in which nearly one in four Japanese would be 65 and over, and emphasized the

[10] The Gold Plan was not a complete bolt out of the blue: the government had been moving toward a commitment to expanding programs for the elderly ever since the neoconservative "administrative reform" and "reconsideration of welfare" movements had faded out in the mid-1980s, as indicated by a series of "visions" from various agencies in 1986–88. This saga is recounted in more detail in CAMPBELL (1992: 241–253).

> need to create a longevity-welfare society of bright vitality (*akarui katsuryoku aru chōju-fukushi shakai*) in which citizens can be assured of living out a healthy and meaningful life. Therefore, based on the goals of introducing the consumption tax, we will move forward in building up provision of public services in the area of health and welfare for the elderly […]

The body of the plan was 25 numbered points including many very specific and very expansive targets – for example, to increase the number of homehelpers from 31,000 in 1989 to 100,000 in 1999, institutional beds (other than hospitals) from 191,000 to 520,000, short-stay beds from 4,000 to 50,000, adult day-care centers from 1,000 to 10,000. It also would create several new programs such as sheltered housing (for 100,000 people) and local home-care coordination centers (10,000). Incidentally, the specific ideas included had mostly been talked about for a long time among old-age experts in and around the Ministry of Health and Welfare (MHW).[11]

A high-profile campaign promise in Germany, a campaign promise backed by a specific cabinet resolution in Japan – should these events be seen as the key policy changes? Clearly not. Campaign promises are often broken everywhere, and in Japan many expansive and detailed "visions" soon fall by the wayside despite official Cabinet endorsement. Only when a new policy is embodied in legislation and actually implemented should we acknowledge change as real. What Blüm and Hashimoto accomplished was to get the issue of long-term care for the frail elderly on the policy agenda, meaning that a real policy change would at least be seriously discussed.

What happened then had little to do with the hullabaloo of election campaigns, and much to do with the goals and strategies of powerful political, bureaucratic, and interest group actors. The nagging operational problems with existing programs mentioned above were quite important: in Germany, by turning municipal governments worried about welfare budgets into vocal and effective supporters of policy change; in Japan, less obviously, by making the actors who were affected by fiscal pressure in health insurance (MHW and MOF officials, big business and big labor, even the Japan Medical Association) at least receptive to the idea of a new approach.

Still more important as a pressure for enactment, in my view, was public opinion. Not an explicit demand for a new policy, much less an

[11] This ministry was expanded to become the Ministry of Health, Labor and Welfare (Kōsei Rōdōshō in Japanese, MHLW) in 2001, but as the events recounted here are prior to that time the old acronym will be used.

organized social movement, but rather a broad and deep concern about the frail elderly that, I suspect, many Germans and Japanese felt both as a tough personal problem and as a key national issue. A policy entrepreneur tries to transform potential into active support by coming up with an attractive formulation of the issue. In both countries, the public did respond, and indeed their continued support (as expressed in public opinion poll results) was an important resource for the actors who were trying to get a concrete new system enacted.

Finally, note that this first question cannot be answered systematically without comparing Japan and Germany to the various countries that did *not* enact major LTC programs. However, the fact that the problem of frail older people was unusually severe in both countries is clearly an important Type A explanation, as is the immediate financial pressure both felt. In a different sense, politics, Type B, was also quite important. Types C and D are not needed for answering *this* question, though they are significant elsewhere.

3. Why Did Both Germany and Japan Opt for the Social Insurance Model?

The issue that had reached the policy agenda in both countries might be formulated as "the government should do a lot more for frail old people". In neither country did the public have a firm idea of what solutions to the problem were best, and in fact in both countries a debate about what to do soon developed.

What were the possibilities? At the level of ideal types, there are two main alternatives for a comprehensive long-term care program (and various other social policies): direct service provision financed by taxes, and social insurance financed by contributions (see Ikegami and Campbell (forthcoming)).

As of the early 1990s, the only comprehensive large-scale LTC programs were in Scandinavia. These worked by direct service provision – local governments provided in-home or institutional services (with public employees or via contracts with other organizations), paid for by a combination of local taxes and subsidies from the national budget. In Sweden and Denmark, in the 1980s, nearly all services were provided to anyone who asked and spending was quite high. However, the direct-service approach is also quite compatible with tight expenditure controls since decisions on whether an applicant is eligible and on how much of what services will be provided are made by caseworkers or "care managers" employed by the local government. They can and often do apply

such criteria as an income or assets test, whether family care is available, and "deservingness" of the recipient. The United Kingdom is an example of direct service provision with fiscal caps and rather tight eligibility.

The alternative ideal type is social insurance, financed by premiums paid into a fund rather than by taxes, and with benefits provided to any participant who meets the specified conditions. The fund is not part of a governmental budget, and benefits are not subject to an appropriations process. The benefit could be unlimited (as it is for the most part in health insurance), but in long-term care one would expect the amount of the benefit to be determined by the extent of disability. The recipient should be able to choose what services he or she wants and who should provide them, by getting the benefit either in cash or as a voucher. The criteria for eligibility should be quite objective, such as age and degree of disability, with no room for arbitrary bureaucratic decisions. The individual who meets those criteria has a "right" to the benefit by virtue of having paid the premiums. Public LTCI would be very expensive if the government wanted to cover all the costs of independent living for anyone, but it is quite possible to economize by just covering a portion of costs (although "rationing" once the program is in place would be much harder than in a direct provision system).

These two ideal types are approximated by Sweden on the one hand and Germany on the other, but there are many variations and mixed programs around the world. The Netherlands finances long-term care from social insurance revenues rather than taxes, but its service delivery is similar to Scandinavia in both method and scope. In the United States, Medicaid (the major source of public support for LTC) is financed from taxes and means-tested, but service delivery is closer to that in a social insurance than a direct provision system. LTC in Canada is provided as part of its direct-service medical care system, and in Austria as part of its universal health insurance system. Institutional and community-based services are handled differently in many nations, and so on – there would seem to be quite a few choices to make when devising a new system.

In real life, however, the choices are most often heavily constrained by institutional legacies – Type C explanations are crucial. Most changes in long-term care policy, even very large ones, have been to extend or otherwise tinker with structures already in place, or to use accepted approaches even to a new problem. Radical departures from past practices may be discussed but they do not often get much further than that.

LTCI in Germany is a classic case. The promise by Blüm and the CDU to do more for the frail elderly led to a debate over how to do it. The idea of a Scandinavian-type system of direct service provision paid by taxes, which at the time was the only functioning large-scale precedent, was

favored by a few academicians and professionals in the field, and drew some support from the opposition Social Democratic Party (SPD). The idea of encouraging voluntary, private long-term care insurance was supported by some economists and by the small Free Democratic Party, representing its attachment to free-market ideas and its business constituency. The idea of public, mandatory social insurance was preferred by CDU politicians (albeit not always with much enthusiasm) and most bureaucrats (whether of the Ministry of Labor, the new Ministry of Health, or the financial authorities, also with varying enthusiasm), and no doubt was assumed to be the logical way to proceed by most of the public.

Germany had after all invented social insurance, more than a century before, and had a long tradition of meeting one social need after another by having members of some social group (usually defined by occupation or residence) pool their resources to support those in a situation of need – unemployment, accident, illness, old age. Indeed disability was already covered, but mainly with regard to income replacement and medical care; the need for care services was different but seen as comparable.

And just as important as what people thought would be appropriate policy was what kind of policy could be carried out – the institutional resources available, or not available, to manage the program. Germany had nothing like the cadres of local government managers and employees that provide long-term care in Scandinavia.[12] It did have big organizations well experienced in collecting premiums and managing benefits for individuals – in this case, the Sickness Funds that manage health insurance.[13]

The direct-service model thus had two strikes against it – it violated German ways of thinking, and it would have been hard to implement. The third strike was that it would have required new taxes, which particularly in the context of expensive unification with East Germany were seen as impossible. Though still mentioned as an ideal by many experts, it never really had a chance. The private insurance idea would no doubt have been attractive to many conservatives as well as to free-market liberals, since it would require little public money or management, if only it looked like a plausible solution. In Germany as elsewhere, experts not directly connected with the insurance industry agreed that voluntary

[12] The paucity of directly provided social services is true in other fields as well: for example, Germany provides very little day care for children though it does have a generous cash children's allowance.

[13] Note that the countries that handle LTC by a direct service model, such as the UK, Australia, and New Zealand as well as Scandinavia, also pay for medical care from taxes rather than through social insurance.

private LTCI simply would not work, and even the insurance industry was uninterested.[14] Another possible alternative, merely adding a new benefit into the existing health insurance system, was not really considered because it would not allow costs to be contained.[15]

In short, once the German government decided to do something in long-term care, despite the appearance of debate, the decision to take the social insurance approach was nearly inevitable. Real attention was directed to questions of how much it should cost and how the costs and benefits should be allocated.

Japan was quite a different story. Although it had a social insurance tradition for providing pensions and medical care that went back well before the war, in the social welfare (*shakai fukushi*) field itself – public assistance; orphanages, nursing homes, and other institutions; community-based services – provision had always been directly carried out by municipal governments, financed from ordinary budgets (i.e., tax revenues) at all three levels of government. The Gold Plan of 1990 greatly expanded social welfare programs for the elderly, and de facto broadened eligibility, but it left the financing and administrative system unchanged. In that sense Japan seemed to be headed in the direction of Sweden and Denmark, where coverage for old people had been greatly expanded without much change in the social welfare administrative apparatus.

However, some Japanese experts had thought for some time that a social insurance approach was better for expanding care for the frail elderly. The Gold Plan was thrown together in such a rush that there had been no time for such fundamental debates, but even before 1990 diffuse but heated arguments had flared up in and around the MHW. Ideas proposed for covering long-term care included extending the existing system for old-age medical insurance, adding an extra amount to public pension benefits for people who were disabled, expanding direct services, and creating a new and independent social insurance program.

As might be expected, the most vehement arguments came from those who wanted to preserve and expand the current direct-services system, including MHW officials in the "social welfare" tradition associated with the Social Affairs Bureau, nearly all practitioners in the field (nursing home administrators, social workers, the homehelper association, etc.), most professors of social welfare, and many reporters and commentators.

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[14] That is, it could work for some well-off individuals but would not solve the problem at a national level. See Cuellar and Wiener (2000).

[15] That is, health insurance benefits are unlimited, and increases in spending mean higher contributions. As will be explained below LTCI costs were to be sharply constrained (Stefan Pabst, personal communication, July 20, 1999).

The main proponents for a sharp switch to a new social insurance system were MHW officials in the "health insurance" line, with support from a few economists and other experts. Within the Ministry, the latter group of officials had gained power over the years at the expense of the former, and in the early 1990s had the advantage of being led by Okamitsu Nobuharu, the most dynamic and influential MHW bureaucrat in years.[16]

The opposition to social insurance at the time is well reflected in the criticisms of the new system that were heard up to the time of implementation and indeed even today: many people formerly receiving benefits would be cut off, people who had gotten free benefits face a co-pay, the premium is burdensome for low-income elderly, the level of services and of burdens vary among localities, local governments cannot cope with their responsibilities, quality of services will suffer, current providers will be driven out of business, money is wasted on people who do not really need care, and so on. Values, ideology, sentiment, self interest, and practical concerns were all mixed together.

Advocates of social insurance similarly argued from values, ideology, emotion, and practicality. The principles they emphasized were individual rights and consumer choice, plus in some cases more elaborate rationales based on American health-economics theories. The emotions were an extreme reaction against the old "placement" (*sochi*) system of arbitrary bureaucratic decisions, such as the prototypical story of a woman seeking help for her frail mother-in-law and being told she should care for her herself (even if she had to quit her job), and against cozy self-protecting and rent-seeking bureaucracy-provider empires.

The practical arguments were most persuasive. First, simply fiscal pressure: the expansion was starting to cost some real money, and at some point would require higher taxes. Second, operational problems (beyond those mentioned in the discussion of "why do anything?"): the *sochi* system had been designed for rather small "residual" means-tested programs. The Gold Plan was explicitly aimed at broadening the reach of public services for the frail elderly beyond the poor or people who had no access to family care. However, lacking those criteria, it was quite unclear

[16] Indeed, since his mentor Yoshimura Hitoshi, who had become Vice-Minister in 1984 and died in 1986. For his career and the importance of individual bureaucrats in policy change, see Campbell (1992: 297, 383–396). Like Yoshimura, Okamitsu was famous for his dedicated "school" of young officials; he was the first chief of the Health and Welfare for the Elderly Bureau, and was the driving force behind LTCI before and after his appointment as Vice-Minister in 1994. The bribe he took as Vice-Minister to approve a nursing home construction project caused the biggest bureaucratic scandal in Japan for decades, leading to his arrest and contributing to a delay of two years in the enactment of LTCI.

how to decide who should be eligible for what services, and beyond that, administrative accountability and supervision had become extremely blurred as local governments struggled (or more often did not struggle) to maintain control of all the new services with inadequate tools.

Having said that, it is true that compared to Germany Japan did have a substantial infrastructure for directly providing both institutional and community-based long-term care. It could have been adapted to higher volume and broader clienteles, possibly with rather less disruption than was required for a full-scale shift to the social insurance approach. And on the other hand, the administrative resources for running a social insurance program were quite problematical. Japan had no institution similar to Germany's large "sickness funds" – health insurance for employees was managed either at the company level, several thousand separate systems, or (for small business employees) by the national government in one gigantic pool. Neither was appropriate for managing LTCI. It was decided that the insurers would be municipal governments, because they were already the insurers for Citizens' Health Insurance (for non-employees), and also were responsible for social welfare planning and administration. This role for municipalities would be new and substantial, and many of them were afraid of the responsibilities and the risk of managing LTCI. The MHW subsequently had to make many concessions to local government interests to get most of them to agree to the new program.

A further point is that Japan lacked the "service corps" of doctors and nurses that work for the sickness funds in Germany, and so were available to do the assessments for LTCI. Such a system would therefore have to be cobbled together.

In short, the choice of social insurance in Japan was not an open-and-shut case as in Germany. In fact, if a sudden attempt to drastically shift Japanese tax policy in early 1994 had succeeded, Japan would have wound up with a big new "Welfare Designated Tax" to finance the Gold Plan and much else.[17] If this plan, which was motivated by tax politics, had succeeded, Japan almost certainly would have stayed on the road to Scandinavia in long-term care rather than switching to social insurance. That is a good example of a Type D or "artifactual" explanation.

[17] The idea was to substitute a 7% earmarked tax (called *fukushi mokutekizei* or *kokumin fukushizei*) for the 3% consumption tax. It was proposed by the Ministry of Finance (out of despair of any other way of raising indirect taxes) and accepted by Prime Minister Hosokawa at a midnight press conference without bothering to clear the idea with anyone else. The proposal died a quick death and came to be seen as a major blunder.

In the end, Japan wound up with a system financed one-half from social insurance and one-half from taxes, but run on social insurance principles. The key to this outcome was that the officials who had decided on the social insurance approach kept official MHW policy steadfast. The ministry which has jurisdiction in a given policy area has a great deal of power in Japan, particularly when it operates in a coherent way and the opposition is fragmented and lacks good alternatives. In fact, the counterfactual mentioned just above aside, the most interesting part of the Japanese story is political, Type B. Of course the German story is pure historical institutionalism, Type C, but the Japanese case demonstrates that history is not necessarily destiny (and also that countries may have *various* institutional legacies, not just one).

4. Why Does the German System Apply to Disabled People of All Ages, and the Japanese Program Just to Older People?

Within the limits of my knowledge, this question must be dealt with briefly, but it is important for social policy theory and practice (note that about 30% of German LTCI beneficiaries are under 65 years of age). The main answer is certainly Type C, institutional legacy. The long German tradition of social insurance, and the accompanying highly celebrated norm of "solidarity", seems to favor categorizations based on condition rather than age. It appears that the option of only covering older people was not much debated in Germany. What did cause some controversy was the government's initial disinclination to cover rehabilitation and training institutions for younger developmentally disabled people. Protests led to a small payment for such institutional "care".[18]

In Japan, some academics were in favor of covering the disabled of all ages, out of principle and because they thought everyone should pay premiums and in exchange should be eligible for benefits. Because usage would be so much lower among younger people, that would be positive for the fiscal health of the program. Other experts thought that provision of caregiving was not really appropriate for many younger disabled people, who needed and wanted training and other services that would not fit easily into the LTCI framework.[19] However, this debate did not amount to much. The main consideration was who would have to pay. It was decided that premiums would begin at age 40, as a compromise

[18] Some of these institutions then converted themselves to nursing homes to qualify for higher payments (Cuellar and Wiener 2000: 18).

[19] This appears to have been a problem in Austria as well as Germany.

between those who feared political resistance to a new premium and those who wanted everyone to share the costs. It then seemed only fair to make people 40–64 years old eligible, but in order to keep spending down coverage was limited to aging-related conditions.

In a broader sense, an important factor was that aging had dominated Japanese thinking about social policy since about 1970. The public concern was all about the "aging society" problem and within that, the particular problems of frail older people and their caregivers. There was no such consciousness about younger disabled people. To most people, therefore, having the program basically restricted to the elderly seemed completely natural and not worthy of attention.[20] The logic did not work that way in Germany, where the "aging society" problem had not generated such a sense of crisis.

5. Why is the Japanese Program Bigger than the German Program?

Germany is usually seen as one of the most developed and largest of the "welfare states".[21] Japan is sometimes seen as barely having a welfare state at all, or at least one much smaller than in other rich nations.[22] In terms of public social spending as a proportion of GDP, Germany is near the top of the list of rich nations, while Japan is above only the United States (OECD 2002).[23]

Contrary to this image, however, *kaigo hoken* is more generous than *Pflegeversicherung*. The higher spending in Japan comes from two differences in program design. One is that at least 30% more of the elderly are eligible for benefits in Japan. In 2000, about 2.7 million people or 12.4% of the 65+ population were eligible.[24] In Germany, at the end of 1998, over 1.2

[20] Incidentally, I am not aware of any discussion of why the starting point was age 65 rather than 70, which was the age when people become covered by the old-age health insurance system (except for bedridden people, eligible from age 65). The reason is probably that many people aged 65–69 were already receiving Gold Plan services.

[21] Albeit of the "conservative-corporatist" variety rather than the Scandinavian "social-democratic" model, in the influential typology in Esping-Andersen (1990).

[22] In a short piece on Japan, Esping-Andersen (1997) argued that things have yet to develop and settle down enough to be sure about what model applies, but the best characterization is a combination of "liberal-residual" and "conservative-corporatist" at a low level of development.

[23] According to 1998 statistics, Germany spent 27.3%, Japan only 14.7% of GDP (OECD 2002).

[24] That is, the government estimate used in the budget process. Six months into

million people aged 65+ or 9.5% of that population were receiving LTCI benefits.[25] Japanese LTCI has a category (called "needs assistance" (*yōshien*) rather than "needs care" (*yōkaigo*)) with a minimal definition of disability that covers many people who would not be eligible in Germany. In fact, the actual difference in coverage is greater than 12.4 vs. 9.5% since the elderly population in Germany is older and therefore more frail than in Japan.

Table 1: **Monthly benefit levels in Germany and Japan, in $ PPP**

Germany (1999)

Care Level	Home Care		Institutional Care
	Cash Benefit	Service Benefit	Services Only
1. Substantial	200	375	1,000
2. Severe	400	900	1,250
3. Very severe	650	1,400	1,400
Hardship*	n/a	1,875	1,650

Note: German Mark converted to dollars at the OECD's 1999 PPP rate of 2 DM = $ 1. * Part of level 3 – an extra payment for a limited number of heavy-care people.
Source: Cuellar and Wiener (2000).

Japan (2000)

Care Level		Home Care	Nursing Home	LTC Hospital
Needs Assistance		410	*1,592	n/a
Needs Care	1	1,105	1,592	2,386
	2	1,299	1,682	2,478
	3	1,783	1,770	2,570
	4	2,040	1,860	2,662
	5	2,389	1,948	2,754

Note: Yen converted to dollars at estimated 2000 PPP rate of ¥ 150 = $ 1 (see footnote 26). Co-pay is 10%. Users also pay meal charges in institutions. *Only for "grandfathered" residents when LTCI started.
Source: Calculated from MHW figures.

The other factor is that, at a given degree of disability, Japanese benefits are substantially higher than German benefits. In principle, Germany aims at covering 50% of need, and Japan 90% (taking into account the 10%

the new program almost 2.5 million had been certified as eligible though over 20% had not yet chosen to start benefits.

[25] As will be explained below it is believed that virtually everyone who is eligible does get benefits in Germany. These data were kindly provided by Ulrike Schneider, and are drawn from *Bundesarbeitsblatt*, October 1999.

co-pay). This is true even when only benefits for services are counted, leaving aside the majority of Germans who select the much smaller cash benefit. Table 1 compares the amounts for services at the different eligibility levels in the two countries using "purchasing power parity" estimates of the exchange rate; if market rates had been used the differences would have been greater.[26]

From another angle, note that in 2000 both Germany and Japan were spending about 0.8% of GDP on their LTCI programs. Since the German program was operating at virtually full enrollment while the Japanese program was just getting geared up and will increase spending in the future, it is clear that the Japanese program is bigger.[27]

Why was Germany so thrifty? Or, why was Japan so open-handed? The answer with regard to LTCI itself is Type A – differences in the policy problem – or in a sense Type C, policy legacy. Japan's situation, as of the mid-1990s, was that quite a few people were already receiving free or nearly free long-term care. In community-based programs, most of the people receiving homehelp and other services were paying little if anything. Nursing-home residents were supposed to pay on a sliding scale based on their income or that of their children, but actually most paid quite little.[28] Most important were the vast numbers of older people in hospitals, where regardless of their condition the costs were in principle completely covered by health insurance except for a tiny co-pay. Reality was not quite so comfortable, since many elderly hospital residents paid substantial service charges like "diaper fees" out of pocket, but legally these were in a gray area; so far as the formal system went, elderly inpatients were required to pay almost nothing.

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[26] Market rates have been ¥ 115–125 = $ 1 in this period. The use of PPP rates for services is tricky and I suspect the real differences are greater than this table would indicate. An indication is that these nursing home payments do cover the full costs (less the co-pay and meals) in Japan. The PPP estimate in Japan is for Japanese fiscal year 2000, the first year of LTCI, from April; the OECD PPP estimate for calendar 2000 is ¥ 152. Incidentally, the *Economist's* Big Mac Index for 2001 shows the yen as *over*valued, since it should be ¥ 116 = $ 1.

[27] Note that both countries also have LTC spending outside the LTCI framework, particularly for institutional care. In Germany, nursing home charges above the LTCI benefit are often covered by local public assistance budgets, while in Japan, many older people are still in hospitals for very long periods with the costs paid from health insurance.

[28] Fees for social welfare services including nursing homes were paid to the local government, and the facility's revenues came solely through the local government budget. This system was weak on incentives to charge more, and also on producing reliable statistics on how much was paid.

Given this situation, the German formula of paying only half the costs of LTC would have been politically impossible in Japan. Even though a large number of people would have become newly eligible for benefits, their potential support would have been greatly outweighed by protests from those who were already getting support more-or-less free and faced the prospect of having to pay for half of it. Similarly, a high threshold for eligibility would have excluded many who were already receiving services – as it is, even the quite minimal conditions to qualify were not met by many current recipients, requiring complicated "grandfathering" measures for the transition period.

In Germany before LTCI, community-based care was provided but by the traditional big charity organizations (though financed by grants from local governments), not directly by government, and the amounts were rather small both in terms of both the number of people covered and the amount of services per person. Current recipients of home-care services were thus a minor factor. People in institutions were more important, but most of them were receiving public assistance, which required selling assets and absorbed their pension and other income (leaving the residents only a small amount of pocket money) as well as requiring payments by children. Even though the new program only covers about half the cost of institutionalization, nearly all current residents were made better off. Even those who draw public assistance to cover the difference between the actual charges and their own resources plus the LTCI benefit now have more control over their own finances and indeed have more left over for themselves.

The high eligibility threshold and relatively low benefits, and especially the point that half the residents of nursing homes still need public assistance, have been criticized by German specialists. However, Germany could get away with a small program because even that was a considerable improvement for most current and potential recipients. It was a step backward for hardly anyone. In Japan, even though its new program was much larger, it drew far more criticism. That was because the existing programs had already been generous, enough to create substantial vested interests. This institutional legacy meant that if Japan were to do anything at all, it would have to do something much bigger – its decision about the size of the program was much more constrained than was true in Germany.

To introduce another counterfactual, it is interesting to speculate about what would have happened if LTCI had been introduced in 1990 instead of the Gold Plan. The basic system and the situation of institutionalized people was not so different compared with 2000, but the range of services offered in community-based care was narrower, and the number

of beneficiaries much lower. That might have allowed the government to get away with a less generous program at that time. The institutional legacy here was a quite recent one.

As for why the Gold Plan turned out to be so large-scale, one should recall that it had been thrown together as a quick campaign promise back in 1989. The political need was to get a bunch of programs listed, with ambitious looking targets (which were not legally binding anyway). Once that framework was in place, expansion occurred willy-nilly at an even faster pace than expected because of demand from local governments and ultimately consumers.[29] Since the revenues were all from taxes, the expansion could have been stopped during the annual budget process, but as a practical matter there turned out to be too much support (at least indirectly) for the proposition that care for the frail elderly is an important national priority.

6. Why is the German Program "Capped" to Prevent Expansion at Both the Micro and Macro Level While the Japanese Program is More Open-ended?

Kaigo hoken perhaps had to be big in a Type A and C sense, but that does not mean it had to be open-ended. Japan has few formal or even informal controls over increased spending in LTCI. The process of determining eligibility and assigning levels of need is supposed to be objective, relying mainly on a computerized questionnaire. The committee that reviews the results is independent, and in fact so far has increased the computer-rated level of need in about 20% of the cases. People are entitled to the full benefit as calculated in money amounts for their level – in fact, since there is supposed to be free choice between community-based and institutional care, someone in a high category could select a long-term-care hospital bed and automatically get the extra $ 900 or so a month to cover that cost.[30] In short, at the micro level, there is no mechanism to control spending. Moreover, at the macro level, if spending goes over the estimates – which would mean going over revenues as well – local governments would be hard pressed.[31]

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[29] A "New Gold Plan" with still higher targets for the year 2000 had to be enacted in 1994.

[30] That is, the top category pays ¥ 350,000 a month in home-care services, but up to ¥ 450,000 a month for institutional care (in both cases, less the 10% co-pay).

[31] Two years into the program, it has become evident that municipalities have opposed expansions of LTCI benefits because the immediate effect would be to

Germany, in contrast, has set several tough limits on spending. At the micro level, eligibility is decided by means of an examination by a physician, a member of the "Medical Service Corps" run by the sickness funds. A doctor's examination is somewhat subjective, and these doctors work for the insurers; they presumably can be asked to be a bit more strict if eligibility decisions started to look too soft.[32] At the macro level, the legislation specifies that only revenues from the designated social insurance contributions can be used to pay benefits; subsidies from general revenues are prohibited. The program is thus not allowed to go over budget. The contribution rate and amount benefits are specified in the law and so cannot be raised without new legislation.[33]

Differences in politics and the policy legacy seem to account for why the Japanese program had to be bigger, but when we consider the difference in spending caps, neither country appears to have been particularly constrained by institutional factors. In fact, most German social insurance includes an automatic index to inflation and so LTCI is an exception. A different explanation is therefore needed.

The point that immediately meets the eye is that the debates about LTCI were quite different in the two countries. The questions of who would have to pay and how much was the main topic in Germany, while it was quite secondary in Japan. That is, in Germany discussion of LTCI proceeded along paths that had been well worn by many previous arguments over social insurance. The usual voices of fiscal conservatism – finance officials, conservative politicians, big business – were loud and clear throughout the debate. Much time and energy was required, for example, to deal with the question of whether employers should share the premium costs with employees; big business (backed strongly by the FDP) argued that this hitherto normal social insurance provision was outmoded in an era when fringe benefit costs were damaging German competitiveness, and in any case should not apply to long-term care insurance since the benefit would not go to current employees. In the end

force them to increase the premiums charged to their 65+ residents. It remains to be seen how these tensions will be worked out – possibly by a change in the financing system, or possibly by imposing a more formal cap. This matter is too complicated to explain here, but see Campbell and Ikegami (forthcoming).

[32] Rumor had it that instructions were given to tighten up after the first few months of examinations, although that might have been more for standardization than for economizing.

[33] There have been no significant revisions in the first six years, meaning that the actual value of the benefits has been reduced due to inflation (which incidentally was taken into account in negotiating the prices paid by the system to providers – meaning the quantity of service did go down).

a laborious compromise had to be worked out (employers did pay half the premium, but workers gave up one paid national holiday to compensate).

As well as such issues of who pays, and the overall size of the program, German fiscal conservatives were concerned about the tendency of entitlement programs to expand beyond original intentions as demands grew and political support became more and more established. They refused to sign on unless subsidies from tax revenues were explicitly prohibited. Not only was indexation for inflation not mandated, but cost-of-living increases would not be allowed without passage of a new law. Some hoped that the provision that benefit amounts be specified in the legislation could become a precedent for actual rollbacks of the welfare state later on.

In contrast, the two most surprising aspects of the Japanese debate over LTCI were the lack of opposition from fiscal conservatives, and more generally, the lack of much attention to financial issues at all. In Japan as elsewhere, when a big new spending program is proposed, normally one would expect strong warnings about the government trying to do too much, burdens on employers or taxpayers, inefficiencies of public programs, the dangers of deficit spending and so forth to come from, in particular, the Ministry of Finance, big business, free-market oriented economists, and conservative politicians. But not only did these conservatives not mount an effective opposition to LTCI, they let the Ministry of Health and Welfare get away with estimates of what the program would cost that seemed to be little more than rough guesses – and low guesses at that.[34] To a remarkable extent, the MHW simply avoided talking about future costs and economic implications, but no one seemed to mind.

Why so? It is not that guardians of the market and fiscal orthodoxy are absent in Japan. The health insurance system and particularly public pensions have repeatedly come under scathing and detailed attack by Treasury authorities, business groups, and economists (particularly the public finance group at Hitotsubashi University, which has been criticizing even the mathematical abilities of Welfare Ministry officials since the 1970s – e.g., Noguchi 1987). The critique of big government had been the conventional wisdom of the Administrative Reform period in the early

[34] The MHW has not published the assumptions and calculations it used in forecasting program costs and future premium levels for LTCI. As a few critics have pointed out (from the left rather than the right), the benefit levels projected have been quite generous, even up to Scandinavian levels, while the cost estimates are quite modest, comparable to German costs for its much smaller program.

1980s, and had certainly not been repudiated since; grave worries about the ever-expanding welfare state and resolutions to constrain future spending were commonplace in the 1990s and the recession was producing still more calls for deregulation, liberalization, and other free-market solutions. Why did LTCI with its open-ended financial provisions sneak through so easily?

First, within the government, the Ministry of Finance is expected to take the lead in analyzing new spending programs in a hostile way, but it became a supporter rather than an opponent of LTCI. That was mainly because its obsession for more than a decade had been to move Japan from what it saw as over-reliance on direct taxes to more indirect taxes, in particular by establishing and then raising the consumption tax (Kato 1994). After the failure of its "designated welfare tax" idea in 1994, which would have raised the consumption tax from 3 to 7%, the MOF was intent on achieving at least a 5% hike, and (as in the late 1980s with the Gold Plan) took LTCI as its pretext – again, one-half the revenues were from the new social insurance premium, and one-half from ordinary revenues at all three levels of government. The tax share justified the consumption tax hike.

Second, big business groups perhaps were distracted by all the other problems of the Japanese economy in the mid-1990s. Keidanren, which watches overall economic policy, apparently saw LTCI as a fringe-benefit issue and left it up to Nikkeiren, which specialized in labor-management issues. Nikkeiren held some committee discussions with a few scholars invited as guests, and even undertook a small comparative research project with its counterpart in Germany, but did not carry out or commission any intensive research on the LTCI proposal.[35] Businessmen and particularly Nikkeiren were quite worried about rising costs of old-age medical care, which were putting pressure on company-based Health Insurance Societies, and thus were quite susceptible to the MHW's skillful argument that LTCI would bring about big savings in health insurance.[36]

[35] Interview with a Nikkeiren officer, June 1999.

[36] As with its overall estimates of costs, MHW claims about health care savings appear both vague and overstated, and in any case one does not need an econometric model to realize that the new benefits would require substantial new spending from both taxes and social insurance, costs that companies share. Note that there were initial objections to having employers pay half the premium, as in Germany, but it was not seriously pursued by Japanese business groups.

Third, economists too might have succumbed to MHW tactics, in this case its bland refusal to make its estimating procedures and assumptions public. There were almost no data to analyze and criticize. The absence of major LTCI programs in other countries, and therefore articles by foreign economists about them, meant they also lacked models to follow.[37] The picture might have been different if in fact business groups had been sufficiently motivated to sponsor some critical research on this topic.

Fourth, some politicians did express concern. The most important intervention was by LDP powerhouse Kajiyama Seiroku, who was Chief Cabinet Secretary in 1996 when the MHW first submitted the LTCI bill. Although the proposal had been worked over and assented to by the appropriate party organs, Kajiyama made several critical remarks to the newspapers, and wound up not letting the legislation go to the Diet at that time.[38] Such objections within the Liberal Democratic Party were not coming from such an influential position when the bill was proposed again in the following year, however, though they surfaced again after enactment.

Consistent opposition came from Ozawa Ichirō and his associates, who took a traditional fiscal-conservative view that long-term care should be financed by taxes rather than social insurance, so that it would be subject to annual appropriations at the macro level and a means test at the micro level, both serving as constraints on size. Ozawa (and the Liberal Party of the later 1990s) took this position with regard to pensions and other social policy as well. If LTCI had come to the agenda at a time when Ozawa was in or close to the government (within the LDP as prior to 1993, as leader of a non-LDP coalition as in the Hosokawa-Hata cabinets into 1994, or in coalition with the LDP as in 1998–99) this opposition might have mattered a good deal. However, at the crucial juncture the government parties were the LDP, the Socialists, and Sakigake. Coalition politics thus worked in favor of LTCI since both the smaller parties were considerably more enthusiastic about it than were many LDP members.[39]

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[37] Actually economists had taken part in the German debates on LTCI from viewpoints that Japanese economists might have found interesting, but it appears that they were not publishing in organs that would be seen outside Germany.

[38] For example, purportedly representing the Prime Minister at a committee meeting, he said that the program should be reconsidered because it would raise the tax plus social insurance burden on the nation (Okamoto 1996: 171). See also the account by Masuyama Mikitaka in Sone Purojekuto (1997: 29–30).

[39] In fact, the LDP went along partly as a way to keep the JSP in the coalition. See Paul Talcott's article in this volume and Eto (2000) for the politics of enactment of LTCI.

Such contingent factors – a Type D explanation – help account for why some potential opponents were muted or ineffectual in the decision-making process. However, the more important factor according to several people I interviewed was the general feeling that the "aging society problem" was crucial and needed some solution, and the fact that the proposal for LTCI was getting 70 to 80% approval ratings in public opinion polls. The criticism in the media was all from the left, about how the program would not do enough. Opposition from the right, that Japan would be doing too much, might look mean-spirited or futile. For historical and institutional reasons, the debate in Germany was framed quite differently, and the result was more effective conservative opposition and, as a compromise solution, a program with effective fiscal caps.[40] This is an interplay of Type B and C explanations.

7. Why Does Germany Offer a Cash Allowance to Encourage "Informal" Caregiving by Family Members While Japan Provides Only Formal Services?

In all nations, most care for frail older people is provided by family members, most often a spouse, daughter, or daughter-in-law. Many see family "informal" care as natural, and as preferable to "formal" care by outsiders from the point of view of the older person, although of course the burdens on caregivers are often considerable. A logical approach for public policy is to encourage care by family members (or other informal providers such as neighbors) by paying a cash allowance that the frail older person can use as he or she wishes.

Germany followed this route: the eligible person can choose between institutional care, formal community-based services, a cash payment, or a combination of the latter two. As Table 1 above indicates, for all three levels of need, the cash payment is substantially less than the payment for institutional care or formal community-based services, although there is an additional fringe benefit that LTCI will pay pension premiums for a family caregiver. In 1998, of those who did not opt for institutions, 76.6% selected the cash benefit and 12.8% the combination; only 10.6% (or some

[40] Note that in Japan the time not spent on fiscal matters was devoted to exhaustive discussions of the content of care services, including arguments about detailed sample "care plans", a topic of much interest to the many social welfare specialists involved in the discussion. To the regret of some of their counterparts in Germany, such matters were hardly discussed either before or after enactment of *Pflegeversicherung*.

134,000 people) selected formal community-based services only (Bundesministerium für Arbeit und Sozialordnung 1999: 127).[41]

As to the reasons for this approach, they appear straightforward. Cash payments are seen as normal (and direct services not) in Germany's social-insurance based approach. Moreover, the basic policy problem (along with the increasing number of old people) was perceived as a decline in the capacity of the traditional family to take care of frail older people. Germans saw the cash benefit as a way to prevent or at least postpone this decline by shoring up the family's willingness to provide care. Although a few specialists criticized the cash allowance on grounds that quality of caregiving could not be assured and it really would not change existing patterns very much, there was little real debate over this provision and it was included almost as a matter of course.

In Japan, the question of whether or not to offer a cash allowance for family caregiving was intensely discussed through the entire decade of the 1990s. The official advisory committee charged with preparing the legislation in 1995–96 split on the issue; its report listed pro and con opinions and called for further discussion.[42] The law as enacted did not include a cash allowance, although debate on this point continued in and out of the Diet right up to implementation and there was a last-minute small compromise.

On the face of it, it seems quite surprising that Japan would reject any coverage of family caregiving and come down so strongly for formal services. The prior German example would itself seem to boost the cash allowance idea, particularly in that this approach was demonstrably cheaper on a per-case basis. Popular opinion favored support for family caregiving, at least as an option.[43] And in terms of history and ideology, Japan had relied more on the family for social support than had Western countries, and quite a lot of popular rhetoric ("Japanese-style welfare society" and so forth) had enshrined this custom as a principle and a virtue.

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[41] The proportion selecting services has been rising gradually.

[42] This was the *Rōjin Hoken Fukushi Shingikai*, and its *Kaigo Kyūfu Bunkakai*; the evolution of its non-recommendation can be traced in Kōseishō Kōreisha Kaigo Taisaku Honbu Jimukyoku (1996: 39–41, 128–129, 195–196).

[43] By 58% to 28% in an August 1995 government survey, and by 72% to 24% in a Mainichi survey the following month. In an NHK survey in November with more options, 7% said they preferred cash only, 25% services only, 63% both. In an Asahi Newspaper survey the following February, however, 48% approved and 42% opposed substituting cash for services (results summarized in Kōseishō Kōreisha Kaigo Taisaku Honbu Jimukyoku 1996: 520–523).

The Japanese rejection of a family care allowance would therefore seem to require a lot of explanation. Three reasons were particularly important, matters of ideology, finances, and rational policy choice. First, with regard to ideology, Japanese thinking about families is more ambiguous than the simple image conveyed by "Japanese-style welfare". Note, for example, this remark at a critical meeting on December 4, 1995, of the Long-Term Care Benefits Subcommittee of the Advisory Council on Health and Welfare of the Elderly, the official MHW committee for drawing up plans for LTCI (Kōseishō Kōreisha Kaigo Taisaku Honbu Jimukyoku 1996: 129):

> In some cases, by receiving cash, the pattern of family caregiving would become fixed (*koteika*), and in particular there is the danger that women will be tied down (*shibaritsukareru*) to family caregiving. A cash benefit is allowed in German LTCI, but the family situation is different in Japan and Germany.

The last sentence is telling: the difference between Germany and Japan was that few German older people lived in the same household with their children, while even in the 1990s at least half of Japanese aged 65+ lived with a child.

That is, the classic story of the traditional Japanese household is the tense relationship between the household matriarch and her son's wife, *shutome* and *yome*. The wife "should" respect and obey her mother-in-law, but it is fully expected that she will be resentful and will feel exploited. The *yome-shutome* relationship was the template for talking about old-age care in general – in newspaper articles, TV dramas, and ordinary conversations, the image of the woman who has to provide physical care for someone not even of her own blood (without even a right of inheritance) is brought up again and again. The common image was the daughter-in-law trapped in a perpetual "caregiving hell" (*kaigo jigoku*).

Incidentally, many saw the "caregiving hell" as bad not only for the caregiver. Advisory committee members pointed out that "[w]hen caregiving is completely left to the family it takes place behind closed doors, so to speak. It is impossible to guarantee the quality of care, and there are many problems for the elderly". Worse still, "[s]ince perpetuation of a 'bedridden condition' makes it possible to get a cash allowance, there is the worry that it could actually hinder independence of the elderly". Indeed, it was widely believed that children were overprotective or simply found it easier to take care of a frail older person when they stayed in bed, leading to early dependence, even without a monetary incentive.

Actually, there is much more variety in the living and caregiving arrangements of Japanese older people than in the usual stories. Howev-

er, living in the same house no doubt does make for a more intense relationship and perhaps a mutual feeling of being trapped than would the German pattern of a daughter or daughter-in-law coming from her own house to provide care. The difference of more extensive coresidence does plausibly account for the strength of the feminist argument that the core problem of long-term care is the exploitation of women. This argument was much more important in Japan than in Germany.

The goal for such feminists in Japan was therefore to finish off family caregiving, not to prop it up. That point of view was well represented by two media stars: Okuma Yukiko, long-time *Asahi Shinbun* reporter and member of one of the early MHW advisory committees; and Higuchi Keiko, writer and TV personality who was on key advisory committees throughout the process and became a major promoter of LTCI.[44] Others who were influential representatives of this feminist viewpoint in advisory committees were the sociologist Sodei Takako and nursing home administrator (later Professor) Hashimoto Yasuko.

Japan is not often seen as a country where feminism has much political weight. These women may well have been appointed to the various advisory committees as tokens. They turned out to be quite articulate, but beyond that, their argument was effective mainly because it resonated among many ordinary people – perhaps to the point that it was difficult to contradict.

That is, there were some social conservatives in Japan who opposed their goals and saw "traditional" family caregiving as ideal. However, as was the case with the fiscal conservatives mentioned in the previous section, their voices were surprisingly muted – other than rumors of opposition from right-wing religious groups raising doubts among a few LDP leaders in 1997, it is hard to find criticism of LTCI from a family-values point of view, or explicit calls to maintain family care as long as possible. Those who called for a cash allowance for family caregiving defended it on grounds of choice or fairness, or to make the program more attractive to those who would pay premiums, not to give new life to the traditional system of family caregiving.[45]

The second difference between the two countries is finance. The German example showed it is possible to pay a far smaller amount – less than

[44] Okuma actually opposed LTCI, preferring the Scandinavian system. Higuchi was a key supporter, helping to organize a "Ten Thousand Citizens' Committee of 10,000" to generate enthusiasm. See Eto (2001: 241–246), who emphasizes the roots of these women's perspectives in social movement activity.

[45] E.g., the five positive points from the 1995 advisory committee report cited above: Kōseishō Kōreisha Kaigo Taisaku Honbu Jimukyoku (1996: 128–129).

half – for a cash allowance than for community-based services (let alone institutional care). That provision is why LTCI in Germany was able to run under budget and generate a surplus in its early years.[46] One would think that such savings would have a lot of appeal to Japanese as well.

However, financial considerations cut the opposite way in Japan. It was assumed that if cash were available, everyone who might be eligible would apply immediately (which indeed was what happened in Germany). If only services were available, in the words of the advisory committee, "[t]he present situation is that cases of families providing care are the majority, and this will not change very rapidly" (Kōseishō Kōreisha Kaigo Taisaku Honbu Jimukyoku 1996: 128–129). Particularly in the more rural areas, people would not be very eager to have outsiders come in their house, it was thought, and so at least the community-based care portion of LTCI could be phased in gradually. The MHW estimate was that actual demand would only be about 40% of entitlement in the first year, building up over the next several years.[47] In short, allowing only services would save money in the short run, though costs might be higher in the long run.

This 40% figure in effect represented two guesses, one on the demand side, about how many people would want formal community-based services, and the other on the supply side, about how many services could actually be available when the program started. Community-based services (homehelpers, visiting nurses, day care, bathing services, etc.) do not take as long to establish as institutions, but they cannot be created overnight and they do require investment from someplace, either local government or private organizations. These supply-side considerations provide the third major reason for rejecting a cash allowance. There was a widespread belief that Japan needed to develop formal community-based services for the elderly, to meet several purposes: as an alternative to institutionalization, to provide care to the people who lacked a willing family caregiver, even perhaps as a way to provide employment for women.[48] The fact that providing more services would not require a bigger public bureaucracy, and that even for-profit firms could partici-

[46] Although details of the German cost estimates were not published, it is believed that they were based on one-half cash allowance and one-half services (outside of institutional care), so the savings were considerable when 80% elected cash.

[47] To the surprise of some observers who expected overspending, including myself, this estimate turned out to be slightly high for the first year.

[48] The latter point was heard more in the late 1990s than when the program was passed. Note that the expansion of community-based care in Sweden became the means of pursuing another policy goal, a major expansion of employment for women (Esping-Andersen 1990).

pate, meant that this expansion of government responsibility had an attractive free-enterprise air, defusing possible conservative opposition.

As opponents of family caregiving said on the advisory committee, "[w]hat the people want today is full development of services. If the cash benefit is institutionalized, it is doubtful that the expansion of in-kind services can be completed". This was a chicken-and-egg problem: if services did not seem to be available, people would opt for the cash allowance, and if there did not seem to be much potential demand, providers would be wary of establishing or expanding services. There might not be enough services even for the people who absolutely had to have them unless a critical mass could be, in effect, artificially created.

This viewpoint led to an interesting debate after the law was passed. Some were fearful that many people would apply for LTCI and demand for services would greatly outstrip supply, bringing complaints and criticism of local governments. They called for a cash allowance for family care as a temporary measure, just until enough formal services could be developed. Others replied that if there were a possibility of cash payments the formal services would never develop, but an allowance for family caregiving would be a good idea later, once a true services alternative had come about. The latter view was common among MHW officials. The reasons mentioned were freedom of choice and fairness, but they were probably thinking about saving some money as well.

For Germany, providing a cash allowance for family caregiving was a natural and indeed inevitable choice. For Japan, the emotional reaction against the tradition of family care "exploitation", the practical need to save a bit of money in the short run, and the policy goal of rapidly increasing the supply of formal services, seem to have coincided to produce the decision not to offer a cash allowance. The difference between the two countries is largely the historical legacy of differing family institutions, albeit in the opposite direction of what most people would expect.

8. Conclusion

The main objective of this paper has been to highlight and explain the most significant policy similarities and differences between LTCI in Japan and Germany. Along the way I encountered some counterintuitive points: for example, that familial ideology was more powerful in Germany than in Japan (or maybe, it was so powerful in Japan that it generated a big backlash), and indeed simply that Japanese programs for frail older

people have been more extensive than in Germany, the welfare-state giant, both before and after LTCI.[49]

What about the approach taken here? First, comparing two cases can be quite illuminating. On the one hand, it points up important aspects of policy and process that would be missed when analyzing a single case, such as the lack of spending caps in Japanese LTCI, which so far as I know has not been pointed out by people who looked only at Japan. Investigating this difference led to considering the extraordinary lack of attention to financial considerations compared to Germany. On the other hand, the N=2 approach allows consideration of multiple explanations in a more nuanced way than is possible in a large-N study.[50]

How do our four types of explanations fare? First, to look at just one, since historical institutionalism is currently a popular mode of analysis, it is interesting to see both its power and its limitations. For one thing, the institutional legacy might not be singular (as in Japan with regard to direct services vs. social insurance), or might even be contradictory, at least superficially (the impact of familialism). Second, we can assess interactions among different policy problems, different political configurations, different institutional legacies, and even contingencies of timing and sequence, to construct plausible explanations of quite detailed policy differences. Third, the very process of considering alternative explanations pushes us to think about "what-if" counterfactuals, and avoid the fallacy of retrospective inevitability that plagues so many studies of public policy.

As for the policy itself: Japan and Germany have demonstrated that a social insurance approach to comprehensive long-term care for frail older people is workable. It seems to deal with a significant social problem effectively, without (so far at least) exceeding reasonable spending levels. This system should be considered by policy makers elsewhere, certainly

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[49] It must be emphasized that this finding pertains to policy for frail older people, not the welfare state in general. The "aging society problem" has gotten by far the most attention in the social domain for at least 30 years in Japan (see Campbell 2000: 84–99). That has not been the case in Germany. Incidentally, among other social policies, I personally would see the health care system and pensions for employees as comparable in the two countries, but in most other dimensions of social policy Germany is far more developed and generous.

[50] Which is not to deny that large-N studies are the best if not the only way to reject or support causal hypotheses. A recent, massive, and excellent example is Harold Wilensky's (2002) attempt to sort through many explanatory variables (and even whole theories) to account for, among many other dependent variables, the size of the welfare state and the extent of the backlash against it among the OECD nations.

in countries like the United States where the growing LTC problem elicits little more than bleats of fear and impossible schemes. How the virtues and defects of social insurance balance out against the other major comprehensive approach to LTC, Scandinavian tax-based direct services, requires a different sort of essay that probably should not be written for another two or three years.

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Old Age Security in Japan: The Implications of Recent Public and Occupational Pension Reforms

Harald Conrad

1. Introduction

As several other articles in this volume have mentioned, Japan is the industrialized country with the largest and most quickly growing concentration of people aged 65 and older. As a result of this demographic shift, the population is likely to decrease from currently 126.9 million to 100.5 million in the year 2050, and possibly to 67.4 million in the year 2100 (Sōmuchō Tōkeikyoku 2001: 33). This has important consequences for the predominantly "pay-as-you-go" public pension system.[1] Since the decline in growth rate of the future working population (n) cannot easily be compensated for by a rise in wage rates (w), there are few options left if the financing mode of the public pension system is not fundamentally changed. Benefit levels (p) will have to be curtailed, contribution rates (b) will have to be raised or declining contributions will have to be counterbalanced by an increase in tax-financed subsidies.

This article analyzes how Japanese pension policy has reacted to the demographic challenge and what kind of long-lasting effects these changes are likely to have. Section 2 describes the Japanese system of public, occupational, and personal pension provisions and discusses recent public and occupational pension reforms. Section 3 analyzes the implications of these reforms, focusing especially on following issues:

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[1] There are basically two financing methods for public pension schemes: In a *capital-funded system* people save during their working life in order to finance their own future pension benefits. The pension benefit per capita (p) is a function of the contributions paid during the working life [contribution rate (b) · wage rate (w)] and the interest (r) earned on these contributions: $p_t = (1+r_{t-1}) \cdot w_{t-1} \cdot b_{t-1}$.
In a *pay-as-you-go system* pensions are financed by the contributions of the working population. The pension benefit per capita (p) depends on the growth rate of the working population (n), their wage rate (w), and their contribution rate (b): $p_t = (1+n_t) \cdot w_t \cdot b_t$ (Homburg 1988: 16–29).

- How do the reforms influence the financial sustainability of public pension finances?
- What kind of distributional effects do these reforms cause?
- What impact do the reforms have on the minimum income function of the basic pension?
- What are the shortcomings of the occupational pension reforms?
- How will the reforms influence the public-private mix in pensions and how should this shift be judged from a social policy perspective?

2. THE JAPANESE PENSION SYSTEM AND AN OVERVIEW OF RECENT REFORMS

2.1 The public pension system

The Japanese system of old-age income security consists of public, occupational, and personal pension provisions. The first public tier is the Basic (*kiso nenkin*) or National Pension Insurance (*kokumin nenkin*).[2] In principle, all residents in Japan between the ages of 20 and 59 are eligible, and are required to become subscribers to this scheme. Currently, this system has 70.1 million members (see Figure 1). There are three types of insured persons:

"Type 1 insured persons" includes all residents in Japan between ages 20 and 59 regardless of their nationality. These are mainly the self-employed, farmers, and non-employees. In principle, they are required to pay a fixed contribution of ¥ 13,300 per month (2002). However, low-income earners (about 17% of all Type 1 insured persons) are currently exempt from paying premiums (KŌSEISHŌ NENKINKYOKU 1998: 32).

"Type 2 insured persons" are all employees in private industrial or commercial enterprises that regularly employ one or more workers.[3]

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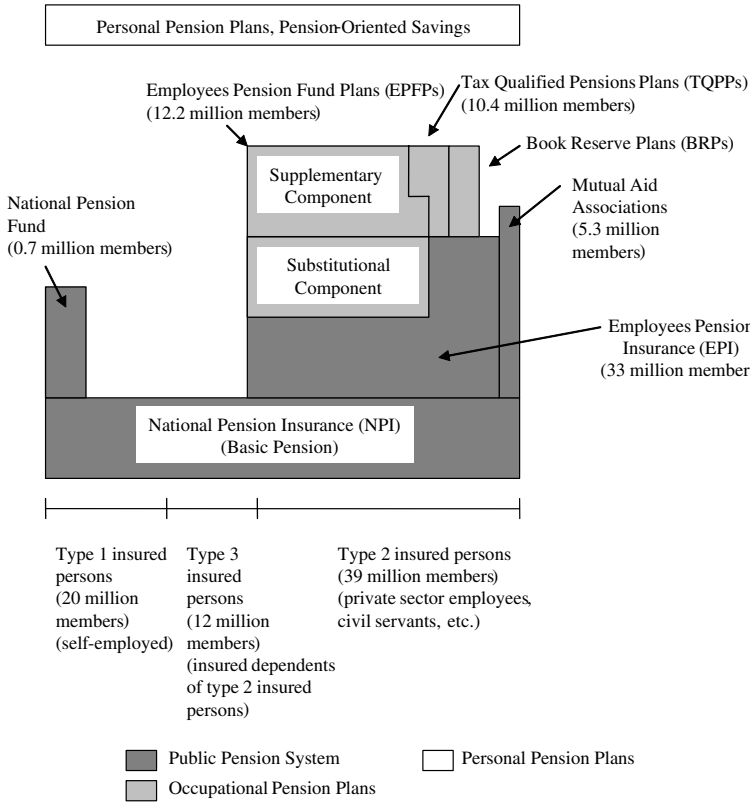
[2] National Pension Insurance (*kokumin nenkin*) is the institutional name, whereas Basic Pension Insurance (*kiso nenkin*) refers to its function. The confusion about the wording results from the fact that until 1985 the National Pension Insurance was the sole pension system for the self-employed. In 1985 this system was reformed to create a non-income-related basic pension system for all residents. In this way, the National Pension Insurance became the Basic Pension Insurance. However, for the self-employed the National Pension Insurance is still the only regular public pension, so that for this group the usage of the term "Basic Pension" does not seem to be suitable. For this reason, this paper refers to this pension mostly by its institutional name, "National Pension Insurance" (NPI).

[3] If the enterprise is owned by an individual, as opposed to a corporate body (a judicial person in Japanese legal parlance), coverage is only compulsory if the firm regularly hires five or more workers.

Figure 1: **The structure of the Japanese pension system**



Source: Based on KŌSEISHŌ NENKINKYOKU (1998: 23).

In contrast to Type 1 insured persons, Type 2 insured persons enroll automatically in this scheme when they become a member of the Employees Pension Insurance (EPI) (*kōsei nenkin*) or a mutual aid association

(*kyōsai nenkin*),[4] which both provide second tier earnings-related benefits. The premiums for these second-tier insurance systems include the premium to the NPI.

Currently, the EPI premium is 17.35% of the employee's monthly gross earnings (including overtime earnings, travel and family allowances, excluding bonuses) divided equally between employee and employer.

At the time of pension payout, the EPI or the mutual aid associations transfer parts of their collected premiums to the NPI to cover the basic pension benefits. Whereas the benefits of the NPI are non-income-related and depend solely on length of participation, the benefits of the EPI and the mutual aid associations are earnings-related.

"Type 3 insured persons", according to the NPI, are non-working spouses of Type 2 insured persons. They are automatically insured through their working spouses and are not required to pay their own premiums.[5]

Current NPI benefits are paid out of currently collected premiums, but one third of the benefit expenditure is subsidized out of the general budget of the government. According to the 1999 reform, the government's share is projected to rise to one-half of expenditure by the year 2004. EPI and mutual aid association benefits are 100% financed by contributions.

The monthly "model pension" of a couple (employed husband, full-time housewife) is currently ¥ 238,125, after 40 years of contributions.[6] This amount provides a replacement rate – in relation to the average net income (including bonuses) of male employees – of 59%. This model pension consists of ¥ 104,092 EPI pension and ¥ 67,017 NPI pension each for both husband and wife. The self-employed, as "Type 1 insured persons", are only entitled to the NPI pension, which has a maximum amount of ¥ 67,017.

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[4] This article deals mainly with the National and Employees Pension Insurance. The regulations of the mutual aid associations are, in principal, similar to the Employees Pension Insurance, although the former tend to pay higher earnings-related benefits.

[5] In case of divorce the non-working spouse is only entitled to basic pension provisions. However, in contrast with Germany's *Versorgungsausgleich*, the non-working spouse is not entitled to the income-related benefits of the EPI or the mutual aid associations.

[6] The concept of the "model pension" assumes that the employee has paid 40 years of contributions, based on an income which equals the average employees' income during this entire period.

As Table 1 shows, the Japanese public pension systems still control enormous capital funds of ¥ 170 trillion (= 33.4% of GDP). However, as will be shown later, this does not mean that these systems are for the most part still capital-funded, because there are already high entitlements which will be paid out over the coming years. Accordingly, the capital funds will slowly melt down in future.

Table 1: **The Japanese pension market (1997)**

Main Segments	Capital in Trillion ¥	Number of Insured in Millions
Public Pension Systems	170.0	70.3
National Pension Insurance (NPI)	8.5	70.3
Employees Pension Insurance (EPI)	125.7	33.4
Occupational Pension Systems	94.0	–
Book Reserve Plans (BRPs)*	13.6	n.a.
Employees Pension Fund Plans (EPFPs)	44.9	12.1
Tax Qualified Pension Plans (TQPPs)	18.5	10.3
Personal Pension Plans	45.0	–
Private insurers	15.3	13.4
Gojo nenkin	10.0	–
Kanpo	10.0	4.5
Others	12.6	–
Total	321.6	–

Notes: 1. The figures indicate capital-funded entitlements only. They do not indicate the total amount of all pension entitlements. 2. The available data allow meaningful comparisons for the year 1997 only. * 1996 estimate.

Sources: Curuby & Company (1998: 13–27); Watanabe (1998: 8); Life Design Kenkyūjo (2000: 17, 23).

2.2 The occupational pension plans

As for the number of participants and the amount of assets, three kinds of defined benefit schemes[7] dominate the occupational pension market in Japan; namely, the Book Reserve Plans (BRPs), the Employees Pension Fund Plans (EPFPs), and the Tax Qualified Pension Plans (TQPPs). De-

[7] Defined benefit plans are retirement income plans set up by a corporation to pay a specified sum to qualified employees, based on number of years in service (Fitch 1993: 185).

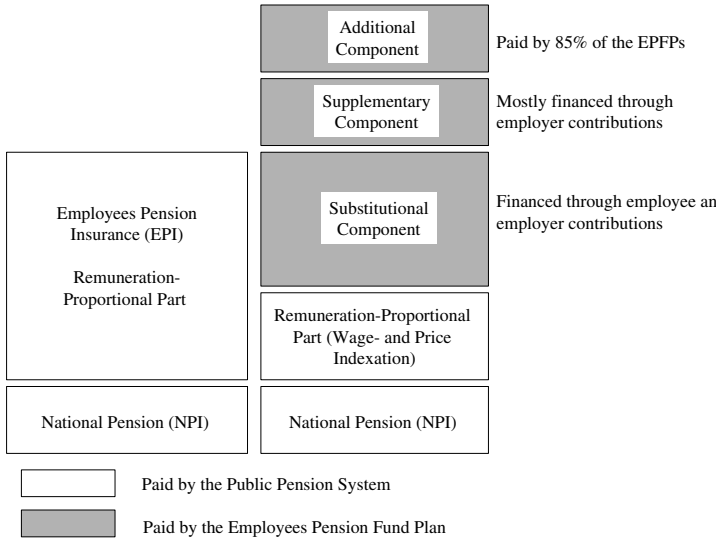
fined contribution schemes[8] have attracted only a small number of participants and control only a comparatively small amount of assets.[9] Several reasons for the limited importance of these types of plans can be identified. There has been a broad consensus in the past on the part of Japanese employers that pension benefits were a "reward for effort"; employees considered pension benefits a form of deferred wages. Because of these perceptions it was natural to set up employer sponsored plans that would pay a specified sum to qualified employees. The other important reason for these plans' limited success is that the authorities encouraged the founding of defined benefit plans by creating a comparatively favorable tax framework.

The perception of occupational pensions, as a reward or as deferred wages, explains why BRPs for severance lump-sum benefits have always played a comparatively large role in the Japanese retirement context. These severance payments, given to employees for faithful service, existed well before the introduction of corporate-type business entities in the Meiji period. The lump-sum benefits paid by BRPs depend on a number of variables such as the size of the company, the total length of employment, sex, level of education, and the reason for leaving the company. Benefits increase progressively with the length of continuous employment; an early company withdrawal results in higher rebates (YAMAGUCHI 1999: 73–75). BRPs receive preferential tax treatment under corporate tax law, which allows employers tax deductions for an amount equal to 40% of the accrued voluntary retirement lump sum benefits (WATANABE 1996: 127). From a taxing perspective, BRPs are not as attractive as the other two important defined benefit schemes to which both employers and employees can contribute.

[8] Defined contribution plans are savings plans allowing employers, and also employees, to make periodic contributions on a tax-deferred basis, for retirement income. In contrast to defined benefit plans, the benefits paid by defined contribution plans are not specified in advance, but depend on the return of investment.

[9] See CONRAD (2001b: 37) for the smaller defined contribution plans.

Figure 2: **The structure of the Employees Pension Fund Plans (EPFPs)**



Source: Based on SHIMADA (1995: 184) and KIGYŌ NENKIN KENKYŪJO (1998: 27).

EPFPs (Employees Pension Fund Plans) were first introduced in 1966. To establish an EPFP, a firm must have 500 or more employees for a single-employer plan or 3000 or more employees for a multi-employer plan. Company unions and the Ministry of Health, Labor and Welfare must approve the establishment of a plan. EPFPs are used to contract-out the earnings-related part of the public EPI in return for lower social security contributions with the rebate rate (see Figure 1 and Figure 2). The benefits of an EPFP consist of two components. The *substitutional component* (*daikō bubun*) is directly linked to the remuneration-proportional part of the public EPI. In exchange for lower social security contributions, the EPFP assumes responsibility for paying this part of the EPI. Meanwhile, the EPI bears the costs for price and wage indexation. The difference between the regular social security contribution rate and the rate for participants in EPFP goes to finance the earnings-related, contracted-out benefits, which are now paid by the EPFP. Contributions to the *substitutional component* are shared equally by the worker and the firm. Employer contributions are treated as business expenses and are deductible from corporate income tax. Employees' contributions to the EPFP are completely exempt

from income tax in the same manner as contributions for public social insurance programs. EPFP benefits are usually paid as annuities.

In addition to the *substitutional component*, the EPFPs are required to pay a *supplementary component* (*fuka bubun* or *purasu arufa*), which must not be less than 30% of the *substitutional* EPI benefits accrued while working for a firm. The *supplementary component* is a tool for incentive used by employers to attract employees, and therefore the main reason for an employer to set up such a plan. Accordingly, most companies pay 100% of the contributions to finance this component. Figure 2 illustrates how the EPFPs function. There are three types of EPFPs, which differ according to how they calculate their benefits.[10] The most common type (85% of all plans) pays a so-called *additional component* (*kasan bubun*) on top of the *substitutional* and *supplementary component* (KIGYŌ NENKIN KENKYŪJO 1998: 27).

TQPPs (Tax Qualified Pension Plans) were first introduced 1962. Until then employees who reached retirement age would only receive lump-sum benefits paid by BRPs. TQPPs have been adopted mainly by medium-sized or smaller employers with 15 or more workers. The establishment of TQPPs requires approval from the Ministry of Finance, which also oversees these plans. Theoretically, contributions have to be borne equally by employers and employees; however, 96.8% of the companies actually pay the full amount of the contributions (MURAKAMI 1997: 111–112). Employer contributions are treated as business expenses and, therefore, a deductible expense in calculations of corporate income tax liability. The funds are invested with life insurance companies, trust banks, and/or investment management companies. The benefits are treated as retirement income and taxed in the miscellaneous income category of the personal income tax. Benefits can either be drawn as lump-sum payments or as annuities. However, most workers choose payment as a lump-sum benefit, because this results in preferential tax treatment.

Whereas the investment regulations for TQPPs and EPFPs had been fairly restrictive, since around 1997 these plans have been relatively free to invest their funds with life insurance companies, trust banks, and/or investment management companies.

Unfortunately, the available statistics do not allow a comprehensive assessment on who gets how much out of occupational pension plans in Japan, since the data are based on surveys limited to firms with at least 30 workers. However, about 54% of the workforce is engaged in establishments with fewer than 30 persons (SŌMUCHŌ TŌKEIKYOKU 1999: 180–181). In addition, there are big differences with regard to industry sector,

[10] See CONRAD (2000b: 256–257) for details.

company size, and sex, so that the averages need to be interpreted with care. According to the available data, 89% of companies with more than 30 employees pay some sort of occupational pension provisions. 47.5% of these companies pay lump-sum benefits only; 52.5% also have some other sort of occupational pension plan. Within the last group of companies, 32.2% pay lump-sum benefits as well as annuities (Life Design Kenkyūjo 2000: 135). Statistically, it would appear that 58% of the 38.7 million employees of the public pension schemes are covered either by EPFPs or TQPPs. However, since some companies offer both kinds of plans, the actual coverage rate is lower, around 50% (Watanabe 1996: 129). There are no accurate statistics on the total number of BRPs. Watanabe estimates that about 5% of companies have BRPs; the total value of the plans equals 18% of the value of these companies (1996: 127).

In 1999 the model severance lump-sum payment at retirement to a typical 60-year-old male employee with a university degree and 38 years of continuous employment was ¥ 26.6 million (Life Design Kenkyūjo 2000: 135). Male employees with a high-school degree receive, on average, around 12% less; middle-school graduates receive payments about 32% lower (Sueki 2001: 49). Female employees with similar levels of education receive on average about 70–85% of the benefits of their male colleagues (Life Design Kenkyūjo 2000: 136; Watanabe 1996: 130).

A very simple calculation illustrates the importance of the lump-sum benefits for retirement: If one considers that the average life expectancy of a 60-year-old male is 21 years beyond retirement,[11] a lump-sum severance payment of ¥ 26.6 million allows for a monthly payment of ¥ 105,500 (even without taking interest payments on the leftover principal into account). This is roughly as much as the model EPI pension! On the other hand, one needs to consider that only male employees with uninterrupted working records can actually hope for such big lump-sum benefits.

In 1998 the average monthly benefit paid out by TQPPs was ¥ 58,499. 40% of the beneficiaries received a TQPP pension between ¥ 50,000 and ¥ 100,000. In the same year, the average monthly pension from EPFPs was ¥ 57,000 (Life Design Kenkyūjo 2000: 22, 27). These numbers indicate that TQPPs and EPFPs also play a major role in terms of income security for the elderly, even though lump-sum benefits might in some cases be more important.

[11] Since April 1998, the legally required minimum age for company retirement has been 60 years (Rōdōshō 1997: 286–287).

2.3 The personal pension plans

As Table 1 indicates, personal pension-oriented savings are also an important source of income for Japan's elderly. However, a problem of definition arises because it is not entirely clear which forms of personal assets should be considered as earmarked for old-age provision. If one follows the official "Family Savings Survey" (*Chochiku dōkō chōsa*), only 4% of personal savings are personal pension-oriented assets. In 1997, these amounted to ¥ 45 trillion. The pension adviser CURUBY & COMPANY (1998: 23) estimates, however, that personal plans could soon total 10% of a projected US$ 18,000 billion of personal savings.

The issue of definition is of paramount importance, because the considerable capital funds in public and occupational pension schemes are tiny in comparison with the *entire* private financial assets of Japanese households, which reached ¥ 1,385 trillion in March 2001 (*The Nikkei Weekly* 02.07.2001: 2). If one did not consider distributional and property issues, which are in fact vital, one might arrive at the mistaken conclusion that the current financial problems relating to public and occupational pension schemes could easily be overcome.

If one follows a narrow definition of personal pension-oriented assets, private insurers with 13.4 million pension insurance policies have a market share of roughly 30%. About 22% of all personal pension-oriented assets are invested with an association, called *gojo nenkin*, formed to manage the post-retirement assets of public employees. Many retirees who opt for lump-sum payment of their pension benefits roll them over into *gojo nenkin*, which invest them mainly in loan trusts with trust banks. Another 22% of the pension-oriented assets are invested with the postal insurance (*kanpo*), as well as regional agricultural co-operative insurance organizations which offer personal pension products.

2.4 The background behind the recent reforms

As has been pointed out already, demographic change poses the single most important challenge to the country's public pension system. Yet, this problem was not widely recognized until the late 1970s and pension policy in those years was characterized by frequent generous benefit hikes. The 1973 reform marked, for example, a milestone in Japanese pension policy because it introduced, for the first time, a system of price and wage indexation for both pension entitlements and pensions after commencement of payment. This had an immense effect on the benefit levels of both EPI and NPI. The replacement rate of the model EPI pension increased rapidly from 45% in 1969 to 62% in 1973 (KŌSEISHŌ

Nenkinkyoku 1998: 42). However, at the same time, contribution hikes were much lower than what would have been prudent from an actuarial point of view, which soon led to financial problems, especially in the old NPI. Because of the financial deterioration of the pension finances, the 1985 and 1994 reforms intended the eventual shift from an expansive policy to one that has been seeking to curtail future expenses in order to deal with the rapid aging of society. The last public pension reform, which was enacted in April 2000, saw another round of reform measures which reduced benefits in aggregate by approximately 20% until fiscal year 2025. The next paragraphs evaluate the implications of these measures in closer detail.

Naturally, the aging process of society also influences occupational pension plans. However, the current crisis in many occupational schemes is more closely related to factors such as the ailing Japanese stock market and obsolescent accounting and calculation practices. Until 1997, the government's actuarially mandated deferral interest rate for EPFPs and TQPPs (i.e., the expected rate of return) was set at 5.5%. However, the yield from fund reserves has been substantially lower than this deferral interest rate for several years because of an ailing stock market and continued monetary policy of low interest rates. As a result of rigid actuarial assumptions and a number of investment restrictions, many EPFPs and TQPPs have carried unrealized losses (*fukumi-son*). Yet, recent low interest rates alone cannot explain the worsening financial situation of many funds. In fact, it can be shown that the 20-year return on investment of a mixed portfolio in Japan was on average higher than 5.5%. In other words, older funds, at least, should not have ended up facing such large financial troubles. However, in reality, older funds seem to be especially vulnerable. Asano and Kaneko (1998: 73–75) state four reasons for this phenomenon: 1. Because of an increasing life expectancy and wage increases and a decline in the number of fund members, the financial situation of funds has worsened over time. 2. Older funds have frequently used yearly surpluses for benefit hikes. 3. If the surpluses surpassed a designated limit, funds used these revenues to finance the construction of leisure facilities for their members. 4. Until recently, most funds have accounted for their financial holdings through purchasing prices. However, the market value of these holdings has declined considerably since the burst of the bubble economy sent the stock and real estate markets falling. Most funds have not parted with their holdings because that would have made the underfunding problem obvious. For many years, a reluctance to sell unprofitable holdings has prevented a management of investments that is oriented toward earning returns. Even after the "deferral" interest rate was lowered for the first time in 1997, many

funds kept using the old rate of 5.5% because switching to a lower rate would have made the underfunding problem visible (WATANABE 1998: 10). So far, the magnitude of the funding problem has been impossible to quantify because plan sponsors have not revealed enough financial data. New accounting rules, which will gradually come into effect in March 2002, will require all such liabilities to be disclosed in the future (OECD 2000: 129). If one considers the fate of the 27 leading Japanese companies that do reveal most of their pension finance data in the U.S. under the Generally Accepted Accounting Rules, one can already catch a glimpse of the problem's magnitude. At the end of fiscal year 1996, these companies had, on average, an underfunding problem of ¥ 140.8 billion, which was equivalent to 15.5% of their combined shareholders' equity. Since these companies are among the best Japanese companies, one can rightfully assume that the situation in the rest of the market is much worse (ASIA AGENDA INTERNATIONAL 1998: 15). High pension expenses arising from underfunding will negatively affect net income, price/earnings ratios, debt/equity ratios, and cash flow. Since many companies fear these unpleasant revelations, they have gone ahead and recognized their pension fund deficits, shoring up their funds. In fiscal year 1998, ending in March 1999, 230 defined benefit plans received contributions from sponsoring companies to cover shortfalls (SHIBATA 1999: 30). In fiscal 1999, companies paid ¥ 1.01 trillion to 1800 EPFPs. Nearly every EPFP received additional funds to cover pension shortfalls (*Nihon Keizai Shinbun* 18.08.2000: 3). About a third of Japan's major companies contributed to their pension plans through specially designed trusts to offset unfunded liabilities. This allows them to remove contributed portfolio shares from their balance sheets, which in turn shrinks their asset base and opens the way for more efficient use of assets (*The Nikkei Weekly* 31.07.2000: 17).

Regulations concerning EPFPs provide fairly strict protection for the vested rights of employees. This obliges the EPFPs to shore up their funding, which is not so much the case with TQPPs. Nevertheless, around 10% of all EPFPs had to lower their payouts during fiscal 2000 (*Nihon Kin'yū Shinbun* 19.10.2001: 10). Small- and medium-sized companies, which constitute the largest share of the sponsors of TQPPs, often lack the financial resources to eliminate pension shortfalls. An increasing number of companies are therefore allowed to dissolve pension plans. In recent years, an average of 3000 to 4000 plans per year ceased their operations (*Nihon Keizai Shinbun* 18.08.2000: 3).

Several of these problems with occupational pension plans were addressed by the occupational pension reforms of June 2001, which altered plan design choices and aspects of existing plans. The next paragraph

describes these changes in closer detail, while paragraph 3.4 analyzes their implications.

2.5 An overview of recent reforms

The 1999 public pension reform, which was enacted in April 2000, consists of several parametric reform measures in the sense that they seek to curtail pension payments by an adjustment of parameters such as entitlement age, benefit level, or financing mode. In this respect, the measures are similar to the ones taken up in other industrialized countries in recent years. Three measures are especially noteworthy (SHAKAI HOKEN KENKYŪJO 1999):[12]

1. The complete gradual increase in the entitlement age for regular pension benefits to 65,
2. a 5% cut of benefits to newly awarded pensions (a grace period worked into the bill will delay the actual reduction until fiscal 2004) and
3. the abolition of wage indexation after commencement of pension payment of people 65 and over.

Combined, these measures will slash aggregate pension benefits by about 20% by 2025 (*Nihon Keizai Shinbun* 22.03.2000: 1). The replacement rate in the model pension (which does not reflect the influence of the entitlement age increase and the change in the indexation mode) will sink from 62% of net working income, including bonuses, to 59% (SHAKAI HOKEN KENKYŪJO 1999: 23). This replacement rate is slightly lower than the new replacement rate in Germany's model pension,[13] which the latest reform, in May 2001, set at 64%.[14]

Besides the reform measures on the benefit side, the 1999 reform also introduced four important measures on the financing side.

First, since April 2002, pensioners between the ages 65 and 69 who have additional working income are subject to an earnings test. The first-tier basic benefits are fully paid regardless of salary and wage earnings,

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[12] For details see CONRAD (2001b: 41–49), SHAKAI HOKEN KENKYŪJO 2000 and SHAKAI HOKEN KŌHŌSHA 2000.

[13] The German concept of the model pension is similar to the Japanese, except that contributions over 45 years are required to reach this pension in Germany.

[14] The official replacement rate in Germany is 68% (BUNDESMINISTERIUM FÜR ARBEIT UND SOZIALORDNUNG 2001: 6). However, this number reflects purely a cosmetic change in the calculation method of the underlying net wage (SCHNABEL 2001: 6).

but if the total amount of pension benefits and additional earnings exceeds ¥ 370,000, the earnings-related pension benefits are reduced by ¥ 10,000 for each ¥ 20,000 increment in wages. TAKAYAMA (2001b: 3) reckons that this earnings test may induce earlier retirement for those still working in their late 60s.

Second, starting in April 2003, the calculation base for social security contributions will change. The 1994 pension reform introduced a contribution rate of 1% on bonuses. If one considers that the average bonus is 20% of an industrial worker's salary of one year (RŌDŌSHŌ SEISAKU CHŌSABU 1994: 30), then this was an important measure to increase pension revenues. However, this system is also highly unfair, because these contributions are not taken into account when calculating the remuneration-proportional benefits; in this sense the contributions become similar to a 100% tax. From April 2003, the contribution base will shift from current monthly standard earnings to annual earnings, including half-yearly bonuses. This widening of the calculation base means that a lower overall contribution rate will suffice to raise the same amount of contribution revenues. Therefore, there is a plan to lower the contribution rate from the current 17.35% to about 13.5% in 2003 (TAKAYAMA 2001b: 7). However, thereafter the rate will have to be raised again, because of increasing benefit expenditures over the coming years.

The third important aspect of the 1999 reform is that it alters future revenue streams. In 2004, general revenues flowing into the NPI are to be boosted, with the state subsidy rising from one-third to one-half of the NPI's annual cost. Yet, as of the time of this publication it is still unclear where the necessary tax revenues will come from.

The fourth area that will attract attention in the future is the shift in the management of the pension reserve fund, which started in April 2001. Up until then, the Trust Fund Bureau of the Ministry of Finance managed the pension fund reserves on behalf of the Social Security Agency. The Trust Fund Bureau used this money as part of the Fiscal Investment and Loan Program (FILP). In overall terms, this program is a huge public financial institution whose main purpose is to provide long-term loans to public finance corporations, public corporations and agencies, local authorities, and private companies. Now the pension fund reserves are to be managed independently by the Ministry of Health, Labor and Welfare. Over a period of seven years, funds amounting to ¥ 150 trillion, currently invested in the FILP program, will be transferred to the Ministry of Health, Labor and Welfare (*Nihon Keizai Shinbun* 29.03.2000: 3).[15]

[15] See CONRAD 2000b and CONRAD (2001b: 77–82) for a more detailed analysis of this issue.

New legislation in the occupational pension arena, which passed the Diet in June 2001, is likely to have an immense impact because it alters plan design choices and aspects of existing plans. The first law, effective since October 2001, concerns the introduction of defined contribution plans modeled on the U.S.'s so-called 401(k) plans.[16] The other law, effective since April 2002, concerns the regulations of defined benefit plans. It is also a widespread belief that cash-balance or hybrid schemes will be allowed, although the method for establishing such plans was still unclear at the time of this article.[17] The key elements of the occupational pension reform are (TAKAYAMA 2001a, 2001b; MERCER 2001):

- Companies are given greater choices in terms of plan design. As Figure 3 below indicates, companies can transfer their current schemes to a number of new plans.
- Employers offering EPFPs will be permitted to divest themselves of the contracted-out substitutional component of their plan. This will permit plan sponsors to gain relief from paying that portion of the government earnings-related pension by transferring a lump sum of assets to the government. However, participants in these newly constituted defined benefit plans, called "Fund Type" (*kikinkei*), will no longer be granted an exemption from the asset tax of 1.173% that had been imposed only on TQPPs. The specific rules governing this restructuring of old EPFPs remain to be clarified. The Pension Fund

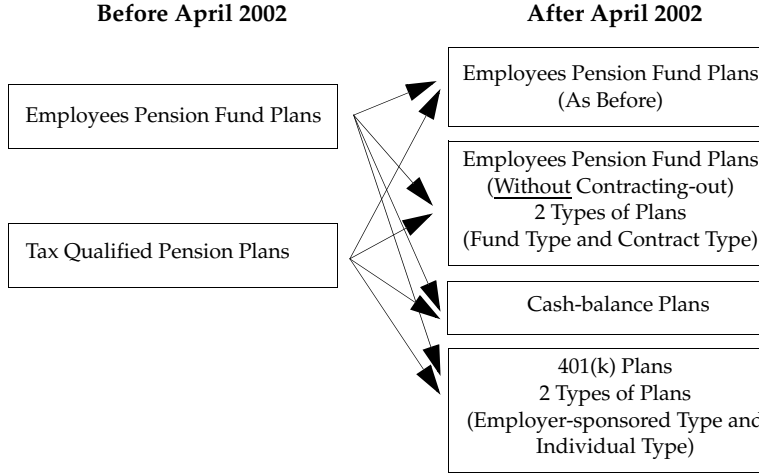
[16] 401(k) plans in the USA are constituted as mutual fund-type investment vehicles designed to attract pension assets. In contrast to defined benefit plans these schemes do not guarantee a definite benefit level dependent on former contribution payments and qualifying times. Instead, the benefits are dependent solely on the investment returns yielded by contribution payments. Contributions to these plans are tax-deductible. In general, the employees make their own contributions, but in most cases the employers match these contributions. The employee can choose investment strategies according to his own risk adversity. In case the employee changes his workplace, he has full control over his own contribution payments and their investment earnings (portability). In accordance with employee's service time in the company, he gradually becomes the owner of the employer's contributions and investment earnings (vesting) (KATZEFF 1996: 1–11, 108).

[17] Many contribution and participation features of a cash balance plan are similar to those of traditional defined benefit plans, rather than most defined contribution plans that allow employees to make decisions about participation and contribution rates. On the other hand, cash balance plans largely eliminate penalties for workers who terminate employment prior to retirement, which makes them similar to defined contribution plans. The accumulation of accounts and provision of lump-sum benefits at termination facilitate communication and portability like 401(k) plans.

Investment Fund will manage these assets and be responsible for paying the previously contracted-out benefits (CERULLI ASSOCIATES 2001).

- Companies offering TQPPs will be required to terminate them by March 2012 (LIFE DESIGN KENKYŪJO 2000: 24). The new legislation creates another new defined benefit scheme of the so-called "Contract Type" (*kiyakukei*) to replace existing TQPPs. Unlike the new defined benefit plans of the "Fund Type", setting up these schemes does not require a pension entity separate from the employer (TAKAYAMA 2001a, 2001b).

Figure 3: **The 2001 occupational pension reform**



Source: Own representation.

- After employers and employees have worked out a set of rules agreeable to both parties, companies can set up defined contribution 401(k) plans of the "Employer-sponsored Type" (*kigyōkei*). Entitlements for existing defined benefit plans may be transferred into these new schemes. If the employer does not have a contracted-out EPFP or a TQPP, an annual tax-qualified contribution of up to ¥ 432,000 per employee is permitted. If the employer already runs a defined benefit scheme, only ¥ 216,000 per year can be put into the 401(k) plan. No matching employee contributions are allowed.
- Self-employed and non-salaried workers can contribute to a new type of 401(k) plan of the "Individual Type" (*kojinkei*). The tax-qualified

ceiling is ¥ 816,000 per year. Employees whose company does not have an occupational pension scheme (excluding BRPs) can also contribute up to ¥ 180,000 a year to such a personal "Individual Type" 401(k) scheme.

- For all types of plans, stricter rules with regard to minimum capital, fiduciary duty, and disclosure standards apply.

3. The Effects of Recent Reforms

The first three subsections analyze how recent public pension reforms can be evaluated in terms of financial sustainability, distributive effects, and minimum income security. The last subsection focuses on the long-term effects of public and occupational pension reforms on the public-private mix in pensions.

3.1 Financial sustainability

As pointed out above, Japan's public pension schemes still manage immense capital funds. In the cases of EPI and NPI – the most important public schemes – the ratios of pension fund reserves to yearly expenditures are 6.1 and 3.3 respectively (2000) (Shakai Hoken Kenkyūjo 1999: 205–209). On the other hand, large pension entitlements are to be paid out in the coming years, so that these reserves will have to be melted down to prevent high increases of contribution rates (Conrad 2000a: 155–161). In comparison with Germany – where the pension fund reserves equal only one month of expenditures – the situation is still comparatively positive. A major reason for this is that the Japanese system has not yet reached the same level of system maturity existing in Germany's case (Conrad 2000a: 135–154).

When judging the impact of the last pension reform on the financial sustainability of the public pension finances, official projections of the Ministry of Health, Labor and Welfare are not very helpful, because their underlying assumptions have proven to be too optimistic, especially with respect to the development of the birth rate. Neither the calculation methods nor the results of the five yearly actuarial reviews are disclosed in detail (Conrad 2000a: 170–173). Also, the financial projection that was the base for the 1999 reform assumed a rise of the birth rate (TFR) to 1.61 by 2050, although the actual birth rate has been sinking for years. In 2000 the birth rate was 1.35 (*Nihon Keizai Shinbun* 09.08.2001: 46). Because there are no significant new family policy measures that would allow a positive

assessment of the development in the birth rate, official statistics should be regarded with care.

Therefore, in order to evaluate the impact of the last reform, this paper draws on projections which a group of well-known Japanese economists published in 1997 (KEIZAI KIKAKUCHŌ KEIZAI KENKYŪJO 1997). This projection differs from the official calculations in that:

1. it specifies assumptions which are more realistic and up-to-date,
2. it includes the interaction of macroeconomic variables, and
3. it simulates the effects of different reform measures.

The reform measures tested by the researchers and the actual amendments of the 1999 reform differ in various aspects. Nevertheless, one can reasonably argue that the 1999 reform measures will considerably improve the finances of the EPI and safeguard its financial sustainability (CONRAD 2001b: 56–60). This positive evaluation is also supported by recent calculations done by KATŌ (2001) and OGUCHI and HATTA (2001), who demonstrate that the EPI is not likely to run any deficits in the projection period up to the year 2050.

The financial situation of the NPI is much more difficult to assess. Hitherto, NPI benefit levels depended largely on political decisions, but were frequently raised in line with changes in the net wages of the working population and the development of the consumer price index. The 1999 pension reform stipulates that starting from April 2000, the benefit level of newly awarded NPI pensions will be decided every five years, at which point the development of the consumer price index in the previous five years is taken into consideration. In future, NPI benefits will only be adjusted to changes in the consumer price index (SHAKAI HOKEN KŌHŌSHA 2000: 2). The projection does not take into account that the NPI faces a problem with participants who either evade contribution payments (8.9% of Type 1 insured members) or who are, because of low income, exempted from paying contributions (17.3% of Type 1 insured members) (KŌSEISHŌ NENKINKYOKU 1998: 32). The problem of contribution evasion might become even more pronounced if the contributions, but not the benefits, are raised. Another factor which makes it hard to assess the future of the NPI is the question of how the government is going to finance the increase of the state subsidy from one-third to one-half by 2004 (*The Nikkei Weekly* 03.04 2000: 7) and how this will influence future contributions. Although the 1999 official projection indicates that, given a state subsidy of one-half of the benefits, the contributions only need to rise to ¥ 18,200 by 2020 – instead of ¥ 24,800 in the case of a state subsidy of one-third – (SHAKAI HOKEN KENKYŪJO 1999: 208–209), this calculation should be regarded with care. Taking all these factors into consideration

one can argue that, at the minimum, the 1999 reform will improve the financial position of the NPI significantly, even if future adjustments are likely to be necessary.

This positive evaluation with regard to financial sustainability does not mean that contribution hikes will not be required in future. With the introduction of annual earnings, including half-yearly bonuses as the new contribution base in 2003, the contribution rate will temporarily be lowered to around 13.5% so that the absolute burden remains about the same. After that, however, the contribution rate should be raised gradually to meet increasing expenditures. The officially projected contribution rate is estimated to top 20% of total compensation in 2025, a figure that the OECD has also adopted in its latest economic survey on Japan (2000: 125–126). However, given the above-mentioned unreliability of official projections, one should rather expect the future contribution rate to be a few percentage points higher than 20% – at least under the optimistic assumption that benefits will not be cut again by future reforms.

3.2 Distributive effects

In terms of distributive effects, one differentiates between inter- and intragenerational redistributive effects. Every pay-as-you-go system causes intergenerational redistribution. This simple truth is based on the fact that the first age cohorts receive benefits without having paid equivalent contributions. Geanakoplos, Mitchell and Zeldes (1999: 83–86) show that the internal rate of return (defined as the inflation-corrected discount rate that equates, for each individual, the present value of the stream of social security benefits to the present value of the stream of taxes paid) in a pay-as-you-go system must fall over time. This happens even in a system where the population has a constant life expectancy and age structure. However, these redistributive effects increase markedly if the growth rate of the working population (n) sinks. In this case the contribution rate (b) of the working population will have to be raised if the pension benefit per capita (p) is supposed to stay the same. In other words, later age cohorts realize an even smaller rate of return.

These redistributive effects have caught the attention of many Japanese economists and there are a number of so-called "money's worth calculations" (e.g., Honma *et al*. 1984; Ueda, Iwai and Hashimoto 1987; Takayama *et al.* 1990; Aso 1992). Most of these calculations on intergenerational redistributive effects are not based on historical data, but define a hypothetical individual (or a type of household) with a certain period of insurance and life expectancy. Assuming that all individuals are identical, this individual represents an age cohort. The contributions of the individ-

ual to the pension system are compared with the received benefits. This kind of comparison is undertaken for the same individual, while assuming that he or she joined the labor force at different times. In this way, past changes in the pension law are reflected in the contributions paid and the benefits received. Discounting contributions and benefits, the "benefit / tax ratio" (*jukyū futanritsu*) represents, for each age cohort, the present value of lifetime pension benefits received, divided by the present value of lifetime pension contributions paid.

Although these calculations are sometimes problematic in the sense that they tend to focus only on old age benefits, neglecting survivors and disability benefits, they show unanimously that today's pensioners receive benefits several times greater than what they paid as contributions and what they might have received had the money been invested in similarly safe investments. On the other hand, birth cohorts since the beginning of the 1960s will receive negative net-returns in the future (Conrad 2000a: 220–231; Conrad 2001b: 67–74).

How will the 1999 reform influence this pattern of intergenerational redistribution in the future? A tentative answer to this question can be given even without exhaustive calculations, if one considers to what extent the reform measures reduce the benefits of current or soon to be retirees without reducing the benefits of future pensioners. It can be shown, for example, that immediately increasing the contribution rate to a sustainable level would improve intergenerational equity, because age cohorts that are close to the pension age have to bear a relatively larger burden. The same is true for a temporary abolition of net-wage indexation (Hatta 1998).

However, the 1999 reform did not improve intergenerational equity (at least as far as currently living generations are concerned). On the contrary, a recent calculation by Katō (2001: 73–89) confirms that the gradual increases of contribution rates and entitlement age in the future will result in a relatively heavier burden for younger age cohorts. The 5% benefit cut concerns only newly awarded pensions; current retirees do not have to shoulder a heavier burden. Finally, the abolition of net-wage indexation will lower pension benefits for all generations in the same way, and does thus not improve the relative position of younger cohorts. Consequently, although the improvement of intergenerational equity is frequently indicated as one of the major objectives of reforms (e.g., Shakai Hoken Kenkyūjo 2000: 13), the 1999 measures have in fact worsened the position of younger age cohorts.

After this assessment of the intergenerational effects, the analysis turns now to the intragenerational redistributive impact of the current system and the 1999 reform.

Among the several functions of a welfare state and of public old age security programs is redistributing income to the poor and securing a minimum level of benefits for all elderly citizens. Although it is frequently argued that any targeted vertical income position can be better achieved through a progressive (income) tax system and social assistance benefits, in most countries, including Japan, public pension systems still count among their goals a redistributive function. The following analysis of the intragenerational effects of the 1999 reform therefore assesses whether the redistribution does indeed target the lower income groups.

In principal, the Japanese pension system is designed as a multi-pillar system in which the NPI fulfills the minimum income and redistributive function and the EPI performs the savings function. Thus, the system follows to a certain extent the philosophy of functional differentiation as it has been promoted by the WORLD BANK (1994). In general, such a functional differentiation is able to minimize the trade-off between social and individual equity aspects and can lead to higher "target efficiency" (KLANBERG and PRINZ 1988).

As described above, the NPI insures three types of participants. Whereas the fixed contributions and benefits of the "Type 1 insured persons" (mainly the self-employed) are closely related, this kind of equivalence principle does not hold for "Type 2 insured persons" (employees). Employees do not pay fixed contributions to the EPI, but a ratio of their working income – currently 17.35%. The remuneration-proportional benefits of the EPI increase in accord with higher contributions. In contrast, the benefits from the basic pension (NPI) are not related to contributions; they depend solely on the length of participation. "Type 3 insured persons" (non-working spouses of Type 2 insured persons) benefit directly from a redistribution, because they are entitled to NPI benefits without paying contributions. On the other hand, non-working spouses of the self-employed are required to pay full contributions to the NPI. The system becomes even more complicated if one considers the different financing sources for these plans, currently two thirds participant contributions and one third state subsidies.

Because of the system's complex setup, the distributive effects cannot be exactly quantified. However, on a higher level of aggregation one can show that "Type 1 insured persons" receive benefits from the basic pension system that are altogether higher than what they pay as contributions and taxes.[18] The same is true for the insured of the mutual aid associations, including their non-working spouses. On the other hand,

[18] This calculation is based on the basic assumption that all insured shoulder the same tax burden.

the overall benefits of the EPI-insured (including non-working spouses) are lower than their overall financing burden (CONRAD 2001b: 69–73).

These findings illustrate the fundamental problem of the Japanese basic pension system, where the redistribution depends more on the insured group type than on actual neediness. Within the Type 1 group, earners of low incomes probably constitute a larger fraction than they do within the Type 2 group (although the data to back up this statement is insufficient). However, it is at least debatable whether the self-employed persons who constitute the majority of participants insured in the Type 1 group are, in general, a needy constituency worthy of income redistribution. This is definitely true for the insured of the mutual aid associations, whose remuneration-proportional benefits are frequently higher than the ones paid by the EPI.[19]

The fundamental problem of the Japanese basic pension system is that, although it has a certain functional differentiation, it still aims to achieve two conflicting objectives within the basic pension pillar. Whereas the tax-financed state subsidies stress the social equity aspect (tax-transfer model), according to which all members of society are taxed according to their ability to pay, the contribution-based financing mode stresses the individual equity aspect by linking former contributions and later benefits (THOMPSON 1983: 1436–1438).

How does the 1999 reform influence this pattern of intragenerational redistribution? The increase of the state subsidy to one half of basic pension expenditures by 2004, part of the last reform, does not fundamentally change the above assessment. Although the planned increase of the state subsidy shows that there is a growing awareness of problematic distributive effects, a parametric change will not result in higher "target efficiency". It is indeed doubtful whether a combination of contributions and tax subsidies for the basic pension makes much sense at all, mainly because the resulting distributive effects remain largely opaque.

3.3 Minimum income adequacy

The above paragraph has shown that the basic pension system fares badly in terms of the distributive effects generated. This paragraph evaluates the system's record with regard to its effectiveness in securing an adequate minimum income.

The NPI model pension is supposed to cover the basic costs for nutrition, clothing, and housing of a non-working, 65-year-old pensioner who lives alone. Based on the National Survey of Family Income and Expen-

[19] In Figure 1, this is indicated by a longer vertical column.

diture (*Zenkoku shōhi jittai chōsa*), the Ministry of Health, Labor and Welfare determines this level at ¥ 72,336 per month (Kōseishō Nenkinkyoku 1998: 179–180). However, the model basic pension, based on 40 years of contributions, is currently only ¥ 67,016 per month. One would expect the Ministry to argue in favor of an increase in the NPI benefit level in order to meet these basic costs of living. Instead, the Ministry suggests, in its first ever Pension White Paper (1998), that the indicator for the minimum level of benefits should not be the basic cost of living for a single-person household, but rather the basic cost of living for an elderly couple (male 65 and older, female 60 and older) and that the median instead of the national average, should be applied as a suitable cost-of-living indicator. If these indicators were applied, an elderly couple would need at least ¥ 100,476 per month (¥ 50,238 per person) (Kōseishō Nenkinkyoku 1998: 179–180). Today's model pension totaling ¥ 134,034 for an elderly couple, would then indeed be sufficient. However, it remains unclear why the Ministry favors a new indicator, especially since the available statistics show that the economic situation of elderly living alone is markedly worse than that of other types of households (Takayama and Arita 1996).

Even disregarding the rather hairsplitting argument about a suitable cost-of-living indicator, the model basic pension is definitely low in comparison to the benefits paid by the national public assistance system. The benefit levels of the public assistance system are set nationally and vary among local municipalities according to variations in living standard. For a two-person, elderly household (male 72, female 67) this subsistence level varies between ¥ 116,120 and ¥ 149,989 among regions. For a single woman aged 70, this level ranges from ¥ 84,064 to ¥ 108,506. If the general assistance standard does not meet needs, a special standard is applied additionally to cover housing deposits, rent, and necessary repair costs up to ¥ 70,000 (Kōsei Tōkei Kyōkai 1998: 99; Eardley *et al.* 1996: 248). These numbers indicate that the current model basic pension for an elderly couple, ¥ 134,032 (¥ 67,016 · 2), suffices to maintain a subsistence level (without additional housing assistance) in some regions. However, the basic pension for a single-person household does not even meet the lowest subsistence level. In conclusion, the basic pension system hardly provides an adequate minimum income. How does the 1999 reform influence this assessment? If basic pension benefits are only indexed to prices, the basic pension will continue to lose its role as guarantor of a minimum income. In this respect, the situation in Britain might be indicative of what could also happen in Japan. Since basic state pension benefits in Britain were indexed to prices only in the 1980s, benefits kept falling relative to general living standards and were only 15% of average full-time male earnings in the late 1990s (Budd and Campbell 1998: 101).

3.4 Changes in the public-private mix in pensions

This paragraph deals with the question of how the 1999 public pension reform and the 2001 occupational pension reform will influence the relationship between public and occupational pension provisions in the long run.

Since the mid-1990s the Japanese government has followed neo-liberal ideas with regard to social policy, according to which the state should provide only a moderate level of benefits. The difference should be covered by private provisions (KŌSEISHŌ DAIJIN KANBŌ SEISAKUKA 1994: 7). The latest reforms have to be judged against this general policy background. The pension commission (NENKIN SHINGIKAI 1998) stated in its final report before the last reform that personal and occupational pensions should play a bigger role in the future so that public benefit cuts can be compensated for. However, for several reasons the chances of success for this replacement strategy appear to be rather limited.

- Occupational pension provisions are first of all a means to motivate and attract a certain type of employee (LOGUE and RADER 1998: 3–13). For this reason, human resource considerations are at least as important as the legal and tax environment when deciding on the implementation or modification of pension plans. Against the background of the ongoing restructuring of Japanese businesses and the massive lay-offs resulting from it, an expansion of occupational benefits certainly has little place in the current primary objectives of most companies.
- The current diffusion of occupational pension benefits is characterized by big differences between small-, middle-sized, and larger companies. Whereas the core work force of bigger companies can expect generous lump-sum benefits plus occupational annuities, employees of smaller companies generally receive markedly lower benefits. Since public benefits are being cut for all insured in the same way, while occupational provisions are, if at all, not extended uniformly, the inequality of incomes will inevitably rise in the long term.
- The dire financial situation of most occupational pension plans complicates the situation even further. It can be expected that many companies will make use of the option to shift their defined benefit plans into defined contribution plans – thereby shifting the investment risk to the employees. However, this does not rid them of the responsibility to close existing financing gaps in the future. Consequently, there will be reluctance to extend existing occupational provisions.
- The new legislation has introduced stricter protective regulations on the fiduciary duties and disclosure standards of the new defined

benefit plans (Contract Type and Fund Type), which are likely to lead to higher administration costs. Therefore, many companies might terminate their TQPPs, but without introducing new defined benefit schemes instead (TAKAYAMA 2001b: 15).

- The new 401(k) plans have a relatively low level of tax-qualified contributions.[20] The low employer contribution ceilings reflect the government's reluctance to allow more compensation to be protected from tax in a time of economic depression and rising fiscal deficits. This low tax-qualified cap, together with a 1.173% special annual corporate tax on pension assets (suspended until March 31, 2003 because of the current adverse investment environment), makes these plans unattractive at the moment. Although experts assume that the Japanese 401(k) market will rise in the next ten years to about ¥ 50 trillion, the initial take-off is expected to be rather slow because of the aforementioned problems (*Reuters Business News* 06.08.2001). According to a survey of the *Nihon Keizai Shinbun* for fiscal year 2001, which centered on stock market listed companies, only 24% of the responding companies named 401(k) plans as the pension plans they would like to introduce in the future. On the other hand, only 4% of the responding companies were considering the introduction of defined benefit EPFPs (*Nihon Kin'yū Shinbun* 19.10.2001: 10).
- With the exception of the 401(k) plans of the "Individual Type", private pension provisions are not supported by tax-qualified contributions and even the "Individual Type" private pensions have a very low tax-qualified ceiling of ¥ 180,000 per year for an employee in a private company. Unlike the newly introduced personal pensions in Germany, there are no subsidies for low income earners, so that there is a substantial risk that only those who have sufficient savings already will be able to put money into additional private provisions.

Even if some of the shortcomings of the current legislation can be addressed in the future, three tendencies support the argument that the shift in the public-private mix will eventually lead to growing inequalities among Japanese households. First, unlike most public pension schemes, private schemes usually do not include redistributional elements that would compensate for a low level of participation in the labor force during working life, low wages, or periods of non-employment. Second, occupational pension schemes frequently cover only the core workforce, while part-time workers are not included. Third, an occupational pen-

[20] In contrast, in the United States employee contributions may total $ 10,500 per year.

sion, where the employee bears some or all of the expense of accumulating savings, requires a certain level of income so that current consumption is not unduly restricted.

In her cross-national analysis,[21] BEHRENDT (2000: 18–23) confirms that private pensions (predominantly occupational pensions) have reproduced or even strengthened existing inequalities in the labor market. However, the study also shows that a high degree of inequality is not necessarily a characteristic of private pensions as such, but strongly depends on other policy factors. Regulation of private schemes can cause a large difference in distributive effects. For example, Finland and other Scandinavian countries have relatively high degrees of equality in private pension distribution, partly because private provisions are mandatory in some of these countries.

How one judges the likely increase in pension and income inequality in Japan depends largely upon one's view about social equity as a moral value underlying the welfare state. Whereas some egalitarians argue for "equal opportunity", others are more concerned about "equal outcomes" (GOODIN *et al.* 1999: 28–30). Followers of the latter school would naturally argue that Japanese pension policy needs better regulation and presumably mandatory private provisions – either occupational or personal. Conversely, for followers of the "equal opportunity" school the outcome of current pension policies is not a major concern.

4. CONCLUSION

This article has shown that the last reform of the pension system has had a considerable positive impact on the financial sustainability of the public pension finances. However, major problems in distributive effects and minimum income security remain. Although the government claims to have improved intergenerational fairness with the last reform (i.e., relieve the contribution burden of younger age cohorts and increase the burden for older cohorts), recent calculations show that the gradual increase of contribution rates and entitlement age in future will in fact result in a relatively heavier burden for younger cohorts. The last reform also fares badly with regards to improving intragenerational fairness. The fundamental problem here is that the basic pension system, although it follows a certain functional differentiation, still aims to meet two conflicting objectives. Whereas the tax-financed state subsidies stress the social equi-

[21] According to Ms. Behrendt, the study did not include Japan because of a lack of suitable data.

ty aspect, according to which all members of society are taxed according to their ability to pay, the contribution-based financing mode stresses the individual equity aspect by linking former contributions and later benefits. Also, the basic pension system tends to favor "Type 1 insured persons", who are not, by definition, a needy group who require income redistribution. The increase of the state subsidy to one half of basic pension expenditures by 2004, instituted as part of the last reform, does not fundamentally change this assessment.

The official replacement strategy regarding the new public-private mix in pensions is problematic because so far it lacks sufficient supportive measures such as higher tax-qualified contributions, or state subsidies for low income groups to foster the new occupational and/or personal pension plans. Partly because of these problems and partly because of more general considerations, it is likely that the pension distribution will show increasing disparities in the coming years. This will further strengthen the already noticeable trend of increasing income- and wealth inequality among Japanese households.[22]

Rising economic inequality in and of itself might not be a problem if only there were effective instruments to ensure an adequate minimum income. However, it has been shown that the basic pension system in Japan does not fulfill this role. This is problematic since means-test social assistance is still highly stigmatized and the take-up rate is low. Only 25 to 30% of those actually eligible are receiving those last-resort benefits (Esping-Andersen 1997: 184). Thus, both the basic pension system and the public assistance system are in need of reforms that will accompany the evolving new public-private mix in pensions.

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[22] See Conrad 2001a for a short overview on the recent development of inequality in Japan.

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Pension Policy in Germany: Major Postwar Reforms and Recent Decisions[1]

Winfried Schmähl

1. Introduction

Germany has one of the oldest public pension schemes in the world. At the end of the 19th century a number of structural decisions were made that influence pension schemes even today. However, many changes have taken place over a period of development of more than one century. An adaptation of pension arrangements to changing conditions in the environment of pension schemes was and remains necessary; changes in demography, economy, household structures, and living conditions but also in political objectives and normative positions have taken place. Pension reform is a topic that has been debated world-wide for many years. One of the central questions is the role of the state in general as well as in pension policy. Especially "pay-as-you-go" (PAYGO) financed public schemes are under severe political pressure in many industrialized countries. Often a radical shift towards capital funding is proposed, which is largely linked to proposals for privatizing at least major parts of old-age security. It is not surprising that the insurance industry, banks, and investment funds are proposing to organize more old-age provisions via capital markets by using financial methods based on (pre-)funding. For a number of years many activities have been initiated by international organizations, especially the World Bank. In addition to these actors, ministries of finance have also become important players.

In Germany a broad-based reform debate has been underway for many years now. Several decisions have been made. The last of these decisions was made at the end of the year 2000 and in the first half of 2001. These decisions will have far-reaching consequences for pension policy in Germany. The transformation process that followed affects not only public pension schemes but also occupational pensions in the private and public sectors as well as additional private old-age provisions. There were and are many reasons to hold debates on reform in Germany. Most arguments are similar to those in other industrialized countries, i.e., demographic aging. A special focus of the public debate in Germany is on

[1] This paper was written at the end of December 2001. Some parts of the paper are based on Schmähl (1999a).

the aging population, resulting from a low fertility rate (which for a long time has been only two-thirds of the amount necessary to keep the population constant over time) and a rising life expectancy. The decrease of mortality has now been placed in the center of the debate concerning demographic changes and its effects for pension policy (as well as health insurance and long-term care insurance). Present life expectancy data for the elderly in Japan are assumed to be "target values" for the further development of life expectancy over the next few decades in Germany. The (official) calculation of the development of pension expenditure is based on the assumption that by the year 2030 the life expectancy of men and women will increase to the level already currently existing in Japan.

There are other changes affecting pension schemes such as a changing structure of private households and intensified international competition (often labeled as "globalization"). Particularly the reduction of non-wage labor costs – and above all the employer's contributions to social insurance – are high on the agenda of politicians, employers, and industrial organizations.

Some challenges are different in their extent, such as the high unemployment rate, which in part is linked to a very specific challenge for Germany, the economic consequences of German unification. In addition, further steps for a closer European integration are taking place, which also affect pension policy. Here the latest developments consist of a new approach – labeled the "open method of coordination" which aims for an agreement on common goals of pension policy, common indicators, a process of (regular) national reports, and some "benchmarking". At the moment it is too early to say what effect the new developments will finally have on the structure of old-age security in Germany and the distribution of costs.

By placing political decisions and recent developments into a framework, some basic information concerning the structure of old-age protection arrangements in Germany will be given as well as some information concerning the design and major objectives of Germany's public pension scheme. Major pension reforms from 1957 to 1999 in West Germany (in unified Germany respectively) will be characterized in their basic elements in the following.[2] I will then discuss the latest decisions of 2000 and

[2] It is beyond the scope of this paper to deal with the different developments that took place after the Second World War in the German Democratic Republic, and the problems resulting from the different structures of pension schemes in East and West Germany in the process of integrating the population of East Germany after 1990 into the West German public pension scheme. For these issues see SCHMÄHL (1992a).

2001 and finish off by making some remarks on possible future developments.

At the center of this article is the statutory pension insurance (i.e., social insurance) because it is the major element of Germany's arrangements for social protection in general and in old age in particular. Changes in this scheme have direct or indirect effects on other elements of Germany's old-age security arrangements, i.e., the special pension scheme for civil servants, occupational pension schemes, and private provision. But there are also political decisions directly focused on these other elements. These will be discussed in the context of the pension reform measures of 2000 and 2001.

2. The Present Structure of Old-Age Protection in Germany

As in many other countries, in Germany, a multi-pillar approach in pension policy (better characterized as multi-tiers or multi-layers) has been in place for many years.[3] The first tier consists of several mandatory pension schemes. The most important element of the first tier as well as of all old-age protection arrangements in Germany is the statutory pension scheme (social insurance) for blue and white-collar workers. It is an earnings-related scheme from the defined benefit type (at least up to the year 2000). Pension calculation takes into account the whole career earnings. Pension claims are accumulated on individual accounts. Pensions are paid in cases of old age (some flexibility exists in retirement ages), disability, and death of the spouse (widow's as well as widowers' pensions and pensions to orphans). The scheme is mainly financed by contributions (from employees and employers in equal parts).

Several special schemes exist alongside social insurance, e.g., for civil servants. These are of the defined benefit type as well, but are calculated differently from social insurance pensions; civil servants' pensions are linked to their last income. This specific scheme can be interpreted as a mix of first and second (occupational) tier. Civil servants' pensions are tax-financed. Special schemes also exist for farmers and several other groups of professions (such as doctors, lawyers, and architects).

The second tier consists of supplementary occupational pension schemes in the private and public sector. While, in principle, all blue and white-collar workers of the public sector are covered by such an occupational scheme (based on collective agreement), only about 50% of employees in the private sector are covered by voluntary occupational pension

[3] An overview is given in Schmähl (1998a and 1998c).

schemes. Coverage is very unequally distributed according to size and branch of the firm.[4]

The third tier consists of many different types of private savings (and insurances) for old age. It is, however, difficult to give an exact amount of private old-age provision.

Social insurance for old age, disability, and widow(er)s is by far the most important scheme (a) in macroeconomic terms as well as (b) a source of income in old age for the majority of elderly in Germany.

Statutory pension insurance covers nearly 70% of all expenditure for old-age security in Germany. This is nearly 10% of GNP. More than 80% of the West German population is insured through this pension scheme; in East Germany the percentage is even higher.[5] For the majority of retired people social insurance pensions are by far the most important source of income in their old age. Recent research, trying to analyze the pension claims for prospective retirees over the next twenty years, reveals that this will basically apply for this time frame as well. Therefore, it is not astonishing that the scientific and political debate was and remains predominantly focused on the social pension insurance.

In Germany – as compared to many other countries – the PAYGO financing in pension protection carries a very heavy weight in absolute and relative terms. A rough estimate shows that about 80% of financing is covered by PAYGO and 20% by funding (occupational pensions and private provision cover 10% each). It is not surprising that there are strong forces behind proposals to change this mix. In the year 2001 political decisions supported this by aiming to increase occupational and private pensions and to reduce public (PAYGO financed) pensions.

[4] A detailed analysis of occupational pension schemes and the link to social insurance is given in SCHMÄHL (1997b).

[5] In East Germany occupational pensions in the private sector as well as life insurance expenditure have hardly been relevant up to now. This means that social pension insurance in East Germany is even more important as an element of old-age provision than in West Germany today. Some reasons for these differences are as follows: In the former socialist German Democratic Republic, social insurance covered nearly the entire population. There were, however, some special pension schemes (e.g., for military personnel). After the German unification schemes for special groups of the population were introduced only step by step, and the number of people of these groups (such as the self-employed or civil servants) increases only gradually over time.

3. A Few Historical Remarks on Main Elements and on the Design of Germany's Social Insurance Pension Scheme

When we look back at Germany's social security pension reforms in the period after the Second World War, we must mention some of the major reforms as well as some of the major topics of discussion.[6] The roots of the present social insurance pension scheme go back to the late 19th century when Bismarck was chancellor of the newly founded "German Reich". *Financing* was mainly based on employers and employees' contributions. However, a grant from the central public budget to pension insurance was introduced as an important element of financing (which was reflected in the pension formula as well).

Since then, social pension insurance in Germany has been based on the idea of *insurance*, i.e., inter-temporal redistribution and risk pooling, but also on *inter-personal redistribution.* The mix of different elements – namely, equivalence and inter-temporal redistribution on the one hand, and inter-personal redistribution over the life cycle on the other hand – was and remains a major topic of discussion. The organizational structure created in the founding period of the German social insurance has also remained intact up to the present.[7]

Bismarck's original idea for the pension scheme was, however, quite different from what was established in 1889. He originally aimed at a "tax-financed flat rate pension"; workers should become like "state pensioners". This idea – as a contrasting strategy to earnings-related pension insurance – is often discussed in Germany, especially when major reforms in pension insurance become necessary because of changing conditions in the economy, demography, and society.[8]

The method of financing – *pay-as-you-go (PAYGO) versus funding* – was also intensely discussed in the late 19th century, taking into account, e.g.,

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[6] An overview is given in Schmähl (1999c).

[7] Different agencies existed for blue-collar workers on a regional basis, while for white-collar workers one central agency was established in 1911. Due to the changes in the structure of employment, there are now fewer blue-collar workers. This shift to white-collar workers results only in a shift in pensioners of the two parts of the pension system after an extended time lag. Methods of fiscal equalization became necessary because financing as well as pension calculation are identical for both groups of insured employees. The fact that blue-collar pension agencies have fewer "clients" resulted in a discussion stimulated by the federal states (*Bundesländer*) to reorganize pension agencies, to strengthen agencies on the regional level, and to make cuts at the central agency (on the federal level).

[8] An overview of this discussion is given in Schmähl (1993a).

the effects on individual and national savings. And although public pension insurance in Germany was originally based in principle on full funding, this decreased over time because of inflation, war, economic crises, and by using accumulated funds for purposes other than pension financing.[9]

4. Major Pension Reforms in West Germany: 1957 up to 1999

4.1 Introducing a dynamic pension in 1957

The first major pension reform in postwar Germany took place in 1957 by introducing the so-called *dynamic pension*. This reform sought to link pension calculation as well as pension adjustment to the development of gross wages (earnings). A major shift in the method of financing towards PAY-GO was realized as well. Only a limited reserve, covering pension expenditure for one year, was required.[10] This reserve requirement was later reduced to three months in 1969 and finally to one month only in 1992.[11]

In the 1960s, there was already a discussion on the future development of the pension scheme, with a particular focus on the *aging* of the population. In order to cope with the expected financing problems it was proposed to accumulate, for example, some reserve by increasing the contribution rate to a higher level than necessary to balance the current budget, and to use these reserves later in order to avoid a steep increase in contribution rates – the image of "digging a tunnel into the pension mountain" was frequently used to illustrate this.[12] But in contrast, a reduction in reserve requirements was, in fact, politically decided.

4.2 The Pension Reform of 1972: Flexible retirement age and increasing pension expenditure

Especially in the early 1970s – based on optimistic projections of future economic development over the next decades – an enormous surplus in

[9] Mörschel (1990) describes the development over time.

[10] At the end of a ten-year period a reserve to cover pension expenditure for one year was required.

[11] It was only recently that the *Bundestag* (Federal Parliament) decided to reduce the minimum reserve requirement from one month's expenditure to only 80% of this amount. It thereby avoided increasing the contribution rate in 2002.

[12] The focus, therefore, was not mainly on additional saving, investment, and economic growth, but on inter-temporal aspects of sharing the "burden" between generations.

the pension scheme was calculated for the future. This was in the years just before the first oil price crisis. Based on these calculations, a political race between all political parties in proposing alternatives for *increasing pension expenditure* occurred and resulted in several reform measures taking place in 1972. For example, the *flexibility of retirement ages* was introduced, allowing retirement before the former reference retirement age (for men, 63 instead of an age of 65 years)[13] *without* introducing *actuarial* deductions from the pension. The possibility to retire at the age of 60 without deductions from the full pension already existed for women and the unemployed (meeting several requirements). Later, a further lowering of the retirement age was also decided for the disabled (see JACOBS and SCHMÄHL 1989). A few years later the oil price development shocked the economy and several ad hoc measures were taken to reduce pension expenditure.

4.3 The "1992 Pension Reform Act" (of 1989): Net pension adjustment and a self-regulating mechanism

Demographic scenarios showing a rapid change in the age structure of the population, and the consequences for public pension schemes were the main reason for a major pension reform that was decided on November 9, 1989 (the same day that the Berlin Wall was opened). Most elements of this Pension Reform Act were to be implemented in 1992 (which is why it is called the "1992 Pension Reform"). Nobody expected that the introduction would take place not only in West Germany but – following German unification – in East Germany as well. The reform measures were thus to influence the future development of the pension insurance in West Germany.

After several ad hoc interventions over the past 15 years one aim of the Pension Reform Act was to re-establish a set of clear regulations, a self-regulating mechanism to stabilize the financing development over time and to reduce the financing burden for the working population in future. The other aim was to maintain an appropriate level of pensions compared to earnings.

For a better understanding of the 1992 reform and more recent reform measures and debates, some basic information concerning the design of the social insurance pension scheme is given below. As already mentioned, social pension insurance in Germany is a mixture of a pure "insurance scheme" (aiming ex ante at inter-temporal redistribution plus

[13] It became possible to retire at the age of 63, if 35 years of insurance were fulfilled.

risk pooling) and a "tax-transfer scheme" (aiming at inter-personal redistribution, also over the life cycle). The "insurance approach" dominates in Germany. The result is, for example, a (relatively) close link between individual contributions and later benefits, which is nevertheless modified by measures of inter-personal income redistribution (e.g., by crediting those years spent without gainful employment and without paying contributions during periods of schooling, illness, or child care).[14] For many years now it has been a major political issue in Germany how benefits aiming for redistribution should be financed adequately. The results were higher transfers from the general public budget to social pension insurance – based on decisions of the "1992 Pension Reform" as well as on decisions made in 1997.

The German public pension scheme is earnings-related because:

- The individual pension benefit is linked to former earnings of the pensioner.
- The absolute amount of the individual pension at the time of retirement depends on the nation-wide average earnings close to the year of retirement.
- The development of the pension benefit during retirement is linked to the development of nation-wide average earnings.

The contributor acquires a pension claim according to the *relative* amount of his gross earnings (= wages or salary). The individual gross earnings are compared to average gross earnings of all employees each year. This ratio gives the amount of the pension points (Earnings Points, EP) for one year. If, for example, individual gross earnings are equal to average gross earnings in one year, the result is one EP for this year. When claiming the pension, the sum of all EPs is taken (including EPs credited according to special regulations connected to child care, schooling or times of unemployment, for example).

To calculate the individual pension benefit the sum of individual EPs is multiplied by a factor (ARW, "Actual Pension Value") representing the value (in Euro per month) of one EP in a specific year. ARW is the dynamic factor of the German pension formula, because it changes every year according to the growth rate of average earnings. With regard to the development of ARW over time, the 1992 Pension Reform Act introduced an important change, i.e., by linking ARW to the development of average

[14] No general minimum pension exists. To avoid poverty in old age a means-tested social assistance assessment can be carried out. But less than 2% of all pensioners claim additional social assistance.

net earnings instead of average gross earnings as was done in principle in previous years since the 1957 pension reform.[15]

The rate of change of ARW is also the factor for adjusting all pensions calculated in former years. This also means that all pensioners who have the same sum of EP receive the same pension benefit, irrespective of the year of retirement.

It was possible to claim a pension before the "reference retirement age" of 65 years without reducing pension benefits because of the extended period for receiving the pension. This was an incentive to retire early.[16] Since the introduction of "flexible retirement age" in 1972 a radical reduction of the participation rate of the male labor force has taken place (e.g., for men at the age of 63 from 67% in 1972 to about 20% within less than 20 years). Although incentives in the pension scheme are not the only reason for this development, there are, however, clear indications that this was a major influencing factor.

The 1992 Reform Act also aimed to postpone the age of retirement. After a drawn out period of controversial discussions it was decided that as of the beginning of the year 2001 some deductions from the pension should be introduced step by step over a period of more than ten years, if retirement takes place before the age of 65. The age of 62 should become the earliest retirement age for starting an old-age pension, and would apply equally to both men and women. The deductions were decided to be 3.6% (below an actuarial fair rate) per year of earlier retirement. Disability pensions, however, should not be burdened by a deduction. It was obvious that the regulations for claiming disability pensions would have to be changed in the future in order to avoid disability pensions becoming part of a loophole for early retirement.[17]

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[15] Net earnings are defined as gross earnings minus income tax on earnings and employee's part of social insurance contributions to statutory pension insurance, health insurance, and unemployment insurance.

[16] Retirement age, however, is not identical with an exit of older workers from the labor force. Several other possibilities exist to end official gainful employment without claiming an old-age pension, i.e., a disability pension (the number of disability pensions is to a certain degree also linked to the labor market conditions) and several pre-retirement agreements. A detailed discussion of possibilities as well as of the changes decided upon in the "1992 Reform Act" is given in Schmähl (1992b) and in Schmähl, George and Oswald (1995).

[19] The introduction of a partial pension was another new element. This possibility for a phased retirement has until now enjoyed little success mainly because of the unfavorable labor market conditions, as well as other possibilities to leave the labor force early. Only a negligible number of pensioners claimed such a partial pension. It is possible to claim either one-third, one half, or two-thirds

Another element of the 1992 reform package was a new formula for federal grants aiming to stabilize the relative amount of the federal grant at about 20% of pension expenditure. In addition to the development of average gross earnings, the formula for calculating the federal grant now also includes the development of the contribution rate to social pension insurance.

The changes of the adjustment procedure and the new formula for federal grants are elements of a self-regulating mechanism for the pension insurance scheme.[18] This seems to be an important decision from a political as well as an economic point of view. For example, since 1992 no parliamentary decision about the pension adjustment rate or the contribution rate has been necessary. This is done automatically by the government according to clearly defined statistical data of the Federal Statistics Office. However, such regulations only exist for as long as the *Bundestag* (Federal Parliament) does not change them.

A political objective concerning the level of pensions compared to earnings was decided upon in the 1992 Reform Act. For a so-called standard pension with 45 Earnings Points the pension should be about 70% of present average net earnings of all employees.[19] Because pension adjustment rates are linked to the increase of average net earnings, the individual net pension level (individual net pension compared to average net earnings) remains constant over time.

The 1992 Pension Reform Act was based on broad political consensus among the governing coalition parties and the major opposition party in the German parliament as well as among employers' organizations and trade unions.[20] This consensus was in line with the experience of former major changes in pension policy in Germany. The search for solutions on a broader political basis in this area with a long-term perspective could be interpreted as being an element of "political culture" in Germany. Contrary to some other countries, the biggest political parties (Christian

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of the pension and supplement earnings from part-time employment. VIEBROK (1997) analyzes in a very differentiated manner the labor supply effects of the German social security scheme, theoretically (taking into account the institutional arrangements), as well as simulating effects based on a dynamic programming approach.

[18] For a more detailed analysis, see SCHMÄHL (1993a).

[19] For employees with lower pension claims this percentage is lower and vice versa. For example, for a pension based on 40 EP the target pension level is $40/45 \cdot 0.7$ (= 62.2%) instead of 70%.

[20] The "social partners" – unions and employers' organizations – also work together in the self-administration bodies of social insurance.

Democrats and Social Democrats) were both in favor of the "social state"[21], and shared many basic values.

4.4 1996: Breaking the trend of early retirement

For many years there was a broad consensus among employers, trade unions, and governments that the reduction of unemployment through an early retirement of older workers from the labor force would be a socially acceptable measure, because this would give younger people a better chance to enter the labor force. A low youth unemployment rate in Germany compared to many other European countries seemed to confirm this. This consensus soon broke down. Since the summer of 1995 a political discussion has emerged that sought to reduce early exits and associated costs, particularly for unemployment insurance and social pension insurance, although unemployment remained at a high level.[22] The effect on contribution rates and therefore on non-wage labor costs was especially regarded as being a negative factor in times of intensified international economic competition.

In February 1996 the federal government decided upon measures to stop the growing number of early retirees claiming an old-age pension at the age of 60 following a phase of unemployment. The phase-in of the deductions from the full pension (3.6% per year) started already in 1997 (and not in 2001) and will be much quicker compared to the regulations of the 1992 Act. For pensions after periods of unemployment (age 60) the reference retirement age was increased within three years (until the end of 1999) by three years; thereafter for all types of old-age pensions[23] within the following two years up to the age of 65. For the specific female retirement age (at 60), this process (after strong resistance by several

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[21] The term "social state" (*Sozialstaat*) is used in Germany instead of "welfare state"; *Wohlfahrtsstaat* is the German literal translation. "Wohlfahrtsstaat" has a different meaning in German compared to "Sozialstaat".

[22] A widely used measure for pre-retirement was and remains laying off older workers and supplementing their unemployment benefit with a payment from the employer so that the net income of the now unemployed person stays nearly the same as in the period of employment. After a period of unemployment, the old-age pension can be claimed at the age of 60. There was a sharp increase in those who took up this type of pension. In 1994 about 20% of all male pensioners claiming a pension took this path to obtain the old-age pension; in East Germany this percentage was even much higher with more than 40% doing so. This measure was used particularly by big companies.

[23] This means that the existing "flexible" pension, which can be claimed from age 63, will be "burdened" by deductions.

organizations) started in the year 2000 and the reference retirement age will become 65 at the end of 2004.[24]

For those wishing to claim a pension at the age of 60, an additional possibility was created beside unemployment, "part-time employment" for older workers after the age of 55, which – under special conditions – is supplemented by benefits from unemployment insurance. However, there is a lack of part-time jobs, especially for men.[25] Therefore, in reality, this "part-time" employment means full employment for half of the period, and employment with zero working hours thereafter.[26]

Another starting point for reducing pension expenditure in the future was the reduction of the number of years of schooling that is credited without paying contributions.

The reduction of credited years of schooling as well as the introduction of deductions from the full pension in case of early retirement can be interpreted as elements of an underlying strategy to strengthen the contribution-benefit link – a strategy the government seems to have become convinced of in the past years, especially as a counteraction to proposals for shifting public pension policy to a flat-rate approach.[27]

4.5 The 1997 reform measures (the "1999 Pension Reform Act")

Although in 1996 the financial outlook of social pension insurance hardly differed from that in November 1989 in the long-term perspective, when the "1992 Pension Reform Act" was decided, discussions about its future development were re-introduced into the political arena in the summer of 1996.[28] Several politicians and leading members of employers' organiza-

[24] According to the 1996 decisions, old-age pension could be claimed at the earliest at age 60, however with a deduction from the full pension of 18% ($5 \cdot 3.6\%$).

[25] This is also the main reason why the "partial pension" introduced in 1992 has not become an effective instrument. For example, in 1994 only 0.15% of all new pensions were partial pensions.

[26] For a detailed discussion of early retirement, see GATTER and SCHMÄHL (1996).

[27] For a detailed discussion of arguments in favor of such a strategy aiming at a closer contribution-benefit link, see, e.g., SCHMÄHL (1985).

[28] In 1989 it was calculated that the contribution rate would be about 27% in 2030 (including the 1992 reform measures), while in 1996 (taking into account the additional decisions up to 1996) the contribution rate was expected to become 25.5%. It should be taken into account when looking at these contribution rates that the rate is about one percentage point higher because of transfers from West to East Germany, about two percentage points are used to finance redistributive measures (instead of financing by taxes), and at least one percentage point is due to the fact that the pension scheme was used as an instrument of labor market policy.

tions argued that more has to be done to avoid the consequences of the "demographic time bomb" and the expected increase in contribution rates. The role of the mass media as the reinforcing agent in the process of agenda-setting has increased during the past years.

While the development of calculated contribution rates based on assumptions of demographic and economic development was not new, the climate had obviously changed. Some of the elements behind this new discussion on social policy, and not only on pension policy, include having to cope with the economic and social consequences of German unification – a process that, in contrast to earlier more optimistic political statements, lasted longer than expected –, high unemployment, the political will to meet the Maastricht convergence criteria leading to policies of retrenchment in several fields, backed by mainstream economic supporters of a supply side strategy and industrial interest groups. The climate between the federal government and employers' organizations on the one hand, and labor unions on the other became chilly especially after the government (and the majority in parliament) decided to change regulations for continued wage payments in case of illness of employees – a highly sensitive topic for trade unions because the existing regulation was the result of a severe strike in the past.

Mass media (especially newspapers and television) pushed the topic of a "collapse" of the pension scheme; banks and insurance companies argued along the same lines. As so often in periods of turbulence, radical proposals for abolishing the social pension scheme and introducing flat-rate pensions or, at least, drastically reducing the pension level were published. Although the common argument was to give people more space for "self-reliance", these proposals were nevertheless blatantly linked to the self-interests of many advocates for radical changes from the business community.

At the beginning of this debate the government reacted in a very passive way, promising that "pensions are secure". However, in the summer of 1996, because of the growing public debate, the federal government decided to appoint a commission of experts (chaired by the Federal Minister for Labor) to propose additional measures for a new pension reform. At the same time another commission (chaired by the Federal Minister for Finance) was to develop proposals for a major income tax reform.[29] Both projects were to be realized toward the end of 1997 at the latest, i.e., near the end of the government's legislative period (the next

[29] In addition, the Christian Democratic (and Christian Social) Parties also established party commissions.

parliamentary election was scheduled for September 1998).[30] While the government had a majority in the *Bundestag*, the second chamber, the *Bundesrat* (representing the federal states, the "Bundesländer"), was dominated by the Social Democratic Party.[31]

The debate in the commissions and among the public concentrated on two main areas:

- Possibilities for a further reduction in the development of pension expenditure, aiming above all at a reduction of the financing burden for "future generations".
- A "fair" distribution of "burden" in financing of current pension expenditure, taking into consideration the different distributional targets (inter-temporal versus inter-personal redistribution), and especially aiming to reduce non-wage labor costs because of labor market reasons.

The proposals of the expert commission aimed to maintain the concept of an earnings and contribution-based (defined benefit) pension scheme, while the concept of tax-financed flat-rate pensions was rejected. This was also backed by the majority in the political decision-making process. The main instruments to realize the above-mentioned goals – as proposed by the commissions in principle (EXPERT COMMISSION 1997) and finally politically decided – were as follows:

In addition to already introduced changes in *retirement ages* for old-age pensions, deductions from the full pension were decided for *disability* pensions as well. This was linked to some changes for old-age pensions once more; starting in 2012, the youngest age that an old-age pension can be claimed, shall be the age of 62 years, but only for those who have 35 years of insurance. The deductions would be $3 \cdot 3.6\%$ from the full pension. This 10.8% should also be effective for disability pensions in general.[32]

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[30] There was scarcely any direct contact or coordination between the two reform commissions, as well as between the two reform projects, although some direct links of tax policy and pension policy do exist. For a discussion of this issue, see SCHMÄHL (1998b).

[31] It is not possible to enter into detail here of how laws are passed in Germany. But in every case the *Bundesländer* are affected, they have to approve the law, too. Even in all other cases, a complicated, time-consuming process is necessary if there are different majorities in *Bundestag* and *Bundesrat*.

[32] There are some other technical changes not discussed here, as well as changes for pensions for disabled people.

Additional pension expenditure, however, would result from higher *crediting years for child care*, a measure that, in general, is an element of family policy (resulting in inter-personal redistribution that should be financed from general public revenue and not from earnings-based contribution payments. This will be discussed below).

The most important change concerning expenditure was the decision to introduce a so-called "*demographic factor*" as an element of the formula for calculating and adjusting (all) pensions. The main argument was as follows. With increasing life expectancy, a reduction in the pension level becomes necessary, if the contribution rate shall not increase. The solution proposed by the majority in the government's expert commission – and later decided by the Federal Parliament – was a compromise:

The development of ARW should be linked in addition to the rate of change of average net earnings[33] to one half of the development of (further) life expectancy of people aged 65, but with a time lag of eight years. The parameters of this formula were chosen in such a way that – in combination with other assumptions determining the financing of the pension scheme – the so-called standard pension level should be reduced from today's rate of 70% to 64%, until the year 2030.[34] How quickly such a reduction of the standard pension level could take place according to this formula depends in reality on other factors, such as the development of life expectancy.

The parliamentary decision to include such a factor – aiming to reduce the pension level – could, at least in the long run, have some very negative effects. Some arguments to explain this include:

(1) Transparency of the pension formula is reduced, it becomes less understandable for the insured.[35] This may lower the acceptance of the scheme.

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[33] Which reflects the increase in life expectancy as far as this increases the contribution rate of the pension scheme.

[34] If a pensioner has 40 EP instead of 45 EP (standard pension) the present pension level is $40/45 \cdot 0.7 = 0.62$ and would decrease according to these plans to $40/45 \cdot 0.64 = 0.53$ for the full pension when claiming the pension at reference retirement age (i.e., in the future at age 65).

[35] In my view, it would be preferable not to make pension insurance directly dependent on the development of other variables (like the different contribution rates to social insurance and income tax), but on the contrary, to limit the number of these variables. This would link ARW only to the growth rate of average gross earnings and the contribution rate to pension insurance. This is discussed in Schmähl (1997a).

(2) The introduction of the additional factor is a (first) step to break the link of pension development and earnings development. This earnings-linked pension development has been a cornerstone of the German public pension scheme since 1957 (and in principle it exists in the specific pension scheme for civil servants as well).
(3) The pension level becomes a variable; a specific number of Earnings Points no longer provides the insured person with information about the relative amount of the pension compared to average net earnings. Planning for own additional old-age provisions becomes more complicated.
(4) The reduction in the pension level has remarkable consequences for the income of the insured.
(5) The general reduction of the pension level can have the effect that a great number of employees even after extended periods of paying contributions to the scheme only receive a pension that is scarcely higher than social assistance. This could undermine legitimacy and acceptance of the mandatory contributory scheme.

The last two points shall be illustrated by some numerical information. Based on the regulations for calculating and adjusting pensions as decided in 1989 and explained above, the "standard pension" (45 EP) is about 70% of average net earnings (of all employees). Compared to this, a full claim for social assistance (if no other income exists) amounts to 40% of average net earnings. A contributor who was an "average earner" needs 26 years of insurance to receive a pension equal to this social assistance level. Somebody who only earned two-thirds of average earnings will need 40 years of insurance. If the pension level is reduced generally, as the additional factor in the pension formula aims for, more years of insurance are required for a pension that is as high or even above the social assistance level.

Therefore, it will be decisive in the future how many EPs workers can accumulate during their working life. Here one has to take into consideration the following facts:

(a) Today, about 50% of male and 95% of female old-age pensioners have less than 45 EP.
(b) Future working live (and development of earnings) may be less stable than in the past. This may reduce the possibility to accumulate pension claims (EPs).
(c) There are already changes in regulations for pension calculation that do not affect the (fictitious) standard pension (which is always based on 45 EP) but the individual EPs (an example is the reduction in years credited for schooling).

(d) In the future a "full" pension without deductions will be paid at age 65. Those who retire earlier (e.g., at age 62) will have a reduction of 10.8% in their pension amount.

Assuming a standard pension level of 64% (45 EP at age 65), even the standard pensioner has a pension level of only 57.1% (of average net earnings) when claiming the pension already at age 62. If a pensioner has 40 EP (instead of 45), his pension level is less than 51% (while the social assistance level is 40%).

In the long run, such a development could undermine the legitimacy of a scheme obliging employees to pay (high) contributions for an extended time without creating pensions that are remarkably higher than social assistance.

However, alternatives exist for a general reduction in the pension level to cope with the consequences of an increasing life expectancy, i.e., an extension of retirement ages. The reference retirement age could be linked to changes in life expectancy, while the pension formula itself remains constant (proposed in SCHMÄHL 1997a). Such an increase in retirement ages could start, e.g., at around 2010/2015, in a period when labor market projections show a change in labor market conditions because of demographic developments, etc. (resulting in a remarkable reduction in labor supply). This would show workers very clearly that they have to make a decision. To work longer and have the same pension level as today for about the same length of retirement or to receive the pension for a longer time but at a reduced level (because of the deductions from the full pension).

Due to its majority in parliament, the government was able to realize changes which affected the expenditure side of the social insurance budget. The opposition parties were strongly against making changes to disability pensions and introducing the new factor into the pension formula. They promised that these reform measures would be cancelled if there was a change in government after the 1998 elections took place, which in fact then happened (see below).

To avoid higher contribution rates in the pension scheme under unfavorable political conditions as well as to reduce the contribution rate and thereby (non-wage) labor costs, the government planned to allocate more money from the federal budget to the pension scheme in order to cover some of the expenditure aiming at (inter-personal) redistribution, but which was still financed by contribution revenue. An increase to the value added tax required the agreement of the second chamber, the *Bundesrat*, where the opposition party had the majority.[36] Although all

[36] Revenue of value added tax is allocated to the *Bundesländer,* as well as to the federal level.

political parties were in favor of such a change in the structure of financing (including employers' organizations and trade unions)[37], it was only after a process of many months that the opposition agreed to increase value added tax.[38] The revenue of one percentage point of value added tax was then allocated as an additional federal grant to the pension scheme.

4.6 Decisions in pension policy after the election to the German Federal Parliament in September 1998 up to the end of 1999

The coalition government of Christian Democrats and the Liberal Party was replaced after the federal elections in September 1998 by a coalition of Social Democrats and the Green Party. As announced and proposed by the Social Democrats prior to the election, they sought to abolish some of the measures that had been decided by the former governing coalition. However, the Green Party was, in principle, in favor of a general reduction of the pension level in combination with greater redistribution within the scheme. The Green Party's arguments are particularly focused on the "younger generations", and they seek to lower their contribution "burden", and give them more opportunities for private capital funded pension claims. Therefore, at the beginning the new coalition only agreed upon a suspension of two major elements of the "1999 Pension Reform Act", i.e., the so-called "demographic factor" of the pension formula and new regulations for disability pensions. But to replace these elements decisions had to be taken until the end of 2000, otherwise the old regulations would be implemented. Some decisions were taken very quickly by the new government, namely to increase the transfers from the federal budget to cover expenditure for redistributive measures within the pension insurance, resulting from German unification as well as from crediting Earnings Points for child care. For the latter, contributions will be paid in the future by the federal budget to pension insurance to cover these pension claims. This is in line with already existing regulations. For example, during periods of unemployment the unemployment insurance pays contributions to the pension scheme as well as to the new long-

[37] A detailed discussion of the financing structure, its effects, and the arguments for change is given in SCHMÄHL (1998d).

[38] The reason why they agreed was mainly due to the unfavorable labor market situation (especially a downward development in the number of contributors and a slowdown of contribution revenue), otherwise the contribution rate in 1998 would have had to be increased from 20.3% to 21%.

term care insurance for care providers (see SCHMÄHL and ROTHGANG 1996).[39]

The additional payments from the federal budget made it possible to reduce the contribution rate from 20.3% (in 1998) to 19.5% (in April 1999). The money is from an energy tax (on gasoline and electricity). This became the third source for financing federal grant to pension insurance beside the general federal grant from general revenue, and the additional federal grant from the revenue of one percentage point of the VAT. However, the development of these three elements of federal grant is linked to different assessment bases: The general federal grant is linked to an increase of average gross earnings, the additional federal grant is linked to the revenue of one percentage point of VAT, and the supplement to the additional federal grant is linked to the revenue of the energy tax (ecological tax), but only up to the year 2003. Then it will be linked to the growth rate of the sum of gross earnings. This tripartite federal grant is not easy to calculate because of the different assessment bases. In my view, transparency would be increased by having only one assessment base.

Additional decisions aimed to increase the number of contributors to the pension scheme, i.e., by covering new types of self-employment[40] as well as employees with earnings below a lower contribution limit. The existence of such a limit (about one-seventh of average gross earnings) without paying contributions gives an incentive for employers to offer such jobs as well as for employees to accept them (in addition to perhaps another job which is covered by social insurance).[41]

The new government, similar to its predecessor, tried to reduce contribution rates, which are based on labor income. A reduction of labor costs remained an important objective.

A reduction in income tax, which the new government decided, would increase pension expenditure via the net pension adjustment formula because of the link between pension adjustment to the development of (average) net earnings of employees. This ran against the objective of

[39] This is an approach, which – from my point of view – could result in a clear general regulation. Pension claims are only granted if an adequate contribution payment exists (from gainful employment or from other public budgets, which are responsible for the specific task). This would make the contribution-benefit link in social pension insurance closer than it already is and may increase acceptance for the scheme.

[40] Resulting, e.g., from the outsourcing of activities from companies.

[41] If the contribution-benefit link of the social pension insurance is very close, then the attractiveness of not being covered will be reduced as well as the "tax wedge" – compared to the difference of labor costs and net earnings of employees (for a detailed discussion, see SCHMÄHL 1998d).

reducing non-wage labor costs. Therefore, the government decided to increase pensions (originally) for two years only (2000 and 2001) in accordance with the increase of a consumer price index (for living costs) and not in accordance with the growth rate of average net earnings.[42]

A new debate about the appropriate pension adjustment formula followed. In the process of the discussions the federal government's Social Advisory Council proposed a much simpler adjustment formula, taking up a proposal that had been made also by the author in the 1980s. According to this proposal only the development of average gross earnings and the contribution rate to pension insurance should be taken into account (SCHMÄHL 1999d).[43] The idea behind this is that only those elements that are directly linked to pension issues as well as to financing pension insurance should be used within the adjustment formula. The government rejected this proposal at the time and announced that it would re-implement a net adjustment formula.

5. CENTRAL ELEMENTS OF THE REFORM MEASURES OF 2001 AND THE DOMINATING OBJECTIVES BEHIND[44]

The objective of limiting the increase in the contribution rate became a central issue for governmental pension policy. Up to the year 2020 the contribution rate to pension insurance should not be higher than 20%, and in the year 2030 it should not exceed 22%. By taking into account existing regulations, the contribution rate was calculated at around 24% for the year 2030. According to official statements, this burden was characterized as being far too high.

Therefore, several instruments were used to realize the target contribution rates (20 or 22%). Only a few of the elements can be mentioned here.[45] In addition to measures to reduce public pension expenditure, and thus the necessary contribution rate, incentives for private (including occupational) pensions, tax (and transfer) were given.[46] These incentives are increased step by step.

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[42] In fact, it was only for the year 2000.

[43] While pensioners themselves have to pay an individual contribution to health insurance, as well as to long-term care insurance, the difference to the net adjustment formula is that income tax on earnings and the contribution rate to unemployment insurance are not taken into account when calculating the adjustment rate.

[44] A detailed analysis is given in SCHMÄHL (2000b, 2000d).

[45] Changes in disability pensions are not discussed here.

[46] Originally such incentives for occupational pensions were not on the agenda of the government. Trade unions pushed this element.

The pension adjustment formula became a central element of the government's strategy which now took up the proposal for a formula that no longer included income tax burden on earnings. But apart from the two elements mentioned above – average gross earnings and the contribution rate to pension insurance – an additional element was included. This factor is defined as a voluntary contribution rate for (different types of tax privileged and licensed) private old-age provision. This contribution rate is fixed by the government, and increases from 1 to 4% of earnings in four steps. It is not known whether and how many households will save with these new (tax-privileged) types of private old-age provision. Nevertheless, it is assumed that all those who are eligible will contribute the full amount. This is a virtual factor in the pension formula. The effect is that due to the increase of this factor (from one to four percentage points of earnings) the growth rate of the assessment base for the pension adjustment is reduced. This lowers the increase of pension expenditure. But it also lowers the benefit level for the present pensioners as well as for all future pensioners. This additional (and arbitrary) factor in the pension formula is a lever for reducing public pensions. It is unknown whether the (virtual or fictitious) rate will remain constant at 4% in the future.

The effect of this new pension formula is, for example, a net pension level for the "standard pension" (45 Earnings Points) of about 64% in 2030 instead of 70%. This is the target value that the old government also aimed for. However, the reduction will take place even quicker now.

The arguments still remain the same with regard to the valuation of such a reduction of the benefit level which were mentioned above. When we take into account changing economic activity over the life cycle, interruptions within the earnings career, etc., together with the reduced benefit level, it can be expected that, even after an extended period of contributing to this public scheme, a majority of the contributors will only receive a pension that is below or not much above the level of a (full) social assistance benefit. It is quite another question whether these pensioners will need a social assistance benefit because this depends on total (household) income. But the acceptance of such a mandatory public pension scheme – which is at least today characterized by a close contribution-benefit link – depends on the willingness to contribute to such a scheme. Putting it another way, a mandatory public pension scheme with a close contribution-benefit link will not be sustainable if the benefits fall below a certain level. It can be assumed that the mandatory scheme will then be increasingly used for interpersonal redistribution purposes, which finally requires tax financing.

However, Germany's pension policy may already be beyond the crossroads.[47]

The effect of the new measures on the financing of the public pension scheme is not a convincing argument for these measures because instead of 24% now 22% are calculated for the year 2030, but adding 4% – if we follow the argument of the government that additional private saving is necessary to compensate for the benefit reduction in the public scheme – in total this means a contribution rate of 26%.

However, there is a shift towards more direct financing of the employees because the private pension is solely financed by employees. In 2030 the employers' part of contributions will be reduced from 12% to 11% according to official calculations, while the employee has to contribute 15% instead of 12%.

In addition, there is a shift from a defined benefit towards a defined contribution – as a tendency in the public scheme and, in fact, in private provision. This will also require higher contributions of women compared to men because of higher female life expectancy.

The rate of return was an important argument in the German public debate. However, the cohort-specific effect is only marginal. For all cohorts born before 1975 there will be a reduction in the (total) rate of return for public and private old-age provision and an increase for younger cohorts born 1975 or later. However, the difference in rate of return is at maximum 0.2 percentage points (at a retirement age of 65). This means that an increase according to these calculations can be expected for all cohorts retiring after the year 2040. The changes in the rates of return – beside all problems in calculating and evaluating such figures – are not really a convincing argument for the new pension policy strategy.

[47] There is not only a reduction of benefits for the insured person (in case of disability or retirement) but also for the surviving spouse (and orphans). Widow's and widower's pensions are linked to the pension of the former insured spouse. Widow(er)'s pensions were in general 60% of the pension of the insured person. But since 1985, own earnings (wages and salary) as well as own insurance pension of the surviving spouse were taken into account for calculating the benefit transferred to the widow(er). Now, the percentage has been reduced from 60 to 55%, and all types of income (for example income from assets) are included into the formula for calculating widow(er)'s pensions. But there is an additional bonus for those who raised children. There always was and will be a debate on the topic of family (care) and old-age security and how to take into account caring for children when calculating retirement benefits. An overview is given in Horstmann (1996).

Those who are already pensioners or near retirement will not have the opportunity to compensate for the reduction in benefits of the social pension insurance through private savings.

There are of course winners in this policy strategy – those who supply products on the financial market. In connection with additional capital funding of pension schemes, global problems will emerge, for example, if a growing number of elderly want to finance their standard of living during old-age from former savings and by reducing formerly accumulated assets. These problems were denied by many actors (including many academics) for a long time and were neglected in public debates. Now there seems to be a rethinking of this because the stock market development at the moment does not look as favorable as it did a few years ago. But shifting pension money from PAYGO to funding first of all means additional liquidity and not necessarily real capital investment. Liquidity may flow to stock exchange and increase equity prices for some time. But if the baby boomers need their money, the reverse effect may take place.[48]

The remarks concerning capital funding should not be misunderstood. In principle there is no argument against mixing PAYGO and capital funding. However, what is necessary is an unbiased discussion, taking into account the possibilities, risks and costs, advantages and disadvantages in order to achieve a realistic view on the adequate mix[49] and the effects of the ways to realization.

6. Neglected Aspects in Present Pension Policy – Topics of Future Discussion

Beside the topic of taxing different types of provision for old age as well as income in old age from different sources (which is on the political agenda after a decision made by the Federal Constitutional Court in early 2002), the topic of retirement age needs careful consideration.

The pension reform of 2001 explicitly did not tackle the topic of retirement age. It was mentioned by politicians that it might become a topic for decision-making at around 2010. Although Germany today has a high unemployment rate, the retirement age should be on the political agenda. This means a decision should be made now to increase retire-

[48] These and other effects resulting from the strong tendency towards capital funding are discussed in Schmähl (2000a: 195–208).

[49] Which will depend on country-specific conditions, and expected development for the future.

ment ages, but it should first become effective, for example, at around 2010, when a change in labor supply can be expected due to demographic reasons. This would give employers and employees time to adapt their decisions to changing conditions.

For some years now I have been proposing to link the retirement age for taking up a full pension (i.e., without deduction) to the increase of (remaining) life expectancy at age of retirement.[50] This would mean that the ratio of years in employment to years in retirement could remain more or less constant, dividing additional years of life expectancy into working and retirement years. Today additional years (because of increasing life expectancy) are only "used" for a longer life spent in retirement.

After the reform measures were decided by the government as well as by employer's organizations, the need for employing older workers was stressed. But this will require measures for improving the qualifications of older workers, for example, through further training and education. This will not be without costs. However, all other strategies in order to increase the labor supply will be accompanied by costs, too: increased migration needs measures for integration as well as improved qualifications; additional female labor supply requires more opportunities to combine work and family life (for example, by introducing all-day schools, which are an exception in Germany).

Human capital is of central importance for Germany's economic development in the future. In light of a shrinking and aging potential labor supply, the increase of human capital is decisive. This will also require thought about the allocation of public expenditure. Today the trend is to subsidize the formation of financial capital. It must be questioned whether this is the right strategy in comparison to spending more (public) money for investment in human capital.

The tendency towards privatizing social security – in old age pension, but perhaps also in health insurance – places the distribution of income on the agenda, too.[51] It can be assumed that there will be a greater diversity of income in old age. This will raise the question to which degree society is willing to accept inequality. In order to be better able to cope with challenges that result from changes in income distribution linked, for example, to a rapid aging of the population, a higher growth rate of income would be favorable. An increase in productivity is the source for a growth rate of income – and this particularly depends on the

[50] See SCHMÄHL (1997a, 1999b, 2000c, 2000e) as well as SCHMÄHL and VIEBROK (2000) for a discussion on measures to react to increasing life expectancy in PAYGO pension schemes.

[51] Some aspects are outlined in VIEBROK and HIMMELREICHER (2001).

development of human capital. Education, training and further education during the working years are therefore of central importance and require more public attention. This will also be the main source for realizing an adequate standard of living for the growing number of retirees in the future.[52]

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4. Specific Aspects of Long-Term Care in Germany and Japan

Long-Term Care in Germany: Projections on Public Long-Term Care Insurance Financing

Heinz Rothgang

1. Introduction

As a general trend in OECD countries the rate of mortality has been declining for decades while fertility remains below replacement rate. As a consequence, the population is aging.[1] Against this background problems connected with the provision of long-term care for an increasing number of elderly people have become a major concern for Western welfare states, leading to respective legislation in Austria, Germany, Japan, and Luxembourg, and ongoing debates in England, France, and Italy about the necessity to introduce new social security systems.[2] Any social security system for long-term care, however, will have to deal with increasing associated costs for long-term care not only as a result of demographic developments but for other reasons as well.

In this paper, the financing implications for the statutory public long-term care insurance (LTCI) in Germany shall be examined. In section 2 basic information about this insurance system is provided, in section 3 a simulation model is introduced, and in section 4 the development of the number of LTCI beneficiaries is discussed. Based on the respective results, expenditure can be calculated (section 5). Using information about contributory income (section 6) the contribution rate necessary to finance the insurance system can be derived (section 7). In section 8, the major findings are summarized.[3]

[1] See, e.g., Höhn (1996) and Enquete Commission (1998, chapt. 1).

[2] For an overview, see Eisen and Mager (1999), Igl and Stadelmann (1998), MISSOC (1999), OECD (1996), Sieveking (1998), Schulte (1997), and Pacolet *et al.* (1998), as well as the respective contributions to this volume.

[3] To better assist the reader all equations have been compiled into a technical appendix.

2. THE NEWLY INTRODUCED LONG-TERM CARE INSURANCE IN GERMANY

In 1995 a statutory long-term care insurance (LTCI) was introduced in Germany covering about 90% of the population.[4] Those who have private health insurance are obliged to buy private long-term care insurance guaranteeing at least as much coverage as public funds do. As a result, more than 99% of the population is eligible for respective benefits.[5] Public long-term care insurance is almost entirely financed through contributions calculated as a legally fixed percentage of individual gross earnings up to a contribution ceiling. Following the pay-as-you-go principle contributions are spent within the same period. The building up of a capital stock is not intended.

There are three grades for those eligible for LTCI benefits: those who are in considerable (grade I), severe (grade II), or extreme (grade III) need of care. Severity of need is measured with respect to the ability to perform activities of daily life without help. Benefits, which are not means-tested, depend on these three grades of severity of need. Benefits include cash benefits for family care, benefits in kind for professional home care, and a certain allowance for nursing home care. Beneficiaries in home care are allowed to choose between (and even combine) cash and benefits in kind. Table 1 contains the respective amount of money.

Table 1: **Monthly LTCI benefits (in Euro)**

Grade of severity	Home care		Nursing home care[a]
	Family care	Professional care	
I	205	384	1,023
II	410	921	1,279
III	665	1,432	1,432
Special Cases		1,918	1,688

[a] Figures are valid until 31.12.2004. In general, however, there is an upper limit of 1,432 Euro per case (special cases excepted) and a ceiling on the average at 1,279 Euro per month.

In addition to those listed above, LTCI provides further benefits. These are in order of budgetary relevance:

[4] For a more detailed description of the institutional arrangements, see NAEGELE and REICHERT as well as KNÜVER and MERFERT in this volume; see also IGL and STADELMANN (1998), SCHULTE (1996), and ROTHGANG and SCHMÄHL (1995).

[5] In contrast to the Japanese system, benefits are not limited to the elderly in Germany.

- contributions to the pension funds for non-professional caregivers;
- funding for day care, night care, or short-term nursing home care;
- payments for substitutes while non-professional caregivers are on holiday; and
- special equipment and teaching arrangements for non-professional caregivers.

By adding administrative costs, the overall expenditure amounted to 16.673 billion Euro in the year 2000.

Finally, the adjustment mechanism for the amount of benefits must be explained. These amounts are neither indexed to prices or income, nor is there any provision for regular increases. Rather, increases depend on discretionary decisions made by the federal government, taking into account the effects on the contribution rate.

3. The Simulation Model

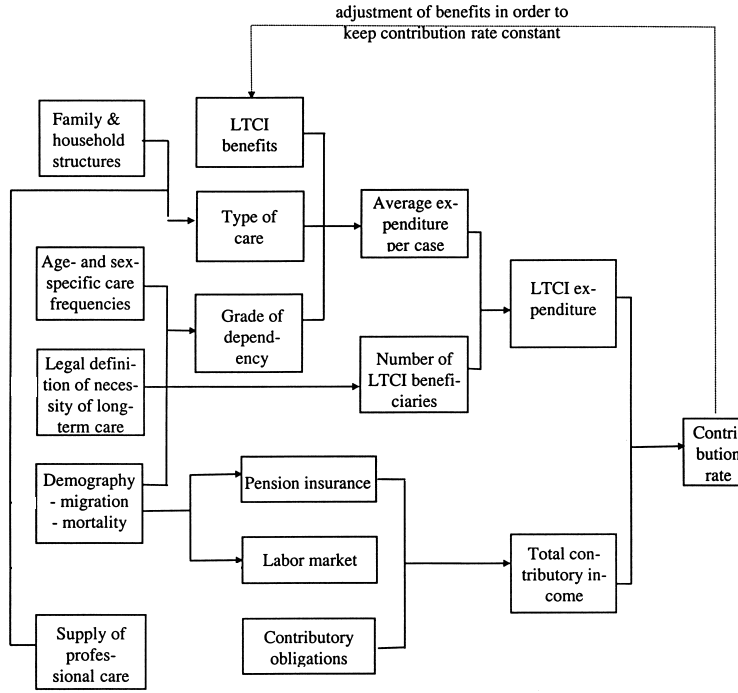
Figure 1 contains the major factors determining the necessary contribution rate of the public long-term care insurance in Germany. Since LTCI is a pay-as-you-go system, the necessary contribution rate can be derived as the quotient of LTCI expenditure and total contributory income.[6] Of course, LTCI expenditure can be calculated as a product of the number of beneficiaries and the average expenditure per beneficiary. Apart from the legal definition of being in need of care, the number of beneficiaries depends on age- and sex-specific care frequencies on the one hand, and level and structure (age and sex) of the population on the other. Average expenditure per beneficiary is determined by the grade composition of beneficiaries, the type of care chosen and the respective LTCI benefits. The former depend on numerous other factors, while the development of the latter can be influenced through repercussions from the development of the contribution rate. The sum of contributory income consists basically of income from employees, pensioners, and unemployed, thus resting on developments in the labor market and the pension insurance. Both are, once again, heavily influenced by demography.

[6] Contributions have been paid since January 1995, benefits, however, have only been granted since April 1995. Due to this schedule and other introductory effects, a small capital stock has been built up in the 1990s which yields additional income and can be used to cover temporary deficits. Effects, however, are small and only transitory (see Rothgang (2002c) for details). Hence, in the following a pure pay-as-you-go scheme is assumed.

In order to calculate future contribution rates, assumptions must therefore be made about:

- the population size and structure;
- care frequencies;
- utilization patterns;
- LTCI benefits and their adjustments; and
- the number of contributors and their respective contributory income.

Figure 1: **Determinants of LTCI contribution rate**



4. The Number of Beneficiaries and its Development

Demographic information is taken from the "9. koordinierte Bevölkerungsvorausberechnung", the latest forecast released from the Federal Statistics Office, which contains four versions (Table 2). Version 0, 1, and

2 differ only with respect to migration, while version 2a assumes an even higher decline in mortality than version 2.[7]

Table 2: **Assumptions of the Demographic Forecasts of the Federal Statistical Office**

	Version			
	1	2	0	2a
Fertility				
constant 1,400 children per 1,000 women	X	X	X	X
Mortality				
Life expectancy of new-borns in 2050: male: 78.1 years, female: 84.5 years	X	X	X	
Life expectancy of new-borns in 2050: male: 80.1 years, female: 86.4 years				X
Migration				
Declining migration of German descendants; long-term annual net migration of foreigners:				
100,000	X			
200,000		X		X
0			X	

Source: Federal Office of Statistics, translation by author.

The respective care frequencies are estimated through the relative frequencies of LTCI beneficiaries among their age group and sex in the year 1999. While these frequencies are kept constant over time in model 1, declining care frequencies are assumed in model 2 (Table 3).[8] The rationale for this assumption is Fries' (1980) "compression of morbidity" hypothesis, which states that an increase in life expectancy might lead to reduced age-specific morbidity.[9]

[7] The alternative scenario 2a must be regarded as a reaction on criticism from demographers who claimed that in former forecasts the Federal Statistical Office was too restrictive with respect to gains in life expectancy (see Rothgang (2002a)).

[8] Declining age-specific morbidity is also assumed in projections published by the OECD (Jacobzone *et al.* (1998); Jacobzone (1999)).

[9] The dispute between those who follow Fries and those like Verbrugge (1994) who expect the additional lifetime to be spent in poor health is not yet settled. For a more in-depth discussion with respective references, see Rothgang (2002c).

Table 3: **Model assumptions for the calculation of the future number of beneficiaries**

Model 1: Constant age- and sex-specific morbidity
• Population according to recent forecast from the Federal Statistical Office.
• Constant age- and sex-specific care frequencies over time (1999 figures).
Model 2: Declining age- and sex-specific morbidity
• Population according to recent forecast from the Federal Statistical Office.
• Declining age- and sex-specific care frequencies: An increase in (further) life expectancy of persons aged 65 of one year yields a shift of care frequencies to the right of half a year.

Figure 2: **LTCI beneficiaries (baseline model)**

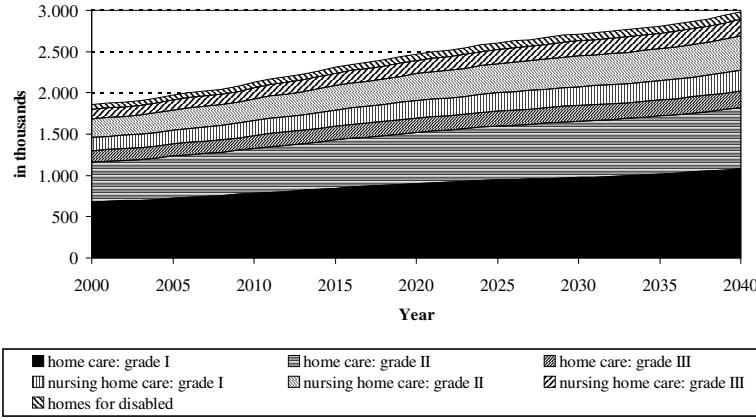


Figure 2 contains the results from model 1 with demographic version 1. This combination is hereafter referred to as the "baseline model". According to this baseline model the number of LTCI beneficiaries rises from 1.857 million in 2000 to 2.983 million in 2040, which is an overall growth of about 60.6% representing an average annual growth of 1.2% (geometrical mean). Interestingly enough, the growth rate is much higher for people in nursing home care (72.9%) than for people in home care (55.4%)[10] due to a higher institutionalization rate among very old persons in need of care (see ROTHGANG (2002b) for details).

[10] Since benefits for nursing home care for the elderly and nursing home care for the disabled differ, both types are distinguished in Figure 2. The given growth rate, however, relates to both types of nursing home care. For nursing home care for the elderly the growth rate is even higher (74.3%).

The robustness of this forecast against changes in demographic and morbidity assumptions can be checked by variations of migration and mortality patterns[11] and care frequencies. Table 4 shows the respective effects.

Table 4: **Growth in number of beneficiaries in the years 2000–2040 in percentage of figures in 2000**

Morbidity	Demographic Forecast			
	Version 0	Version 1	Version 2	Version 2a
Constant (model 1)	55	61	63	76
Declining (model 2)	35	40	42	45

Column 2 vs. column 4: "migration effect"
Column 4 vs. column 5: "mortality effect"
Row 2 vs. row 3: "morbidity effect"

The number of immigrants, which are assumed to be fairly young, has only a small influence on the number of LTCI beneficiaries ("migration effect"). Respected increases reach from 55% (no net immigration) to 63% (high net immigration of 200,000 per year). An increasing life expectancy, on the other hand, is highly relevant if age-specific care frequencies remain constant ("mortality effect"). According to version 2a the growth in numbers of LTCI beneficiaries therefore increases to 76%. Declining morbidity produces even greater effects. According to model 2 the increase in the numbers of LTCI beneficiaries will only be 40% in version 1 of the demographic forecast ("morbidity effect"). Moreover, with declining morbidity (model 2) the effect of increasing life expectancy almost vanishes with an overall growth rate of 45% in version 2a, which is only slightly higher than the rate in version 2. Thus, the mortality effect might be countered through a "morbidity effect" of similar weight.

5. Expenditure According to Different Utilization Patterns

Overall LTCI expenditure can be calculated as product of the number of beneficiaries and average expenditure per beneficiary. In order to compute the latter, information about utilization patterns are needed. The "purely demographic" model 1 assumes that the utilization figures of 1999 remain constant over time. Model 2, on the other hand, assumes a shift towards professional care (Table 5).

[11] Since long-term care predominantly occurs in advanced years, fertility figures are fairly irrelevant. See Rothgang (2002b) for respective simulations.

Table 5: **Model assumptions for the calculation of LTCI expenditures**

Model 1: Constant utilization patterns
• Number of public LTCI beneficiaries according to demographic forecast and constant care frequencies.
• Constant utilization patterns with respect to home versus nursing home care and with respect to family (80%) versus professional (20%) home care over time.
Model 2: Growing share of professional care-giving
• Number of public LTCI beneficiaries according to demographic forecast and constant care frequencies.
• Growing share of nursing home care (+0.5 percentage points per year) and declining share of family care within home care (-0.5 percentage points per year).

The latter assumption is based on at least three secular trends, which will briefly be explored:

- the declining caregivers' potential;
- the growing female work participation; and
- changes in family and household structures.[12]

The declining caregivers' potential is due to demographic changes. Today about 80% of all main caregivers are women (SCHNEEKLOTH and MÜLLER 2000: 54), and it is difficult to imagine that the share of male caregivers might increase significantly in the future. More than half of all caregivers are aged between 40 and 64 (ibid.). Hence care-giving is predominantly carried out by "middle-aged women". As the ratio of middle-aged women per LTCI beneficiary is going to decline heavily (see ROTHGANG 2002a), it is hard to imagine that the amount of family care given will not decrease accordingly.

Moreover, caregivers bear a heavy burden, which makes it hard to continue working in the formal labor market. Since younger women are better educated and thus receive higher incomes, opportunity costs for a withdrawal from the labor market will increase for future generations. Hence, a declining willingness to care has to be expected (ENQUETE COMMISSION 1994: 145).

Finally, the consequences of changes in family and household structures have to be considered. Over the past decades the share of elderly living in single households has constantly increased.[13] A continuation of this trend is to be expected for the future (see HULLEN (2002); YI *et al.* (2002); ALDERS and MANTING (2002)). Since care potential is lower in single households this will add to the trend towards professional care.

[12] For a more detailed discussion, see ROTHGANG (2002a).
[13] See ROTHGANG (2002a) with further references.

Figure 3: **LTCI expenditures with constant benefits (baseline model)**

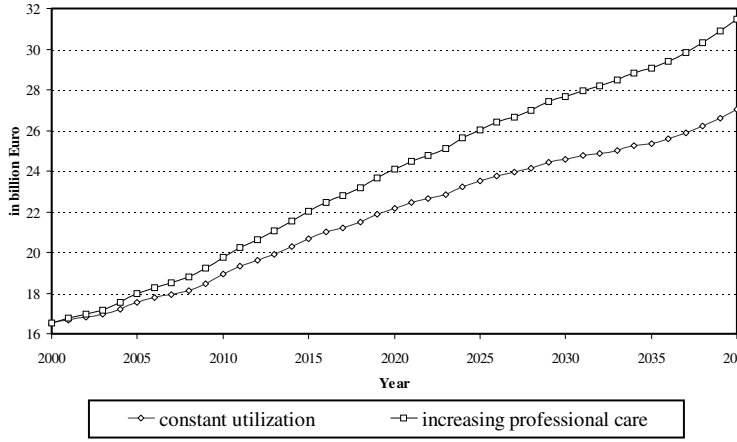


Figure 3 shows the resulting expenditure figures for both models with constant benefits based on the (demographic) baseline model. With constant utilization patterns (model 1) the growth in expenditure closely follows the growth in the number of beneficiaries. Small extra expenditures result from structural shifts (age, severity of care requirement) within the beneficiaries. As model 2 reveals, however, a declining amount of family care adds considerably to the expenditure, which is then estimated to be at 31.4 billion Euro by 2040.

Table 6 shows the overall growth rates for both models and all demographic versions. According to this, more than a doubling of expenditures between the years 2000 and 2040 follows if mortality and utilization effect are simultaneously taken into account.

Table 6: **Growth in LTCI expenditure in the years 2000–2040 in percentage of figures in 2000**

Utilization patterns	Demographic Forecast			
	Version 0	Version 1	Version 2	Version 2a
Constant (model 1)	58	64	66	80
Declining family care (model 2)	84	90	93	109

Column 2 vs. column 4: "migration effect"
Column 4 vs. column 5: "mortality effect"
Row 2 vs. row 3: "utilization effect"

6. CONTRIBUTORY INCOME

Among other factors demography influences the total contributory income (see Figure 1). Since more than 70% of all contributions come from the employed, some scholars even assume that the sum of contributory income develops proportionally to the number of persons at working age (see, e.g., ERBSLAND (1995), KNAPPE and RACHOLD (1997), WILLE *et al.* (1998), KNAPPE and RUBART (2001)). This, however, is an inadequate assumption which does not account for high unemployment and low labor force participation by both the elderly and women as an initial condition. Therefore labor supply and demand must be considered separately with employment calculated as a minimum of supply and demand with some "natural" unemployment (see HOF 2001 for a similar approach). Table 7 contains the model assumptions for the respective simulations. Three models are distinguished: While the purely demographic model 1 regards (age- and sex-specific) potential labor force participation rates as given, model 2 allows for changing rates. Using figures from the Institute for Employment Research (Institut für Arbeitsmarkt- und Berufsforschung der Bundesanstalt für Arbeit = IAB) a higher labor force participation rate for the elderly and for women is assumed, while the respective rates for twens are assumed to be declining due to longer periods of formal education. Model 3 differs from model 2 through the recognition of rising wages.

Table 7: **Model assumptions for the calculation of contributory income**

Model 1: Purely demographic projection
• Separate forecasts of the number of contributors and average individual contributory income for employees, pensioners, unemployed and other contributors, based on 1999 figures.
• Constant average contributory income per type of contributor over time.
• Potential labor force according to constant age- and sex-specific participation rates (IAB). Employment as minimum of potential labor force and jobs with a given "natural" rate of unemployment of 4% of the labor force.
Model 2: Demographic projection with changing labor force participation
• As in model 1, but with changing labor force participation (IAB).
Model 3: "Realistic" projection
• Number of beneficiaries as in model 2.
• Growing wages at an annual rate of 1.7%, and 2.7% (as soon as there is labor shortage).
• Demographically induced additional expenditures for pensions are partly financed by cuts in pension.

Figure 4: **Labor market (model 2)**

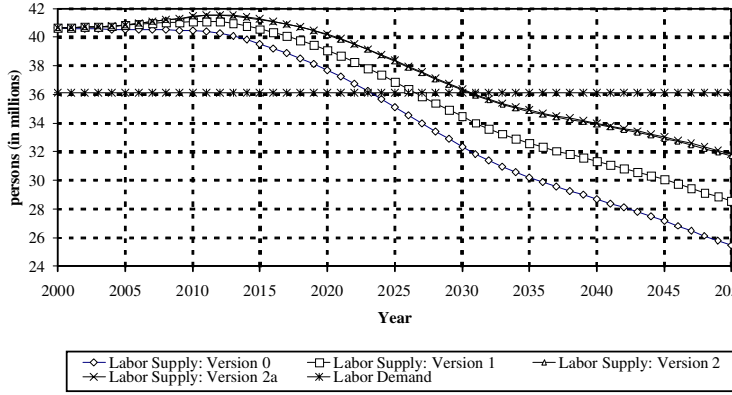


Figure 4 shows the labor market development based on model 2. For about 10–15 years the labor supply remains more or less unchanged. Thereafter there is a constant decline. Depending on migration assumptions between the years 2020 and 2030 the labor supply (already reduced by 4% to account for "natural unemployment") will fall short of labor demand, thus leading to declining employment from then onwards. These curves are mirrored in Figure 5 which plots the development of total contributory income (model 2). Since pensioners also contribute to LTCI the sum of contributory income will increase for more than two decades with a constant level of employees and an increasing level of pensioners. However, as soon as there is labor shortage, a sharp drop in total contributory income will automatically follow (see Figure 5).

The simulations reveal that – due to demographic change – the potential labor force will decline. Due to high unemployment and a considerable hidden labor force,[14] this process will only start to effect the total sum of contributory income in about two or three decades. Thereafter, a declining labor force will lead to a diminishing total sum of contributory income as long as wages remain constant. If immigrants can fill available jobs, net immigration will help to slow down the above process, but it cannot stop it.

[14] "Hidden labor force" refers to those people who would want to work, but – under present labor market conditions – do not even register as unemployed because they believe they have no chance of finding a job anyway.

Figure 5: **Total sum of contributory income (model 2)**

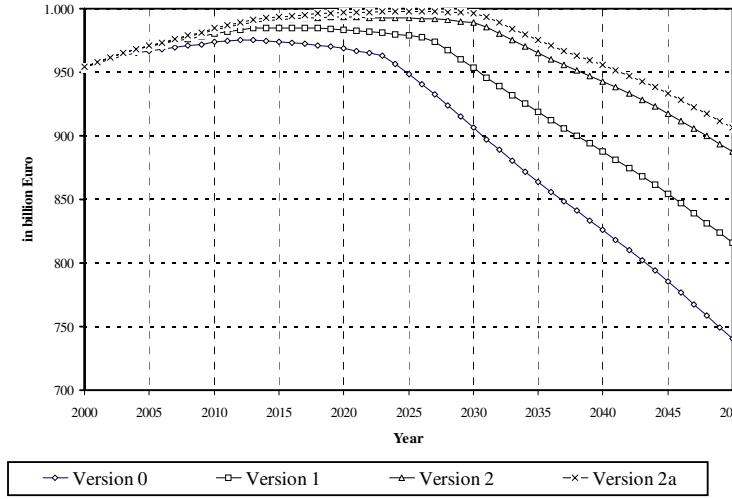


Table 8 shows the overall growth rates of total contributory income for all models and all demographic versions of the demographic forecast. In addition to net immigration, changing labor market participation also helps to slow down the process, but cannot stop it. Obviously, rising wages overshadow all other effects. On the other hand they will lead to increasing LTCI expenditures – given the benefits are adjusted in order to cover increasing remuneration for professional care. Thus, rising wages increase expenditures as well as contributions.

Table 8: **Growth of total contributory income in the years 2000–2040 in percentage of figures in 2000**

Labor Force Participation Rates	Demographic Forecast			
	Version 0	Version 1	Version 2	Version 2a
Constant (Model 1)	-17	-11	-5	-4
Changing (Model 2)	-13	-7	-1	0
Changing (Model 3)	95	103	107	108

Column 2 vs. column 4: "migration effect"
Column 4 vs. column 5: "mortality effect"
Row 2 vs. row 3: "effect of changing labor market participation"
Row 3 vs. row 4: "effect of rising wages"

7. Contribution Rate and Real Purchasing Power

Combining the simulations for expenditures and total contributory income yields the contribution rate that is needed to finance long-term care insurance within a purely pay-as-you-go system. Table 9 contains the model assumptions for the three models that are calculated. The purely demographic projection (model 1) combines the purely demographic models on expenditure and contributory income. Model 2 also allows for changing behavior patterns, namely a growing share of professional care and changing labor participation rates. Model 1 and 2, however, assume constant benefits, wages, and prices.[15] Their main purpose is to isolate the influence of demography and behavior. Only model 3 is "realistic" insofar as rising wages and prices are taken into account. The basic assumption is that wages grow faster than general prices (rising real gross earnings) and that prices of professional long-term care follow wages rather than inflation. The latter assumption is based on Baumol's "cost disease" hypothesis as well as specific conditions on the labor market for nurses.[16] The real question is how LTCI benefits respond to rising prices of professional long-term care.

Three adjustment scenarios are distinguished within model 3 in the following:[17]

- Scenario A: Benefits are adjusted in order to keep the contribution rate stable.
- Scenario B: Benefits are adjusted along with prices of long-term services in order to keep constant the real purchasing power of LTCI benefits. Since long-term care is very labor intensive it is assumed that prices of care follow nurses' wages, which are assumed to increase in line with average gross earnings. As long as real wages grow, benefits therefore must be adjusted at a rate above general inflation.

[15] An alternative interpretation would be that all prices, wages, and benefits grow at the same rate, and that given figures are already deflated.

[16] Baumol's basic idea is that the rationalization potential for personal social services is much lower than for industrial products. Thus, prices for those services increase at a faster rate than general inflation if wages in both sectors grow in line (see Baumol (1967), Baumol and Oates (1972)). Since labor shortage for nurses is to be expected in the near future and the demand for nurses is growing, there is reason to believe that nurses' wages will rise at least in line with wages in other industries.

[17] See Rothgang (1997: 272) for a formal derivation of the respective adjustment rules.

- Scenario C: Benefits are adjusted according to general inflation. Given that real wages rise and prices of care follow wages, this leads to diminishing real purchasing power for LTCI services.

Table 9: **Model assumptions for the calculation of contribution rate**

Model 1: Purely demographic projection
• Growth of expenditure according to expenditure model 1.
• Growth of total contributory income according to model 1.
• Starting point: necessary contribution rate for 1999.
Model 2: Demographic projection with changing behavior patterns
• Growth of expenditure according to expenditure model 2.
• Growth of total contributory income according to model 2.
• Starting point: necessary contribution rate for 1999.
Model 3: "Realistic" projection
• Growth of expenditure according to expenditure model 2 plus regular adjustments for LTCI benefits.
• Growth of total contributory income according to model 3.
• Starting point: necessary contribution rate for 1999.

Table 10: **Growth in contribution rate in the years 2000–2040 in percentage of figures in 2000**

Model	Demographic Forecast			
	Version 0	Version 1	Version 2	Version 2a
Purely demographic (Model 1)	90	83	74	86
Demographic with changing behavior patterns (Model 2)	113	105	95	108
"Realistic" (Model 3) with different adjustments rules				
Scenario A	0	0	0	0
Scenario B	118	111	101	116
Scenario C	-6	-6	-7	0

Column 2 vs. column 4: "migration effect"
Column 4 vs. column 5: "mortality effect"
Row 2 vs. row 3: "effect of changing behavior patterns"
Row 3 vs. row 5: "effect of rising wages"
Row 4 vs. row 5 vs. row 6: "effects of different adjustment rules"

Table 10 shows the overall growth in contribution rates for all three models and the four demographic scenarios. According to model 1 the demographic effect alone leads to a rise in the contribution rate of 74–

90%. In general, net immigration slows down this process while excess gains in life expectancy reinforce it. However, in model 1 the migration effect is stronger than the mortality effect.

Changing behavior patterns produce higher expenditures through an increase in professional care and higher income through additional labor force participation. According to model 2 the former effect is stronger than the latter, thus causing higher contribution rates than in model 1. The highest growth rates with more than a doubling of contribution rate for all demographic scenarios result from model 3 with adjustment of benefits along with prices of long-term services in order to keep constant the real purchasing power of LTCI benefits. In this case rising wages effect the income as well as the expenditure side. Since pensions, however, are assumed to grow slower than wages, an additional increase of the contribution rate follows.

Table 10 also reveals the adjustment mechanism as the key variable in determining contribution rate development. Thus, Figure 6 shows the development of the contribution rate for the three adjustment rules within model 3 for the demographic baseline version. While scenario B produces a constant rise in the contribution rate leading to a rate of almost 3.8% by the year 2040, scenario A and C yield (almost) constant contribution rates.

Figure 6: **Contribution rate according to different adjustment paths (baseline model)**

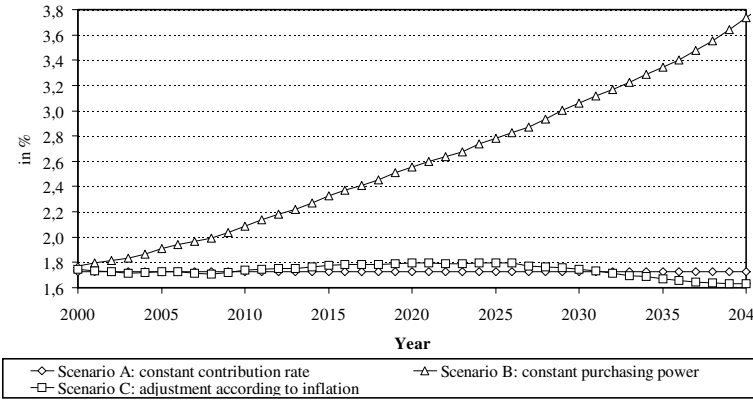
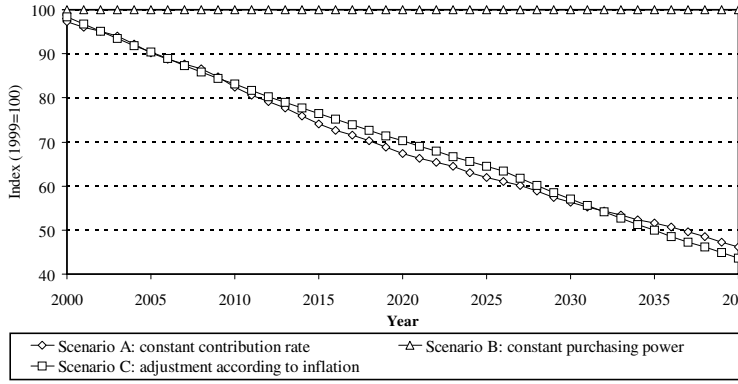


Figure 7: **Real purchasing power according to different adjustment paths (baseline model)**



The "price" for stabilizing the contribution rate, however, is a dramatic decline in real purchasing power. As Figure 7 demonstrates, in the year 2040 real purchasing power will be less than half as much as in the year 2000 if benefits are linked to inflation (Scenario C) or if benefits are adjusted in order to yield constant contribution rates (Scenario A).[18]

Hence, it is impossible to stabilize the contribution rate and real purchasing power at the same time. Rather, politicians will have to choose the lesser of two evils, a rising contribution rate or a declining purchasing power.

8. CONCLUSION

Some general conclusions can be derived from the above simulations:

First, demographic change will lead to a growing number of people in need of care and hence to more and more LTCI beneficiaries. With age- and sex-specific care frequencies that are constant over time, demographic projections, as released by the Federal Office of Statistics, lead to an increase of LTCI beneficiaries and thus LTCI expenditure of about 1.2% per year (geometrical mean). Among other factors, these results from the

[18] According to scenario C, inflation-linked adjustments can almost be financed by a constant contribution rate. This result depends on assumptions about real wage development. If real wages rise slower than assumed, even inflation-linked adjustments produce growing contribution rates, but also a less dramatic decline in real purchasing power.

baseline model depend on migration, mortality, and morbidity patterns. Additional (net) immigration, however, does not change findings significantly; whereas declining mortality on the other hand does, and declining morbidity even more so. Fortunately, declining mortality, which produces additional expenditures, and declining age-specific morbidity, which reduces expenditures, might be related. Therefore, the morbidity effect might counter the mortality effect.

Second, LTCI expenditure also depends on utilization patterns which are in part influenced by demographic development as well. There are good reasons to assume a shift from family care towards professional care leading to considerable extra expenditure. Allowing for such a shift, the baseline model yields an average annual growth rate for overall LTCI expenditure of slightly more than 1.6% (geometrical mean).

Third, a growth rate of that kind can easily be financed from economic growth if LTCI benefits are kept constant. The assumed rise in overall contributory income, however, is due to rising real wages with a declining number of contributing employees. Since expenses for long-term care predominantly depend on wages, the very reason that causes an increase to overall contributory income would therefore lead to a dramatic decline in real purchasing power of LTCI benefits, if adjustment is restricted to inflation or in order to keep contribution rate constant. If benefits are adjusted in line with (average) real wages, the contribution rate increases due to an increasing number of beneficiaries, a shift in utilization patterns, and a declining number of contributing employees. According to the simulation, the contribution rate then approaches 3.8% by the year 2040, which is more than twice as high as the starting value.

Though numerical results of any simulation depend heavily on the input parameters, the trade-off between a constant contribution rate and constant purchasing power following from the above calculations is robust against changes in parameters. Politicians, therefore, unavoidably face a tragic choice between two evils, and it is up to them to find their way between Scylla and Charybdis.

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Technical Appendix: Basic Equations Used

Number of LTCI beneficiaries

The future number of LTCI beneficiaries for a certain type of care and grade of need of care (N_{kl}) for a given year can be calculated as the sum of all products of age- and sex-specific care frequencies for this type and grade (P_{ijkl}) and respected population figures (A_{ij}):[19]

$$N_{kl} = \sum_i \sum_j P_{ijkl} \cdot A_{ij} \qquad (1)$$

with
$i = 1, 2$ sex
$j = 1, \ldots, 100$ age
$k = 1, 2, 3$ type of care
$l = 1, 2, 3$ grade of need of care.

Formula (2) yields the overall number of LTCI beneficiaries for each year:

$$N = \sum_k \sum_l N_{kl} \qquad (2)$$

Overall expenditure

Overall LTCI expenditure (E) can be calculated as product of the number of beneficiaries (N) and average expenditure per beneficiary ($\overline{E}$):

$$E = N \cdot \overline{E} = \sum_k \sum_l N_{kl} \cdot \overline{E}_{kl} \qquad (3)$$

with
$k = 1, 2, 3$ type of care
$l = 1, 2, 3$ grade of need of care.

Total sum of contributory income

The total sum of contributory income of all contributors (= Gesamtsumme der beitragspflichtigen Einnahmen) can be calculated as the product of number of beneficiaries (A) and average contributory income per contributor:

$$Y = \sum_i Y_i = A \cdot \overline{Y}_i \qquad (4)$$

[19] Used frequencies relate the number of public LTCI beneficiaries to population figures (publicly and privately insured).

Taking account of changing structures of contributors makes it necessary to distinguish at least four groups of contributors: the employed (*e*), pensioners (*p*), the unemployed (*u*), and other contributors[20] (*s*). Thus, the total sum of contributory income is:

$$Y = A_e \cdot \overline{Y}_e + A_p \cdot \overline{Y}_p + A_u \cdot \overline{Y}_u + A_s \cdot \overline{Y}_s \quad (5)$$

For the projections each of these 8 independent variables has to be calculated.

Contribution rate

Since LTCI is a pure pay-as-you-go system, overall contributions (*C*) must be equal to overall expenditure (*E*):[21]

$$C = E \quad (6)$$

Contributions depend on the overall contributory income (*Y*) and the contribution rate (*R*):

$$C = R \cdot Y \quad (7)$$

Hence, the contribution rate necessary to balance the LTCI budget can be calculated as the ratio of overall expenditure and contributory income:

$$R = E \,/\, Y \quad (8)$$

If small letters denote respective growth rates, then:

$$r = (e - y) \,/\, (1 + y) \quad (9)$$

Since the LTCI budget for the baseline year 1999 is fairly balanced,[22] the legally fixed contribution rate of 1.7% that yielded this balance can be taken as a starting point. Using the growth rates for overall expenditure and sum of total contributory income (see above) contribution rates can be calculated.

[20] This group contains mainly the self-employed and persons in rehabilitation.

[21] Contrary to old-age insurance there is no contribution from federal or state budget. In the short run, however, a temporary deficit or surplus may occur.

[22] In 1999 overall expenditure of 16.35 billion Euro was only marginally higher than overall income (16.32 billion Euro). In 2000 expenditure was 16.67 billion Euro and income 16.49 billion Euro (http://www.bmgesundheit.de/themen/pflege/finanz/ergebnisse.htm; July 2001).

Real purchasing power

In scenario A and C real purchasing power of LTCI benefits is changing over time. Real purchasing power (X) is given as:

$$X = B \,/\, P \tag{10}$$

with X = amount of care received
B = LTCI benefits (in cash)
P = price index for long-term care.

With respect to growth rates it follows:

$$x = (b - p) \,/\, (1 + p) \tag{11}$$

Demographic and Regional Aspects of Aging and Long-Term Care in Japan

Ralph Lützeler

1. Introductory Remarks

In 2000, the proportion of people aged 65 years or older reached 17.3% in Japan (Kokuritsu Shakai Hoshō Jinkō Mondai Kenkyūjo 2002: 30), thus already surpassing Germany, which has been experiencing a comparable level of population aging since as early as 1970. In the same year, Japan set up a long-term care insurance system much like the one Germany adopted in 1995. It should be interesting, therefore, to study similarities as well as differences in the demographics of aging processes in both countries.

This article will give an overview of the causes of population aging in Japan and some of its more general implications. Comparisons with Germany (and other countries) are included whenever suitable. The basic questions are:

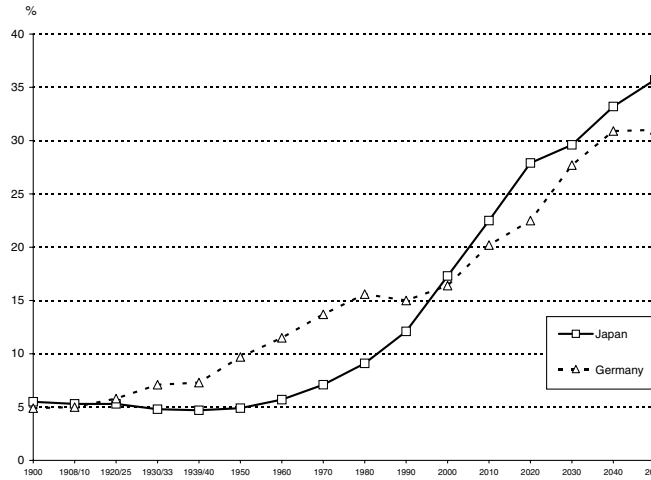
1. How quickly does the demographic process of aging proceed and how urgent is it to introduce social policy measures designed for an aging society?
2. Since it is the municipalities or other regional units (prefectures, *Länder*) who are implementing those measures, are there any remarkable regional differences in the proportion of the elderly, in their living arrangements, or in other life circumstances that should be taken into account?
3. Long-term care insurance plans point to both the family and to old age institutions as potential care suppliers. But who will actually care? Is the family (or other persons close to the elderly) still capable of performing its traditional care role, or is long-term care to be supplied more and more by institutions?

2. The Demography of Aging: Trends and Causes

Figure 1 gives insight into the dynamics of the aging process in both Japan and Germany. It can be seen that in Germany substantial population

aging started around the Second World War. The rate of the elderly population (over 65 years of age) doubled from slightly over 7% in the late 1930s to 15% in 1980, after which a period of stagnation set in. From 2000 onwards, however, increase has begun anew, presumably leading to 31% in 2050. While this trend may sound dramatic, it is still moderate compared to the Japanese situation. Up to the 1960s, Japan still displayed proportions of the elderly below 7%, thereby resembling Third World countries rather than industrialized ones. From 1970, however, an unprecedented high speed of aging set in. From 1997 onwards, Japan has displayed higher proportions of the elderly than Germany. From this it can be concluded that, in comparison to Germany, much less time is left in Japan for social policy-making as well as for value adjustments suited for an aging society.

Figure 1: **Changes in the proportion of elderly population (65 +) in Japan and Germany, 1900–2050**



Sources: MARSCHALCK (1984: 173); KOKURITSU SHAKAI HOSHŌ JINKŌ MONDAI KENKYŪJO (2002: 38).

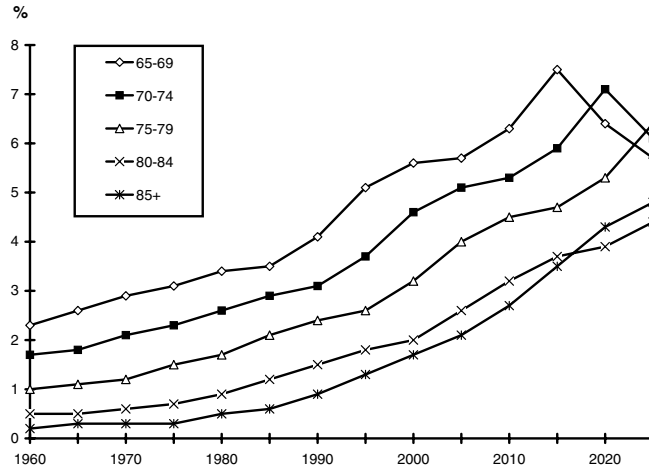
What are the demographic causes that triggered this astounding development? In both countries, there are basically four factors that can be specified: the aging of a numerically strong generation, birth-rate decline, the rise in longevity of elderly people, and the effects of war losses.

It is a basic demographic assumption that the level of natural population movements changes in close relation to a transition from an agrarian to an industrialized society. In such cases, a so-called demographic tran-

sition from high birth and death rates to low ones can be observed (see, for instance, MACKENSEN 1974). Between 1925 and 1950, Japan went through the middle stage of its demographic transition, i.e., the population still displayed high birth rates while mortality levels had already started to decline. Hence, age groups were born who surpassed the size of any other age group born before or after it. At first, as there were more young people alive, this contributed to a slightly declining proportion of elderly persons. Since around 1975, however, the proportion of the elderly has started to rise quickly due to the aging of this generation (ITŌ 1994: 188–191). In Germany, on the other hand, high birth rates and falling death rates were prevalent during the so-called Second Empire (1871–1918), which contributed decisively to a rising level of elderly people from around 1950 to 1980. The short and moderate recovery of the birth rate during the 1950s and early 1960s produced another robust generation, the effects of which will be felt from 2020 onwards.

The succession of different-sized age groups also has important repercussions on the internal age structure of the elderly population. This is important to know because the so-called "younger elderly" between the ages of 65 and 75 may be considered by and large as still healthy and thus able to contribute actively to society and the economy.

Figure 2: **Changes in the proportion of Japan's elderly population by age groups, 1960–1995 (actual figures) and 1995–2025 (estimated figures)**



Sources: Own calculations, based on SŌMUCHŌ TŌKEIKYOKU (1993: 48; 1996: 6–7); KOKURITSU SHAKAI HOSHŌ JINKŌ MONDAI KENKYŪJO (1997a: 74–77).

Figure 2 shows how the relative sizes of different elderly age groups in Japan have changed during the course of general population aging. It can be seen that, as a result of the aging of the large generation born between 1920 and 1935, the proportion of 65–69-year-olds has increased between 1985 and 2000, whereas the 70–74, 75–79, and 80–84 age groups will grow stronger from 1990 to 2005, 1995 to 2010, and 2000 to 2015 respectively. By contrast, the residual category of persons over 84 years of age will increase continuously from 1985 onwards. The postwar baby boom will have an effect on aging after 2010 by again raising the proportion of the "younger elderly". From 2015 onwards, however, there will be no further large-size generation entering old age, thus indirectly contributing to a marked "aging of the aged" that will aggravate the strains on both the health care and long-term care systems.

After the postwar baby boom of the late 1940s, fertility fell dramatically in Japan. The birth rate almost halved between 1949 and 1960, plunging from 33.0‰ to 17.2‰. Since infant mortality, too, declined during that period, the reduction in the number of surviving children was only moderate at first. Nonetheless, from the 1950s onward, the proportion of the elderly rose due to the relative decline of the younger age groups. Since the mid-1970s, a second baby bust has contributed further to aging. In Germany, as far as can be judged from the graph, such indirect aging effects due to declines in fertility seem to be less important causes in aging. There was a steep decline from around 1910 into the 1920s and again during the 1970s. In both cases, however, the correspondence with rising aging proportions is only moderate at best.

Until recently, the influence of mortality reductions, or the increase in life expectancy on population aging, has tended to be neglected by demographers (Höhn and Störtzbach 1994: 198–199). In part, at least, this was due to the fact that up to the 1960s life expectancy gains in industrialized countries were mostly attributable to declining infant and adolescent mortality. As a result, more children and young adults survived, thereby increasing the proportion of young people and softening the aging trend. Since then, however, both in Japan and Germany, it has been predominantly the older age groups that have contributed to the further rise in life expectancy (see Table 1 for Japan). As more older people can expect to survive to very advanced ages, aging will increase especially in the growing proportion of the often disabled "older elderly". This is particularly so in Japan, currently the country with the highest life expectancy in the world. Vaupel (1997) suggests that the trend of enhanced survival at older ages over the next decades will by far outstrip current expectations and warns that "[b]ecause the belief [that old-age mortality is intractable] is so prevalent, forecasts of the growth of the elderly

population are too low, [and] expenditures on life-saving health-care for the elderly are too low […]." Since the enhancement of old-age survival is proceeding gradually, however, its effect on population aging cannot be detected from graphs like Figure 1, and hence may have contributed to the underestimation to which Vaupel refers.

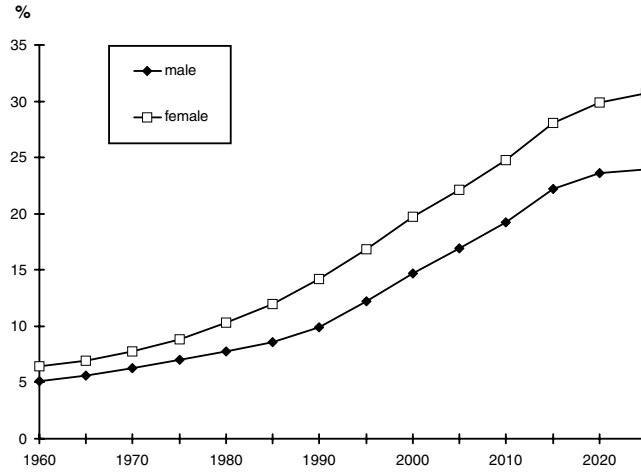
Table 1: **Contributions of mortality reductions by age groups to the increase in female life expectancy in Japan, 1947–2000 (%)**

	Average life expectancy (in years)		Contributions of different age groups (%)					
Period	Starting point	Increase	0–1	1–4	5–14	15–39	40–64	65+
1947–1950/52	53.96	9.02	18.5	24.0	6.2	31.0	13.2	7.1
1950/52–1955	62.98	4.77	18.0	20.7	6.0	26.9	17.6	10.8
1955–1960	67.75	2.45	27.6	18.6	6.9	26.3	21.4	- 0.8
1960–1965	70.19	2.73	29.6	10.5	5.2	20.2	21.6	12.9
1965–1970	72.92	1.73	20.8	4.9	2.5	11.2	24.0	36.6
1970–1975	74.66	2.23	9.5	2.4	2.2	10.3	29.5	46.1
1975–1980	76.89	1.88	8.9	2.5	2.0	10.1	24.7	51.8
1980–1985	78.76	1.72	7.0	2.4	1.4	4.8	18.5	65.9
1985–1990	80.48	1.42	5.2	1.0	0.6	4.5	19.6	69.1
1990–1995	81.91	0.95	2.7	0.4	-0.6	2.9	6.3	88.3
1995–2000	82.85	1.75	3.8	1.8	2.4	1.4	12.7	77.9

Source: Kokuritsu Shakai Hoshō Jinkō Mondai Kenkyūjo (2002: 84).

Substantial war losses can also influence the aging process. While it is true that the Second World War claimed an unprecedented number of civilian deaths, it is the casualties among the military, mostly young men, which distorted the age structure of the population. As the war generation entered old age, the aging problem became associated predominantly with elderly women. Figure 3 shows that in Japan from 1975 until 1990, when the veteran generation born between 1910 and 1925 entered advanced ages, male aging proceeded much slower than did female aging. By contrast, it is the increasing gap between female and male life expectancy that will be responsible for the continuance of the trend in the feminization of old age from 2000 onwards (see Kokuritsu Shakai Hoshō Jinkō Mondai Kenkyūjo 1997a: 22).

Figure 3: **Changes in the proportion of the elderly by sex in Japan, 1960–1995 (actual figures) and 1995–2025 (estimated figures)**



Sources: Own calculations, based on Sōmuchō Tōkeikyoku (1993: 48; 1996: 6–7); Kokuritsu Shakai Hoshō Jinkō Mondai Kenkyūjo (1997a: 74–77).

Compared to Japan, Germany's losses were even higher and may be partly responsible for the halt in the increase of proportions of the elderly during the 1980s and 1990s (the generation born around 1920; see Figure 1).

3. The Regional Dimension of Aging

Since modern populations are highly mobile, and population migration tends to be age-selective, demographic aging is not spread evenly across the territory of an industrialized country. Japan is a particularly striking example for this rule. There it is the remote rural areas that display the highest proportions of aged people, clearly the result of the strong migration flows from rural to urban areas during the era of rapid economic growth (ca. 1956–1973). In those days, the cities offered many employment opportunities for young adults (mostly younger male siblings) who could not find jobs in an overcrowded countryside. Consequently the proportion of the elderly rose in rural areas, further increased by the fact that a lack of young adults meant a deficit in births and a surplus of deaths. In 2000, the rural southwestern prefecture of Shimane already displayed a high proportion of elderly at 24.8%, while in suburban Saita-

ma-*ken*, part of the Tōkyō conurbation, no more than 12.8% of the population was 65 years or older.

Table 2: **Changes in the proportion of the elderly by municipality size groups in Japan, 1970–1990**

	65–74 years		≥75 years		Change (1970=100)		Dependency ratio (≥75/20–64)×100		
Population of municipality	1970	1990	1970	1990	65–74 y.	≥75 y.	1970	1990	Change
1 M and over	4.0	6.4	1.5	4.2	160	280	2.3	6.5	283
500,000–1 M	3.4	5.6	1.4	3.7	165	264	2.2	5.9	268
300,000–500,000	4.2	6.1	1.7	4.0	145	235	2.8	6.4	229
200,000–300,000	4.2	6.4	1.7	4.3	152	253	2.8	6.9	246
100,000–200,000	4.2	6.3	1.7	4.1	150	241	2.8	6.6	236
50,000–100,000	4.6	7.0	2.1	4.5	152	214	3.5	7.4	211
40,000– 50,000	5.2	7.7	2.3	5.2	148	226	3.9	8.8	226
30,000– 40,000	5.7	7.9	2.7	5.3	139	196	4.6	8.9	193
20,000– 30,000	5.9	8.6	2.7	5.9	146	219	4.7	10.1	215
10,000– 20,000	6.3	9.5	3.0	6.7	151	223	5.3	11.6	219
5,000– 10,000	7.1	10.9	3.4	7.8	154	229	6.1	13.8	226
under 5,000	7.7	12.7	3.9	9.1	165	233	7.0	16.3	233
"DID"-areas	4.1	6.3	1.5	4.0	154	267	2.4	6.3	263
Depopulated areas	7.0	12.0	3.6	8.5	171	236	6.2	15.2	245
Japan	**5.0**	**7.2**	**2.1**	**4.8**	**144**	**229**	**3.5**	**7.8**	**223**

Sources: Own calculations, based on Sōrifu Tōkeikyoku (1975: 278–279, 622–625); Sōmuchō Tōkeikyoku (1995a: 73, 600–603); Kokudochō Chihō Shinkōkyoku Kaso Taisakushitsu (1998: 39–40).

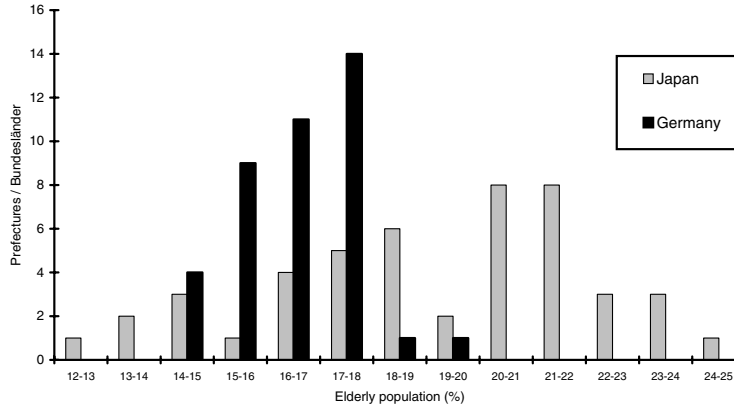
The aging gap between the rural and urban parts of Japan can be further specified by looking at the proportions of aged people by municipality size groups (see Table 2). From this it becomes apparent that it is the smaller metropoles, ranging from 500,000 to 1,000,000 inhabitants, that up to 1990 were the least confronted with aging. In general, however, all municipalities from 50,000 inhabitants upwards show below-average proportions of the elderly, a fact that applies to the "Densely Inhabited Districts" category as well.[1] Starting with towns in the category of 40,000

[1] "Densely Inhabited Districts" or "DIDs" denotes an alternative measurement of urbanization employed in Japan since the 1960 population census. DIDs combine all area units with a total population of 5,000 or more that show population density rates of at least 4,000 inhabitants per sq.km. In 1995, the proportion of the aged (65 years and over) living in DIDs had increased to 12.5% (from 10.3% in 1990), thus remaining markedly below the Japanese

to 50,000 residents, aging gradually becomes more severe as one moves down through each smaller municipality size group. In villages of 5,000 inhabitants and below, there were on average 16.3 older-elderly of 75 years of age and older to 100 persons of employable age (1990).

In Germany, by contrast, regional disparities in the proportion of the aged are not that pronounced (see Figure 4 to compare with Japan). This is mainly due to the fact that rural-urban mass migrations had taken place around the turn of the 20th century, i.e. much earlier than in Japan. Contrary to Japan, there is a slight tendency for urbanized regions to have higher proportions, due to both low fertility and the suburbanization and counterurbanization processes of the 1960s and 1970s.

Figure 4: **Regional dispersion of the proportion of elderly population in Japan (2000, by prefecture) and Germany (1999, by *Bundesland*, *Regierungsbezirk*)**



Sources: Own calculations, based on *2000 Population Census of Japan* (http://www.stat.go.jp/data/kokusei/2000/kihon1/00/13.htm (12.03.2002)); http://www.brandenburg.de/statreg/daten_02/173–11.htm (12.03.2002).

The massive outflow of population from rural areas in Japan had the dual effect of both raising the proportion of the elderly and weakening the financial (tax) base of the municipalities and prefectures concerned. In

average of 14.5% (see SAGAZA 1997: 45). In depopulated areas, the aged accounted for 25.0% of the population in 1995, compared to 20.5% in 1990 (KOKUDOCHŌ CHIHŌ SHINKŌKYOKU KASO TAISAKUSHITSU 1998: 39–40). As for municipality size groups, no actual figures are available.

Japanese regional policy, the term *kaso chiiki* [depopulated areas] has been established and points to municipalities with very high aging rates due to past outmigration (see Table 2). Based on the Special Implementation Law for the Vitalization of Depopulated Areas (*Kaso chiiki kasseika tokubetsu sochi-hō*; 1990) some efforts have been made to subsidize the poorest depopulated areas in order to help them establish and improve elderly-oriented services and facilities (e.g., medical emergency infrastructure, day-care services, public nursing homes) (Kokudochō Chihō Shinkōkyoku Kaso Taisakushitsu 1998: 9–13). Other considerations refer to the revitalization of agriculture as an outlet for the elderly who wish to continue working, as well as social activities (Yamazaki 1994: 134–137).

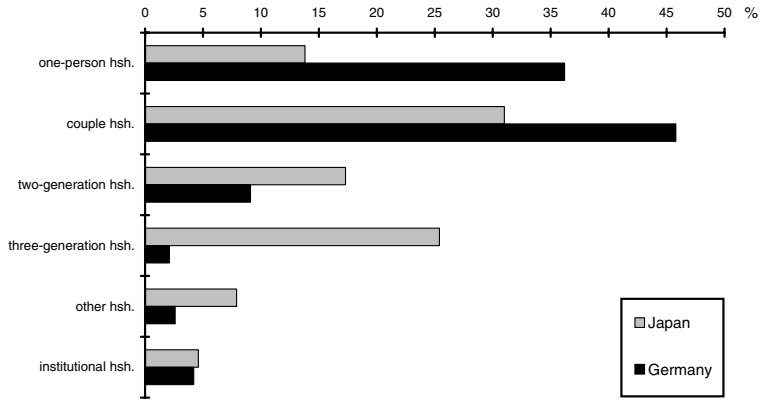
As rural-urban population shifts have almost subsided, however, aging will soon become a problem in the urban agglomerations as well (see Nakagawa 1994: 25; Ōe n.d.: 2–4). From Table 2, it can be seen that between 1970 and 1990 it was the larger cities and metropoles from 500,000 inhabitants and upwards which saw the strongest increase in the proportion of aged. In absolute numbers, urban regions are already burdened with the larger share of the elderly. The latest detailed projection figures show that between 1995 and 2025, the proportion of the elderly population will more than double in the urban and suburban regions of Kantō, Tōkai, and Kinki, while the prefectures already affected by high rates of the aged will face an increase of "only" around 50%. As a result, it is expected that while the pattern itself will remain largely unchanged, by 2025 regional differences will have decreased proportionally, probably showing a range from 22.8% in Shiga Prefecture (located between Kyōto/Ōsaka and Nagoya) to 33.8% in northern Akita Prefecture (Kokuritsu Shakai Hoshō Jinkō Mondai Kenkyūjo 1997b: 13, 32). Since most cities will need their financial resources for further consolidating their general infrastructure (especially traffic, sewerage, and housing infrastructures which are often still inadequate), these areas might be equally unable to cope with the problem by themselves.

4. Who Will Care for the Aged?

It is still widely assumed – and demographers are no exception to this – that it is normal and socially accepted for Japanese to live with their parents (see, for instance, Ogawa and Ermisch 1994: 203). Until recently, this notion even formed the basis of Japanese social policy-making. By promoting the slogan of a "Japanese-type welfare society" (*Nihon-gata fukushi shakai*) during the 1980s, the government reduced social expenditures and instead called upon the population to recall the traditional virtue of caring for their aged in the family without public support

(LÜTZELER and MATHIAS [1990]: 57). There are other factors, of course, such as extremely high housing costs or the economic distress of many elderly, which may explain the high prevalence of extended households in Japan. Whatever the reasons may be, however, compared to Germany (and to all other Western industrial countries as well), many elderly in Japan are indeed still living with their children (see Figure 5 and KOJIMA in this volume). Thus, it might seem that in Japan many families are still capable to perform old-age care functions alone, while in Germany the situation calls for stronger non-family or public commitment. On the other hand, some qualifications must be made to show that these differences between the two countries are in fact diminishing:

Figure 5: **Elderly population by type of household in Japan (2000) and Germany (1998) (%)**



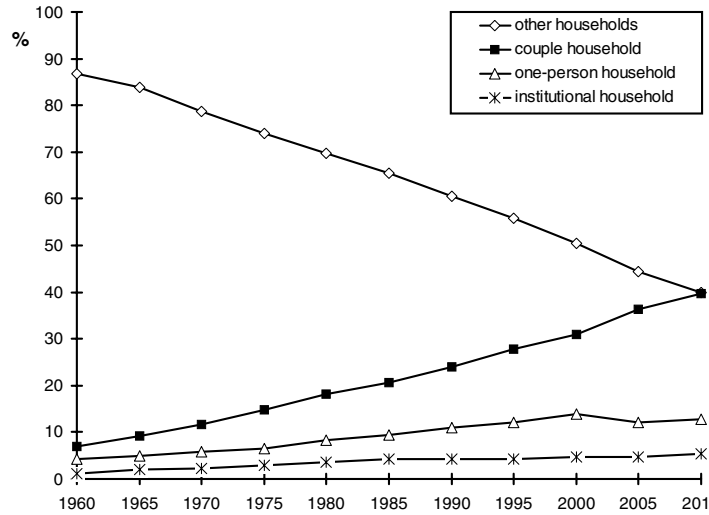
Sources: Own calculations, based on *2000 Population Census of Japan, Vol. 2–1, Table 25* (http://www.stat.go.jp/data/kokusei/2000/kihon1/00/zuhyou/a041–1.xls (12.03.2002)), *Vol. 2–1, Table 9* (http://www.stat.go.jp/data/kokusei/2000/kihon1/00/zuhyou/a011.xls (12.03.2002)); SACHVERSTÄNDIGENKOMMISSION "DRITTER ALTENBERICHT DER BUNDESREGIERUNG" (2000: 267); PRAHL and SCHROETER (1996: 158–159).

First, there is a clear trend which points to a reduction in the proportion of extended households in Japan. According to a projection made by the Institute of Population Problems (Jinkō Mondai Kenkyūjo) of the Japanese Ministry of Health and Welfare (Kōseishō)[2], by 2010 couple house-

[2] The two institutions have been reorganized as the "National Institute of Population and Social Security Research" (Kokuritsu Shakai Hoshō Jinkō Mondai

holds will replace "other households" (most of them two- or three-generation households) as the dominant form of old-age living arrangements (see Figure 6). While this is in part the outcome of increased male longevity, which raises the probability of couples still existing in old age, on the whole non-demographic factors seem to be more important in effecting this change:

Figure 6: **Changes in the proportion of the elderly population by type of household in Japan, 1960–2000 (actual figures) and 2000–2010 (estimated figures)**



Sources: Own calculations, based on Kōseishō Jinkō Mondai Kenkyūjo (1996: 42, 75); Kokuritsu Shakai Hoshō Jinkō Mondai Kenkyūjo (2002: 131); *2000 Population Census of Japan, Vol. 2–1, Table 25* (http://www.stat.go.jp/data/kokusei/2000/kihon1/00/zuhyou/a041–1.xls (12.03.2002)), *Vol. 2–1, Table 9* (http://www.stat.go.jp/data/kokusei/2000/kihon1/00/zuhyou/a011.xls (12.03.2002)).

On the one hand, Japanese elderly no longer expect to be cared for by their children in any case. This holds especially true as long as their spouses are still alive. Already in 1990, 69.1% of surveyed aged persons 60 years or older regarded their spouses as their first-choice caregivers in

Kenkyūjo; 1997) and the "Ministry of Health, Labor and Welfare" (Kōsei Rōdōshō; 2001), respectively.

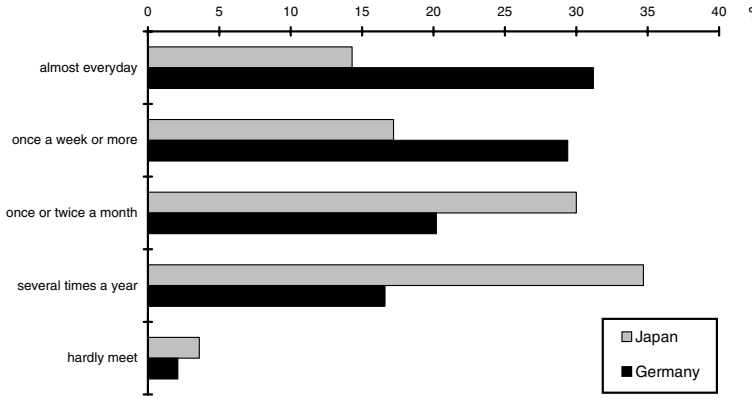
case they became bedridden, whereas 42.9% named those children who lived with them. Another 31.0% counted on children living apart from them (multiple answers possible). This conforms fairly closely to the German pattern (39.8%, 10.9%, 31.5%) but contrasts with neighboring South Korea, where children were regarded as more important (43.9%, 50.7%, 48.9%; Sōmuchō Chōkan Kanbō Rōjin Taisakushitsu 1992: 20).

On the other hand, there are obvious signs of a value change among the younger generation, who no longer seem to be willing to support their parents at all costs. Asked whether they will take care of their parents in their old age, in 1998 only 25.4% of 18- to 24-year-old Japanese answered with an unconditional "yes", far less than same-age respondents in the U.S. (66.0%) or France (56.8%). It is telling that the Japanese figure displayed a marked plunge from 35.0% in 1983 to today's level in 1988, i.e., exactly during the period when the "Japanese-type welfare society" idea was propagated. Under the condition that the financial situation would allow it, another 65.5% were willing to take care of the elderly in Japan, but even with these respondents included, the overall inclination toward providing care was rather lower than in most other fully industrialized societies. It is only the German youth who fell even below the Japanese level (14.7%; 59.6%; Sōmuchō Seishōnen Taisaku Honbu 1999: 18, 100–101). Since care responsibilities were felt more strongly in earlier surveys, one might speculate that – in part at least – these recent low figures have been affected by the introduction, in Germany, of long-term care insurance.

The second set of qualifications that must be made refers to changes on the supply side of intra-familial long-term care. The number of children per married couple in Japan has declined to an average of two and is expected to decline further (Ogawa and Retherford 1993: 705–709). Assuming that daughters remain the principal caregivers, this will inevitably create conflicts as the probability of having only male offspring will naturally rise. Even if there is one daughter, not only will her own parents ask for caregiving but, as has been hitherto the custom in Japan, so may her parents-in-law. Further, as the elderly are getting older, the people who are in charge of caring are getting older too. In 1995, 52.5% of all persons who cared for aged bedridden family members were already 60 years or older (Kōsei Tōkei Kyōkai 1997: 56). This is comparable to trends observed in Germany where most caregivers are said to belong to the 45–75 age group (Veith and Bucher 1994: 221). Naturally, the question of who will care for the caregivers arises. Finally, as can be deduced from rising female employment rates, women, especially daughters-in-law, are becoming less and less willing to stay at home and perform their traditionally assigned function as caregivers for the aged. While in 1970 only 26.9% of all Japanese females aged 15 years or older worked as employees, this

figure rose to 38.0% in 2000 (SŌRIFU TŌKEIKYOKU 1975: 340–341, 356–357; *2000 Population Census of Japan*, http://www.stat.go.jp/data/kokusei/2000/kihon2/00/zuhyou/a002.xls [11.03.2002]). About the same level can be observed in Germany (1997: 39.6%; STATISTISCHES BUNDESAMT 1998: 108).

Figure 7: **Frequency of contact with children living separately from their aged parents in Japan and Germany, 1990 (%)**



Source: SŌMUCHŌ CHŌKAN KANBŌ RŌJIN TAISAKUSHITSU (1992: 17).

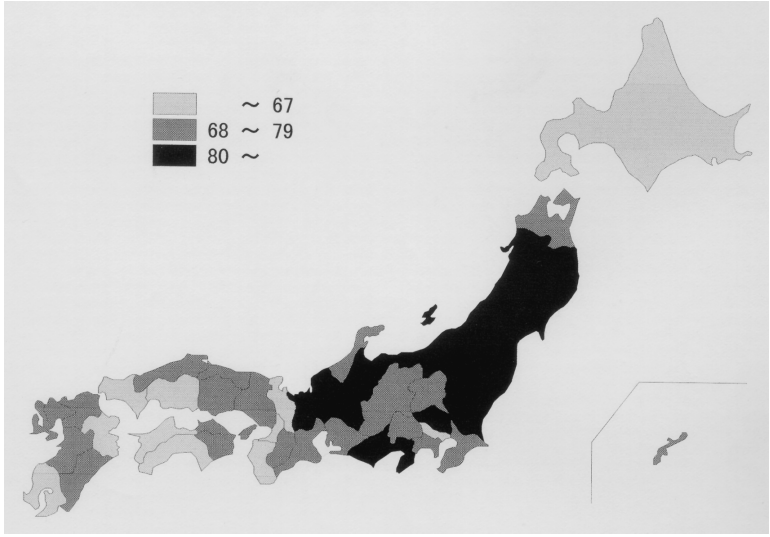
Third, contact with children who do not live with their aged parents is very infrequent in Japan, markedly falling below the level observed in Germany (see Figure 7). This is partly a result of the rural-urban migration shifts mentioned above, which took later-born children far away from their parents' homes. Partly, it is due to the Japanese tradition that only the eldest (male) child is responsible for his parents. Whatever the reasons, however, it becomes clear that the number of potential caregivers in the Japanese family is very limited and will become even more so as trends over time point to an even further reduction in the frequency of contact (SŌMUCHŌ CHŌKAN KANBŌ RŌJIN TAISAKUSHITSU 1992: 17).

5. Regional Disparities in Long-Term Care

In this final section, some remarks on the regional impact of the recent long-term care measures in Japan will be made. Do the measures address regional differences in demand for care sufficiently, and do they thus aggravate or mitigate regional disparities in care supply?

The underlying assumption of the analysis is that there are three possible sources of care for elderly people who need help: the family, the municipality, or the elderly person looking after his or her own care by employing private care services. Since care by close friends or relatives is still not common in Japan (SŌMUCHŌ CHŌKAN KANBŌ RŌJIN TAISAKUSHITSU 1992: 17, 20), it is essential to live together with or close to a spouse or children in order to receive family-like care. In the case of community care, the financial ability of the respective municipalities is a factor which might have an impact both on quantity and quality of care services – notwithstanding the substantial compensatory payments from taxes or contribution fees collected at the national level (see TALCOTT in this volume). Finally, it usually requires a substantial amount of income or capital to be independent of both family and community help and receive purely commercial care services. An interesting feature of the long-term care situation in Japan is the fact that all three factors show distinct regional patterns.

Figure 8: **Extended households among all households with people over 74 years of age by prefecture, 1993 (%)**

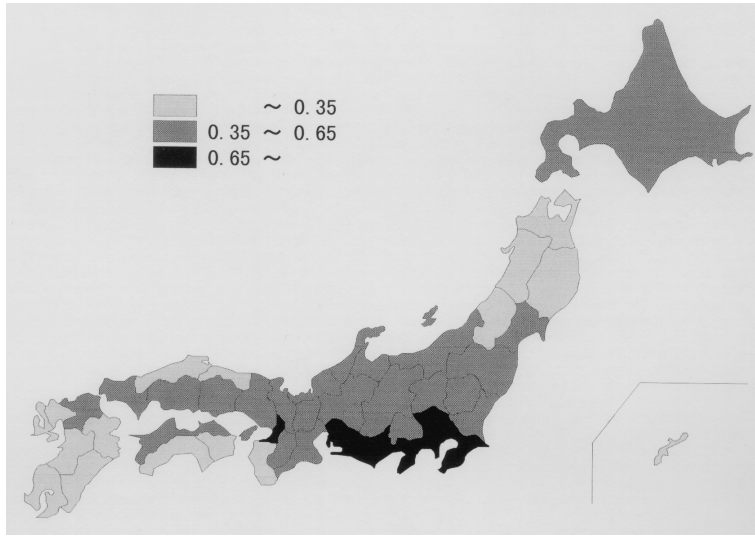


Note: "Extended households" include households located at a walking distance of no longer than five minutes from children's households.
Source: Own calculations, based on SŌMUCHŌ TŌKEIKYOKU (1995b: 3: Tab. 51).

First, it can be seen from Figure 8 that there is a regional pattern in living arrangements among the aged that goes far beyond the simple contrast between rural and urban regions (a contrast still mainly existing in Germany). The countryside itself can be divided into at least two regions with markedly different household structures. That is, extended family households are overwhelmingly dominant in the northeastern rural areas, whereas in some rural parts of southwestern Japan, other, i.e., nuclear or one-person, households prevail due to what may be influences of such historical factors as differing inheritance laws or village society structures (Ōbayashi 1995; Lützeler 1997: 40–41). While the degree of these differences in living arrangements might diminish in the future, as forecasts show (see Kōseishō Jinkō Mondai Kenkyūjo 1995: 81–82), the regional pattern itself will by and large remain stable.

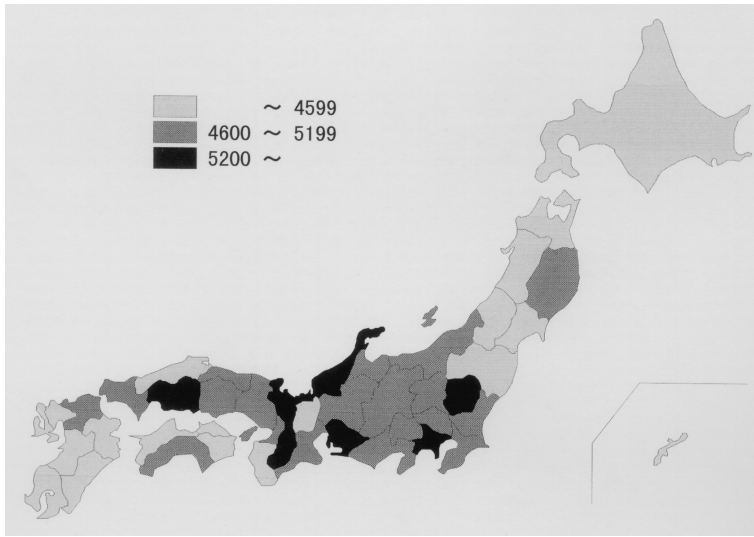
Second, regional differences in the financial potential of prefectural governments, i.e., the ratio between revenues and expenditures, and in the average income of aged couple households are equally striking, as the maps in Figures 9 and 10 show. What becomes obvious in both cases is the fact that highly urbanized prefectures or, more generally speaking, the central parts of Japan show a clear advantage over rural or peripheral prefectures. In the latter regions, public authorities often may only be able to guarantee a minimum standard of care services, while the aged themselves are in general not wealthy enough to afford private services. While in the northeastern rural regions this unfavorable situation might still be mitigated by family care, in large parts of the southwest this is often not possible. Therefore, the rural parts of southwestern Japan might be considered as long-term care problem regions. This judgment becomes even more justified when one takes into account the fact that the regions with the most unfavorable care-supply conditions are by and large identical to those with the highest proportions of the elderly, i.e., regions with the highest demand in care services.

Figure 9: **Index of financial potential by prefecture, 1995**



Source: SŌMUCHŌ TŌKEIKYOKU (1997a: 38).

Figure 10: **Yearly income of elderly couple households by prefecture, 1994 (1,000 yen)**



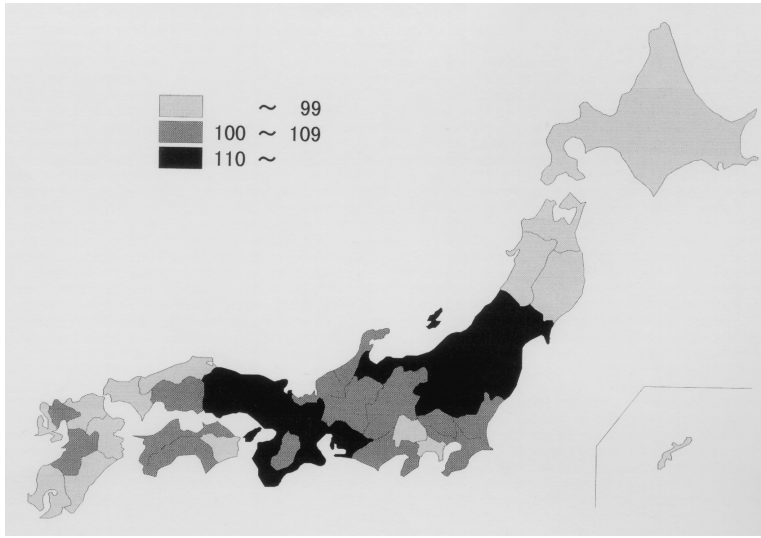
Source: SŌMUCHŌ TŌKEIKYOKU (1997b: 434).

How did the Japanese state and local governments respond to these strong regional disparities? The so-called Gold Plan, set up in 1989 and upgraded in 1994 as a measure to substantially increase the number of old-age services nationwide, has created a new category of nursing homes specially designed for depopulated regions: the *Kōreisha Seikatsu Fukushi Sentā* or Centers for Living and Welfare of the Aged. These are rather small-scale institutions where the disabled aged can live permanently or come in daily for health advice and/or participation in social activities. About 400 such institutions were to be opened for operation in 2000 (Kōseishō 1996: 458).

Apart from this commitment, however, it does not seem that Japanese welfare policy-making has, so far, taken regional aspects of aging and long-term care into appropriate consideration. The maps in Figures 11 and 12 show the changes from 1985 to 1995 in the regional patterns of institutions and homehelpers for the aged. While the supply of homes for the aged is in fact better at the periphery, it is also evident that most of the new facilities have been built in the central parts of Japan, thereby causing a mostly uniform supply level. Accordingly, between 1985 and 1995 the coefficient of variation[3] dropped significantly from 30.4% to 21.2%. The distribution of homehelpers is more complex, but here too there has been a tendency to extend services in the urbanized prefectures, which already showed a high level in 1985. While this is in part justified on the grounds that the larger cities show rather high proportions of elderly living in one-person households, it is also most likely an outcome of the higher financial potential of these regions, because until 1989 communities had to share in the expenses of home care services to a higher degree than in institutionalized care. Further, the problem of long commuting distances between patients discourages the employment of homehelpers or other ambulant care personnel in remote areas.

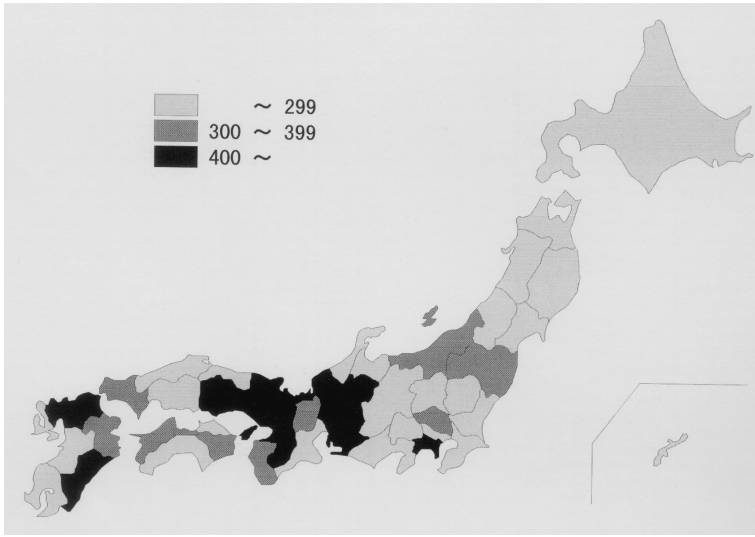
[3] The coefficient of variation is a statistical measure that indicates the relative strength of dispersion for any variable distribution. It is calculated by dividing the standard deviation by the arithmetic mean and multiplying the result by 100. The higher the value, in other words, the higher the dispersion.

Figure 11: **Capacity of nursing homes per 100 elderly 75 years and older by prefecture, 1985–1995 (1985=100)**



Source: Own calculations, based on SŌMUCHŌ TŌKEIKYOKU (1997a: 390).

Figure 12: **Homehelpers per 1000 elderly 75 years and older by prefecture, 1985–1995 (1985=100)**



Source: Own calculations, based on SŌMUCHŌ TŌKEIKYOKU (1997a: 394).

The same results can be seen in the distribution policy of long-term care services within prefectures. In my analysis of several "Plans for Health and Welfare of the Aged" (*Rōjin hoken fukushi keikaku*) issued by the prefectural governments, I have found in every case that the distribution of care services for the aged is specified as "based on the characteristics of the region" (*chiiki no tokusei o fumaete*). There is even the case – as stated in the plan prepared by Niigata Prefecture (Niigata-ken Hoken Fukushibu 1994: 10, 13) – that intermunicipal differences in living arrangements of the aged as well as the problem of great distances in depopulated areas are officially taken into account. The actual figures, however, show that prefectures are aiming at a uniform level of supply regardless of differences in household structure or local income situation of the aged.

It is likely that the implementation of the new long-term care insurance system, too, will maintain existing regional inconsistencies in the care-supply pattern. Unlike the situation in Germany, where premiums are paid to public or private health insurance companies, in Japan it is the municipalities that are in charge of collecting and administering the insurance premiums. While they are obliged to pay a certain amount of benefits depending on the care necessities of the insured, it will depend on the financial ability of each municipality what *additional* benefits and services are given to people in need of care. Thus, some critics even fear the advent "of a new type pf social welfare recipient; one which migrates from one local community to another in search of better services" (see Kimura in this volume). Further, the new law encourages the use of business-oriented welfare services. As these private services will most probably choose locations which promise the highest profits, the peripheral rural areas in Japan will again be left out in the cold.

6. Conclusion

Population aging is proceeding at a very high pace, especially in Japan, which reflects both a rapid reduction in past fertility rates and a remarkable rise in old-age longevity. Thus, aging should be regarded as a "future that has already happened", a reality that cannot simply be remedied by short- and medium-term policy strategies. All current efforts should be concentrated on improving the quality of life of senior citizens. It appears that population aging poses an even greater problem for Japan than it does for Germany, at least in the short run.

Even more important, the conclusion can be drawn that in Japan – as well as in Germany – the family is more and more losing its capability of

being the prime care-providing institution for the aged. Thus, "who will care?" is a question relevant not only to Germany, with its already high proportions of elderly living in relative isolation, but to Japan as well. It becomes obvious that Japan and Germany, notwithstanding their different cultural and historical backgrounds, have comparable situations when it comes to discussing aging and its related problems.

It could further be shown that unlike Germany, Japan has quite substantial regional disparities in aging as well as in the determinants of care; unfortunately, welfare policy-makers do not seem to consider these sufficiently. The Gold Plan of 1989 and its successor of 1994 tended to create a uniform level of supply without really addressing such local characteristics as differing living arrangements or income levels of the aged. There are fears that the new long-term care insurance system, too, might only insufficiently address regional disparities in demands for care. As a result, the peripheral and depopulated regions of Japan will once again be put at a disadvantage. This holds true for much of the southwestern periphery in particular.

To develop a sufficient level of care services that takes local differences into due account might require a fundamental change in the centralist attitudes and practices of both administrators and the general public, the main reasons why balanced regional development is far from being achieved in Japan. As a first step, local governments should be provided with more financial resources collected by their own in order to build up an adequate care level that would prevent the appearance of a "welfare migration" that could further aggravate the difference between depopulated and overcrowded regions.

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The Rhetoric of Reform: On the Institutionalization and De-Institutionalization of Old Age

Sabine Frühstück

1. Setting of the Problem

During the late 1970s and early 1980s, the question of whether Japan cares well enough for its institutionalized senior citizens was discussed with more rigor than ever before. Most agreed that this was not the case. Public nursing homes met severe criticism from both within and without. The quest for their reform was supported by almost 50% of 24- to 74-year-olds in an opinion poll of 1986 (Naikaku Sōri Daijin Kanbō Kōhōshitsu 1987: 189), at a time when a major turn was underway. Community care programs as an alternative to the problematic and rather closed institutions was one of the options most discussed among bureaucrats concerned with the Japanese welfare system.

When more than 5,000 Japanese men and women were asked in 1978 what kind of life they would like to lead when they are no longer able to work, only 4% said that they would live in a nursing home. Only 2.2% of elderly respondents in 1984, but 9.7% in 1990, agreed that living in a nursing home was the ideal living arrangement in old age (Linhart 1997: 309, Tab. 13). By 1990, the percentage had more than doubled, reaching 8.8% (Linhart 1997: 30, Tab. 14). In 1989, up to 13% of respondents in a national poll were willing to put their elderly relatives into a nursing home if they were no longer able to live alone (Linhart 1997: 299, Tab. 1).

In this article, I will describe the two major areas of conflict regarding the turn from institutionalized care toward community care for the elderly in Japan which took place during the 1980s, prior to the "Gold Plan" and the introduction of the long-term care insurance. First, I look at nursing homes themselves and analyze their internal problems (section 2). Second, I discuss the community care programs and examine in what ways they influenced the reorganization of nursing homes on the one hand, and the transfer of responsibility and financial burden from institutions and the state to the community and female caregivers on the other hand (section 3).

The turn in social policy for the elderly was accompanied by mixed feelings among a number of involved groups and was confronted by rather diverse reactions. Originally, it was propagated by the Japanese

health administration, enthusiastically embraced by prefectural and local rhetoric touting the new "light-hearted and happy" city XY, and only moderately criticized by women's groups who did not want to envision themselves at home, caring again not only for their children and husbands, but for parents and parents-in-law as they had for generations. The major criticism of existing nursing homes, however, did not bring about their radical reform but instead led to the creation of new types of more open institutions that were organized and financed differently and which catered to a different range of elderly people.

2. The State of Nursing Homes in Japan During the 1980s

2.1 The inmates

By the time Hata Hiroaki published his book *Rōjin to wa nan da! Shitsurei na* ([What is an "Old Person"? How Rude!]; 1985), the word *rōjin* [old person] for Japan's elderly had come to have a negative connotation. While in direct interaction within the boundaries of the family or the local community, the elderly are addressed with terms such as *jiji*, *ojīchan*, or *ojīsan* [grandpa], *baba*, *obāsan* or *obāchan* [grandma]. *Rōjin* is used in the official language of health and social welfare administrators, as in *rōjin mondai* [problem of old people], *rōjin fukushi sābisu* [welfare services for old people], or *rōjin hōmu* [old people's home], all of which commonly appear in problematic contexts. Institutions for the care of the elderly managed by national, prefectural, or municipal administrative bodies which were founded after the enactment of the "Old Age Welfare Act" (*Rōjin fukushi-hō*) on August 1, 1963, continued to be called *yōgo rōjin hōmu* [nursing home for old people], *tokubetsu yōgo rōjin hōmu* [special nursing home for old people], *keihi rōjin hōmu* [home with reduced fees for old people], or *rōjin fukushi sentā* [social welfare center for old people], while more recent private institutions were founded by using euphemistic names such as "silver home". Institutionalized elderly in nursing homes were termed *zashosha* [residents] or *nyūshoin* [inmates]. In the following, I will use the word "inmates" when I refer to those elderly who live in nursing homes. Contrary to "residents" and other euphemistic terms it makes clear that we are dealing with a relatively closed or "total institution", a term that had been coined by Erving Goffman (1973). "Total institutions" are characterized by a number of core features, namely, the merging of formerly separate areas of living, the administration of life by a bureaucratic organization, deculturation processes, attacks against the self, and particular adaptation strategies of the inmates.

In 1983, 4.3% of the population over 64 was institutionalized, but only 3% were inmates of nursing homes such as nursing homes for old people (*yōgo rōjin hōmu;* in the following abbreviated as *yōgo*) and special nursing homes for old people (*tokubetsu yōgo rōjin hōmu;* in the following abbreviated as *tokuyō*) (KARGL 1987: 370). Although the group of people who live in nursing homes is rather heterogeneous in nature, inmates of both institutions share a number of characteristics with regard to their age, sex, physical constitution, income, social background, and living arrangements.

Table 1: **Age of inmates in nursing homes, 1982 (%)**

Age group	Special nursing home for old people (*tokubetsu yōgo rōjin hōmu*)	Nursing home for old people (*yōgo rōjin hōmu*)
younger than 70 years	16.3	20.1
between 70 and 80 years	40.1	45.7
80 years and older	43.6	34.3

Source: ZSFKK (1986: 41, Table 1/3).

As for the age composition of the inmates (see Table 1), it can clearly be shown that the strongest group is those aged 80 years and older. Throughout the 1970s and 1980s, with slight variations from institution to institution, at least two-thirds of the inmates were females and one-third was male (SOEDA *et al.* 1977: 13; ESKS 1987: 350). This imbalance can be explained in a threefold manner: First, women's life expectancy is more than six years higher than that of men. Second, elderly women are less often taken care of by relatives. In other words, women who have raised their children, who have taken care of their husbands, their parents, and very often their parents-in-law for most of their lives, prefer not to become burdens for their relatives when they need help themselves (SHIMADA 1983: 146). They know from their own experience that for every single year a bedridden person[1] lives and is taken care of by a daughter or daughter-in-law, the life of the caregiver is shortened by one year (GETREUER-KARGL 1990a: 157). Care at home might become even more difficult when the caregiver grows older and suffers from chronic diseases herself (SHIBATA 1988: 55). Third, women become bedridden later in their lives. Only in the group of those 80 years and older are women more numerous (KARGL 1987: 380).

With regard to their familial situation, the difference between women and men is significant. Although the majority or 80 to 90% of inmates is

[1] According to Kargl, "bedridden" (*netakiri*) usually refers to a person that had been bound to her or his bed for more than six months (KARGL 1987: 371).

widowed, the number of widowed women is 20% higher than men in *tokuyō* and 10% higher in *yōgo*, while the number of widowed men is 17% higher in *tokuyō* than it is in *yōgo*. While 66% of *tokuyō* inmates have children, only 46% of *yōgo* inmates do (ZSFKK 1986: 48–49).

More than 80% of all inmates needs daily medication and suffers from more than one disease. About half of the inmates are bedridden and another half are incontinent (Arioka 1990: 4). More than 50% of them needs treatment they would normally receive in a hospital and even patients who need to be taken care of 24 hours a day, including weekends and holidays, are not rare (Miura 1982: 159). However, a nursing home is by law not a medical institution. It is not equipped in the same manner as a hospital and is unable to provide certain services that are nevertheless needed. Thus the personnel sometimes feels they would be better off in a hospital (*iryō kikan de hataraite ita hō ga yokatta*), while the more concerned inmates fear for their lives: "For the elderly in nursing homes, medical treatment is a luxury; hence they die" (Nakagawa 1979: 35).

The lack of mental agility is another significant characteristic of many inmates. Whereas 4.5% of the elderly who live at home are estimated to be senile (*chihōsei rōjin*) (Ikuta and Fujita 1986: 105), more than half of *tokuyō* inmates and at least one-third of *yōgo* inmates are described as senile due to behavior such as for being forgetful, hallucinating, not understanding what the personnel is saying to them, the inability to perform simple tasks in everyday life although they are physically capable of doing so, insomnia, making noise, uncleanliness, or violence (ZSFKK 1986: 96). Most of the elderly defined as "senile", however, were taken care of at home (*Tōkyō Shinbun* 21.11.1990: 14; Miura 1989: 39). It is estimated for the year 2008 that the number of bedridden or senile elderly will equal the number of full-time housewives. It was feared that, without changing the institutional setting, half of all women between the age of 40 and 50 would have to take care of one bedridden or senile elderly person. Considering that the number of working women of that age group was likely to rise significantly, it became clear that soon women would not be available to take care of the elderly in the same ways and to the same extent as they used to. The extension of existing institutions in order to relieve these women, and the reorganization of these institutions so that new inmates would not primarily feel isolated, excluded, and locked up were two aims of the critique the system faced during the 1980s (Ogawa 1990b: 22). According to a forecast, the number of senile over-64-year-olds will increase and reach 2.16 million by 2025. Similarly, the number of bedridden over-64-year-olds is estimated to rise to 1.96 million (Ogawa 1990a: 15).

Many publications describe elderly Japanese as rather well off (Ishii 1991: 11; Ogasawara 1985: 92). However, most of those elderly who live with their children in urban areas are financially dependent on them, and six out of ten of them lived below the poverty line before they moved in with their children (Honma 1985: 42). In fact, a weak financial situation is no longer a reason for entering a nursing home. The elderly are more likely to enter a nursing home because of an unsatisfactory familial situation rather than for financial reasons (ZSFKK 1986: 193). In any case, there were rather few if any well-off elderly who chose to enter a nursing home during the 1980s.

The income of inmates of nursing homes is significantly lower than of those elderly who are not institutionalized. Institutionalized elderly clearly belong to the poorest group among the elderly in Japan. According to the Public Assistance Act (*Seikatsu hogo-hō*), children have the obligation to provide maintenance for their parents in case they are not able to support themselves sufficiently. Only a minority of elderly over the age of 60, however, feel comfortable about being financially supported by their children. More than half of them would prefer to be able to look after themselves and a considerable third thinks that it is the responsibility of the state to provide the social network (ESKS 1987: 601). But for the elderly who are institutionalized in *tokuyō* and *yōgo*, reality looks quite different. Nine out of ten elderly receive financial support from their children, partners, siblings, and other relatives as well as from friends and acquaintances (ZSFKK 1986: 61).

Table 2: **Living arrangements of inmates prior to their institutionalization (%)**

Living arrangement	Special nursing home for old people (*tokubetsu yōgo rōjin hōmu*)	Nursing home for old people (*yōgo rōjin hōmu*)
with children	35.4	19.6
with other relatives	7.1	14.8
as couple	6.6	7.1
alone	12.1	36.3
in another institution, i.e., hospital or other nursing home	35.6	12.1
other	3.2	--
unknown	1.0	--

Source: ZSFKK (1986: 53, Tab. 2/6).

From Table 2, some interesting facts regarding the household situation of the elderly prior to their institutionalization become apparent. While more than 35% of *tokuyō* inmates lived with their children before their institutionalization, only about half or 19% of *yōgo* inmates did so. While slightly less than half of both groups lived with either children, partners, or relatives, the difference between the two groups in regard to other living arrangements is significant. Of *tokuyō* inmates, 35.6% came from other institutions such as a hospital or another nursing home. The opposite applies to *yōgo* inmates. While 36.3% had lived alone, only 12.1% came from another institution.

2.2 Institutionalization and the adaptation process

Although it is advised by the Japanese social welfare authorities, very few families consult one of the consultation bureaus for social welfare or visit a nursing home before deciding to put their elderly relative into one (ZSFKK 1986: 51). Permission for institutionalization is given by the bureau of social welfare on the basis of a formal application. Criteria for acceptance in a nursing home involve three factors: First, the person concerned must be a receiver of social welfare or receive an income below the taxable minimum. Second, she or he must to a considerable degree be physically or mentally disabled. Third, she or he must be unable to live at home (Kōseishō 1990: 238). *Tokuyō* presuppose a serious physical disability or bedriddenness. Although the lack of financial resources is not necessarily a precondition, many elderly apply for acceptance based on financial reasons (Soeda *et al.* 1977: 18). According to §2–11 of the Old Age Welfare Act (*Rōjin fukushi-hō*), only people with serious physical and/or psychological disabilities (*kurushii kekkan*) are accepted at *tokuyō*. But even if qualification criteria are met, many elderly have to wait for years before there is finally a vacancy. This waiting period increased especially since the enactment of a committee in 1984 which was founded in order to keep administrative costs down and to moderate the speed at which new homes were founded (Teruoka 1985: 33). According to a study carried out in 1984, there were 366,000 bedridden people, but only 111,970 places in *tokuyō* (Miura 1987: 130).

What does *kurushii kekkan* mean exactly? Nakagawa Masateru (1979: 25) explains that originally *tokuyō* were built for old people with *kurushii kekkan* in order to separate them from other sick people, emphasizing that *tokuyō* were not hospitals. According to the Law for Medical Treatment (*Iryō-hō*), hospitals have to be equipped with a certain number of personnel in relation to patients: for 100 patients

there have to be at least 3 physicians and 34 nurses. Legal matters for *tokuyō* are formulated in the Old Age Welfare Act which provides only 1 physician and 5 nurses for 300 inmates. Consequently, the motto for nursing homes that "a nursing home is no hospital" proves to be efficient from a financial viewpoint but dangerously fateful for the quality and the potential of nursing. Hence, according to public policy, those elderly who become sick in a nursing home would have to be transferred to a hospital. In reality, however, hospitals are overcrowded, the elderly themselves are reluctant to move from one institution to another, and they are considered "uninvited guests" (*manekarezaru kyaku*) because they cause high treatment costs (Anton 1989: 36; Nakagawa 1979: 35).

Discriminatory practices seem to be common. As Teruoka Itsuko has found, the elderly are often dismissed from hospitals even though their condition may not have improved and are either sent back home or – in case there are no caregivers available – put into a nursing home. When long waiting periods are expected, some elderly end up in psychiatric wards no matter what their mental state (Teruoka 1985: 33; Getreuer-Kargl 1990a: 168).

About half of those who apply for entering a nursing home are accepted. Most of them stay for three to five years in a *tokuyō* or for five to seven years in a *yōgo* (ZSFKK 1986: 192). Those who leave the nursing home are mainly transferred to a hospital or die. More than 70% die in a *tokuyō*, as opposed to more than one-third of inmates of *yōgo*. The rest of the *tokuyō* inmates are transferred to a hospital or to their homes while the other *yōgo* inmates are usually transferred to *tokuyō* or to hospitals (ZSFKK 1986: 67). One out of four *tokuyō* inmates who are transferred to their homes return to die (ZSFKK 1986: 70).

Death is omnipresent in nursing homes. Hence, they are named "place of death" (*shi no ba*) or "last place" (*saigo no ba*). Nevertheless, the topic of death seems to be taboo. The Conference of the Society for Research on Dying and Death (Shi no Rinshō Kenkyūkai) attributes this taboo to the fact that more and more people die in institutions not only in Western European countries and in North America (Ariès 1980: 736), but also in Japan where 70% of all deaths take place in institutions (*Asahi Shinbun* [Sapporo edition], 27.09.1990). In advice columns of magazines for women or the family, one finds many indicators that women worry about the aging of Japanese society, but there, too, problems concerning death are hardly mentioned (Eijingu 1984: 38). This might be taken as another indicator for what Norbert Elias called the far-reaching "hiding and repressing of death, that is to say of the singularity and finality of human existence" (1982: 56).

Reasons for institutionalization are manifold and vary. An analysis of the social background provides a first glance at which factors play a role when an elderly person or her or his family considers institutionalization. Soeda Yoshiya interviewed 144 inmates[2] and placed them into two categories: the general class (*ippan kaisō*) and the unstable class (*fuantei kaisō*). Almost 70% of the 144 respondents belonged to the unstable class, and more men than women. The material situation of institutionalized elderly is significantly worse than that of workers in general, of whom only 20% belong to the unstable class, as defined by Soeda and his collaborators. Class careers differ depending on sex. Most females belonged to the unstable class for a long time before their institutionalization or had descended to the unstable class during the last few years before their institutionalization. The most important reason for the deterioration of their material situation is the separation from their husbands through death or divorce. The fact that the job situation of an elderly woman hardly has any effect on her material situation in old age suggests that most of them were financially dependent on their husbands when they reached old age. Most of the male inmates belonged to the unstable class for all or at least most of their lives. In regard to their material background, we see a significant difference between *tokuyō* and *yōgo*. While almost 80% of *yōgo* inmates belong to the unstable class, only half of the *tokuyō* inmates do so. *Yōgo* are the follower institutions of *yōrōin*, which were built in Japan from 1895 onward and have never gotten rid of their image as institutions for the poor (Frühstück 1991: 20; Campbell 1984: 78; Oberländer 1997: 92–93).

Another reason for institutionalization is an unsatisfactory familial situation. A quarter of all respondents of a study carried out in 1985 said that they did not get along with their daughter-in-law, their son nagged all the time, or they felt more welcome in a nursing home than at home (Ogasawara 1985: 91). The familial situation seems to have become an increasingly important factor for the decision to enter a nursing home. From all the consultations that take place in bureaus for social welfare, in centers for the elderly, or other consulting offices for the elderly, more than 60% of the problems verbalized and taken into account in relation to institutionalization were related to conflicts in the family (Shimada 1983: 149). As can be gathered from Table 3, the reasons are quite different

[2] Of respondents, 33.3% were male and 66.7% were female; 66 people or 45.8% lived in *yōgo*, and 78 people or 54.2% in *tokuyō*; 18.1% were younger than 70 years, 36.8% were between 70 and 80 years old, and 44.5% were 80 years and older (Soeda *et al.* 1977: 3–27).

among inmates of *yōgo* compared to those of *tokuyō*. The major reasons are familial situation (30%) and material situation (20%). Physical weaknesses or disabilities play a minor role as compared to the inmates of *tokuyō*. In general it is important to keep in mind that more than one unfavorable factor leads to institutionalization (ZSFKK 1986: 58). What is more, the elderly are usually not the decision-makers. Only 4.7% of *tokuyō* inmates and 13% of *yōgo* inmates said that it was their own decision to be institutionalized.

Table 3: **Reasons for entering a *tokuyō* or *yōgo* (%)**

Reason	Special nursing home for old people (*tokubetsu yōgo rōjin hōmu*)	Nursing home for old people (*yōgo rōjin hōmu*)
physical weakness	54.0	10.8
familial situation	25.8	29.9
decision of the inmate	4.7	13.0
mental weakness	4.3	4.1
material situation	3.0	20.0
living circumstances	2.6	9.2
other reasons	4.4	6.8

Source: ZSFKK (1986: 58, Table 2/10).

Very often the decision to enter a nursing home is not carefully considered. Rather, it is the result of an acute crisis or made when the burden of care at home no longer seems bearable to the caregiver and her or his family (Ogasawara 1985: 85). Women especially decide to enter a nursing home after a life of caring for their children, their husband, and sometimes his parents or their own parents out of exhaustion after their husband's death (Getreuer-Kargl 1990a: 157). Others make the decision out of a feeling of loneliness or because they are not (any longer) able to take care of themselves or live alone despite a good physical condition (Teruoka 1978: 240).

While in North America the family of the person concerned is the main decision-maker when institutionalization is considered (Brody 1977: 49), the same is only true of *tokuyō* inmates for whom 59.1% of all cases were decided by the family (see Table 4; first survey). The second most important decision-maker is an administrative body, and only 14.9% of the decisions were taken by the person concerned.

Table 4: **Decision-makers for institutionalization in a *tokuyō*, 1981 (%)**

Decision-maker	First survey	Second survey
family	59.1	32.0
administrative body	53.1	28.7
hospital	16.4	8.9
person concerned	14.9	8.0
social worker	13.9	7.5
other relatives	13.6	7.3
other nursing home	11.4	6.2
other	2.0	1.1

Note: Both surveys were undertaken in 1981 and involved interviews with elderly living in *tokuyō*. The sample of the first survey consisted of 23,116 people. More than one answer could be given and therefore co-decisions were taken into account. The sample of the second survey consisted of 42,778 elderly. Here only one answer could be given.

Source: ZSFKK (1986: 52, Table 1/5).

For *yōgo* inmates, almost half of these cases of institutionalization were decided by an administrative body (first survey), 34.9% by the person concerned, and only in 27.6% of the cases was it the family's decision. Tables 4 and 5 show clearly that differences between institutions in regard to the decision-maker are substantial.

Table 5: **Decision-makers for institutionalization in *yōgo*, 1981 (%)**

Decision-maker	First survey	Second survey
administrative body	49.3	29.4
person concerned	34.9	20.8
family	27.6	16.5
social worker	20.6	10.3
other relatives	17.7	10.6
other nursing home	7.3	4.3
hospital	6.8	4.0
other	3.5	2.1

Source: ZSFKK (1986: 52, Table 1/5).

The *White Paper on Nursing Homes* (ZSFKK 1986) does not analyze the relation of the inmates' sex with the question of who made the decision.

Small-scale surveys[3] suggest, however, that women usually actively and deliberately decide to enter a nursing home, while men more commonly end up in a nursing home because a number of authorities (including the family) decides to put them there (SHIMONAKA 1987: 65–75).

In general, institutionalization provokes a temporary deterioration of the constitution of the institutionalized person (OGASAWARA 1985: 85), which has been explained in different ways. Elaine M. BRODY (1977) ascribes the destabilization to the shock caused by the fact that the person concerned had to leave her or his familiar surroundings and is placed into a nursing home. The expectation of the relocation can have the same effects as the relocation itself. Thus, the feeling of isolation usually appears long before the institutionalization takes place. Sheldon S. TOBIN and Morton A. LIEBERMAN (1976: 22) came to similar conclusions when studying the critical implications of institutionalization of the elderly in the United States. The "discontinuity of their surroundings connected with the loss of familial support as well as the beforehand identification with the other inmates can trigger a feeling of isolation which is only reinforced when entering the institution". On the contrary, Erving GOFFMAN (1973: 24–39) tends to ascribe the deterioration of someone's condition to the effects of the nursing home as a total and "totalizing" institution, although he too concedes that in many cases the institution only destroys something that had already been decaying.

There are very few studies on the risk of institutionalization in nursing homes in Japan. Erdman PALMORE (1976: 504–507) has found that the risk is greatest for people who have lived alone before their institutionalization, for elderly who do not have children, and for women in general. As opposed to Palmore's findings, OGASAWARA (1985: 86) found that the effects of institutionalization are more negative for males than for females and that females also enjoy themselves more in nursing homes than males do. SHIMONAKA Yoshiko (1987: 73) defined as additional factors self-confidence and ego, fear of old age, intensity of social contacts, and physical condition. If the person concerned had few social contacts before entering the nursing home, the adaptation process will be less difficult. Socially rather isolated people tend to enjoy life in a nursing home for its possibilities to make contacts and friends and the possibility to live a more "human life" (*ningen-rashii seikatsu*). Those, however, who had satisfying social relations before, are likely to find life in a nursing home less

[3] SHIMONAKA *et al.* (1987) analyzed case studies of 114 men and 232 women. Excluded were sick and bedridden elderly. Respondents were 76 +/- 6.3 years old. The study was carried out in two nursing homes, one of which was in an urban area and one in a rural area.

enjoyable (Ogasawara 1985: 83). In general, we can conclude that the lifestyle of the elderly before their institutionalization has a considerable impact on how they feel about entering a nursing home and how they feel about being an inmate of a nursing home.

2.3 The personnel

Similar to companies, Japanese nursing homes tend to present the idyllic image of family life in regard to the interaction of inmates and staff (Ogasawara 1985: 83; Hata 1985: 117), thus disguising the fact that relations between them are organized in ways significantly different from familial relationships. Inmates and personnel are related to each other by a dependence which is in certain ways mutual. On the one hand, the inmates are dependent on the personnel and their willingness to provide the right treatment. On the other hand, the personnel are dependent on the inmates' willingness to cooperate. Both parties are subjugated to the regulations and restrictions of time and place which will be discussed below. These regulations and restrictions affect the autonomy of inmates and their activities and mark the boundaries of their *Lebenswelt*. Family, friends, and acquaintances of the personnel guarantee them the ability to leave the "totalizing" atmosphere of the institution.

Among all kinds of welfare institutions, next to social welfare institutions for children and youth (*jidō fukushi shisetsu*) the second largest group of people are employed in the institutions for the elderly (Kōseishō 1990: 326). In 1988, 90,060 of these were working in nursing homes. Although the absolute number of personnel doubled between 1978 and 1988, the ratio of personnel and staff has hardly improved. In *yōgo*, the ratio was 3.48 inmates to one staff member, while ten years earlier it was 3.97. In *tokuyō*, the ratio was 2.01 in 1988 as compared to 2.27 inmates facing one staff member. Although there are national norms for the ratio of inmates and staff, they are in many cases twice as high as provided in the law. In about 12% of all *tokuyō* there are three inmates to one staff member and in almost half of all *yōgo* one staff member faces four or more inmates. When necessary, e.g., on bathing days, all staff members have to work together regardless of whether they are qualified or not.

According to Goffman's model of face-to-face interaction, in every society there are preferred ways of entering an interaction between two people. Each of these "systems to make contact" can be a source of identity, a guideline for ideal behavior, and a precondition for solidarity or disunion. Each system consists of a range of interdependent assumptions which are adjusted to each other and form a model. Through an analysis of the assumptions and ideals of interaction between inmates

and staff, one can learn a lot about the problems of institutions. The most important form in which inmates and staff interact with each other is the relation between one who is served and the other who is serving. In the following I will exclude personnel that do not regularly come into contact with the inmates such as cleaning staff or cooks. I will treat only those personnel that interact on a daily basis with the inmates, that offer services in form of treatment in direct and indirect, medical and non-medical ways. In the course of one day, no less than seven nurses and *ryōbo* [literally: home mother] interact directly with the bedridden elderly (see Table 6).

Table 6: **Schedule of a nursing home for a bedridden inmate**

Time	Treatment/activity	Personnel
8:30– 8:50	meeting of personnel	
8:57– 9:40	excretion care	ryōbo A
9:40– 9:54	treatment of bedsores	nurse B
10:00–10:01	questions concerning physical condition	ryōbo C
10:18–10:19	eye drop treatment	nurse D
10:43–10:59	help with eating	ryōbo E
11:41–11:43	excretion care	ryōbo F
13:25–13:26	taking the inmates' temperature	nurse B
13:29–13:31	meals served	ryōbo A
13:40–13:43	help with eating	ryōbo A
14:11–14:13	taking temperature and pulse	nurse B
14:18–14:19	questions concerning general physical condition	nurse B
15:51–15:54	excretion care	ryōbo A and G
16:13–16:14	placing the inmates in comfortable positions	nurse B
16:35–16:50	help with eating	ryōbo A
16:51–16:52	oral hygiene	ryōbo A

Source: ASANO (1975: 136).

The personnel of a nursing home that is involved in direct and indirect care include a psychological consultant (often a middle-aged man), *ryōbo*, nurses, and physicians. *Ryōbo* do not need professional training and are normally forced to "learn by doing". Many of them are former full-time housewives. Their tasks include direct and indirect caring, i.e., emotional support, and thus they are the hinge joint between medical personnel and inmates. Nurses are fewer in number and very often *ryōbo* do some of their work. The willingness and ability to cooperate and work in a team is essential for the functioning of a nursing home. 90% of all activities that

can be categorized as either *kaigo* [long-term care] or *kaijo* [caring help] are done by *ryōbo*. The psychological consultant takes care of questions and problems and of public relations matters.[4] The income of these three groups vary and is for all of them slightly higher in *yōgo* than in *tokuyō*. Two-thirds of *ryōbo* in *tokuyō* earn between ¥ 120,000 and ¥ 175,000, the majority of the nurses between ¥ 140,000 to ¥ 250,000, and the consultant usually slightly more. A comparison with the average income of women in the service sector shows that the average income of a *ryōbo* is only 65% of that, while the income of a nurse is still 10% lower than average (Sōmuchō Tōkeikyoku 1990: 95).[5] The number of physicians varies greatly from region to region but is often significantly lower than prescribed by the regulations for nursing homes (Yano Tsuneta Kinenkai 1990: 314).

2.4 Organizing space

The architecture of a nursing home is usually discussed when questions of privacy arise (Miura 1982; Ogasawara 1985; ZSFKK 1986) or the pressure to identify with the other inmates is problematized (Tobin and Lieberman 1976: 165). An analysis of space and its utilization in nursing homes between 1961 and 1975 shows that the living space (rooms of inmates) decreased from 55.9% to 22.2%, in relation to common and administrative space. Concerning the rooms for inmates, the following changes can be observed: While older homes provide rooms for four or more inmates, the homes that were built during the 1970s provide more rooms for either one, two, or three people. In order to provide a minimum of privacy, new homes integrated more and more single rooms. Their average size is 19.8 square meters, whereas rooms for seven people were often not larger than 35 square meters (Ogasawara 1985: 92). Hence, the fact that single-person rooms need more space and require higher costs than multiple-person rooms became one of the main arguments for administrators who opposed the construction of rooms for few people.

The costs and the requirement of space itself, however, were not the only problems the administration of nursing homes saw in single rooms. In their view, group rooms would avoid the possibility of the elderly becoming isolated and introverted, which would in turn disturb the adaptation process, especially in the context of group activities (Hayashi

[4] The last point should not be underestimated considering that in 1987 half of the elderly did not even know that *tokuyō* exist, and a fifth had never heard of *yōgo* (ESKS 1987: 105).

[5] The average income for women in service occupations in 1989 was ¥ 270,000 for companies with more than 30 employees (Sōmuchō Tōkeikyoku 1990: 95).

and Arizuka 1977: 58). The construction of single rooms would enable the inmate to keep a distance from the all-powerful regulations of the institutions and to withdraw from the observation of other inmates and from the control of the staff.

Group rooms, however, may lead to other side effects significantly not discussed by nursing homes' administrators. Dahms (1985: 35) has argued that the architecture of institutions such as prisons, hospitals, schools, or nursing homes "makes the behavior of inmates susceptible" but also enables without utilizing any restrictive measures to continuously "normalize" and discipline the activities of the inmates. Michel Foucault (1976: 260) described this architecture as follows:

> In order to make constant control possible or at least to let inmates fear this constant control, visibility is necessary. Hence, the architecture is an instrument for the transformation of individuals. […] True subjugation appears mechanically from a fictional relationship so that violent measures are unnecessary in order to force the convict to good behavior, the demented to silence, the worker to work, the student to enthusiasm, and the sick to follow orders.

The effects of control are permanent, and architecture achieves this effect by guaranteeing the visibility of its users at all times, by specifying the traffic roads, by prescribing common rooms, and by dictating their usage (Foucault 1976: 280).

Control (*kanri*) in nursing homes appears as a system-immanent necessity. Arguments against single rooms include the danger of not being able to detect illnesses, accidents, or fires until it is too late, in cases where doors are locked during the night. The lack of personnel would show even more painfully. Sliding doors between the rooms of two inmates seem to provide a compromise or at least the possibility to withdraw oneself from the view of another inmate. More than 70% of inmates always keep these doors closed, either out of "fear of the other person who is unknown and whom they might not want to get to know" or the "feeling of being under continuous observation" (Hayashi and Arizuka 1977: 58). Even if roommates cannot observe each other, they are forced to listen to the noises the other party makes, to her or his soliloquies, and cannot help but hear conversations the other might have with visitors.

Rooms for two or more persons bring about a different set of problems. Again privacy seems to be the main concern and many say that they would rather stay in bed than be observed as soon as they get up (Ogasawara 1985: 98). In these rooms, too, architectural conditions confine the personal freedom of inmates. If we agree with Goffman (1973: 48–50) that a certain amount of space is part of the outer signs of self-

determination, this space is confined to one's own bed. In this context, the physical condition of the person concerned is of great importance. The worse the condition, the smaller the chance of being able to find and keep one's own place. Lovers cannot be alone since double rooms are only for married couples. Inmates feel observed and controlled around the clock by other inmates and by the staff. This was drastically expressed by an inmate who said that "one does not even have enough freedom to hang oneself" (*kubitsuru jiyū mo nai*) or by another who said that "one does not even have enough freedom to jump out of the window" (*mado kara tobioriru jiyū mo nai*) (Ogasawara 1985: 89).

Architectural features become perceptible over and over again, every day and every moment. Changing diapers in the presence of other inmates is a routine that new inmates get used to rather slowly and reluctantly. Statements such as "if I become incontinent I would want to die" (*omutsu ni naru made ni shinitai*), or "diapers that change the heart" (*kokoro o kaeru omutsu*) (ZSFKK 1986: 199) illustrate the fear of requiring care concerning elimination. While in the family it could be considered a private matter, in a nursing home it becomes public. In this way, the architectural conditions turn formerly non-public matters into public controllable ones. Regression, which is partly provoked by this process, promotes *dementia senilis*, which has been interpreted as a psychological escape reflex (Nakagawa 1979: 34). Goffman (1973) emphasizes the de-identifying effects of a total institution in the sense of disturbed privacy and the loss of what he calls "identity equipment". Other researchers have found that an activity such as changing diapers might further the gradual identification of all inmates – including those who are still capable of taking care of their physical functions themselves – with aging and decay. This identification pressure – reinforced by the architectural conditions – not only expresses itself through daily confrontations with the aging and decay of other inmates, but also through the continuous concentration of the personnel on care and treatment (Tobin and Lieberman 1976: 163). Ruth Campbell suggested that this is even more true in Japan where a strong acceptance of dependency exists (1984: 89).

Ikuta Masayuki and Fujita Ayako (1986) have tried to identify the problems in regard to the treatment of senile inmates as opposed to those who they classified as "normal" (*seijō-na rōjin*).[6] There are a few interest-

[6] Apart from the fact that the sample of 96 "senile" inmates is rather small, there are a few other problems involved in such a study. First of all, Ikuta and Fujita do not describe the criteria according to which they have categorized the people in the study. Second, a polarized categorization is always problematic since differences are gradual and people shift slowly from one stage to the other.

ing points the authors make based on their data. Inmates classified as "normal" tend to mobilize their opposition and protest against the personnel more often and in a more radical manner than senile inmates do. They ignore orders of the personnel, react negatively toward the personnel, show less willingness to cooperate in general, and in many cases distrust the staff. Their behavior is also found to be much more egoistic than that of senile inmates. Inmates classified as "senile" oppose the personnel to a lesser degree. They rather wander or loaf about, are unable to differentiate their own belongings from those of others, disturb the sleep of other inmates, and sometimes frighten them. Among those classified as "senile", there are more inmates who wish to return to their family. To a similar degree, both groups oppose the regulations of a nursing home by not eating anything or eating only food they like, by refusing to bathe, or by refusing to change their clothes. All traits of opposing behavior are passive and appear in form of refusal of a specific activity or treatment (Ikuta and Fujita 1986: 105–117).

2.5 Managing time

Restrictions pervade the daily timetable of a nursing home, as I will investigate in this paragraph. A day in a nursing home is regimented according to a timetable that not only normalizes their activities and treatment, but also prescribes in which order, at what time, and for how long the personnel is obligated to perform the treatment and at what time the inmates are allowed to perform certain activities. Ideally, all activities of the inmates are organized in this way by the institution. The schedule for inmates is often determined by the convenience of the personnel who have to perform many activities. Furthermore, acoustic signals and announcements over loudspeakers are also common. To signal the start of new activity a short piece of music is played before an announcement is made, such as "Let's get up and start a fresh day!" or "Ah, today was another good day!". If they are not orders, acoustic signals are often permissions for activities, e.g., drinking alcohol, which the elderly would not normally be able to do without asking for permission (Hata 1985: 86).

The acoustic ritualization of activities spares the personnel from having to personally give permission or orders. In this way, the authority that gives the order becomes anonymous, and to a far greater degree limits the inmates' possibility of opposing the order than would be possible if the authority were personalized. Foucault suggests that power is nothing that can be possessed by one group or an individual, but rather a certain interrelation of forces or a name that is given to a complex strategic situation in society (1977: 114). In this model of power, there is no sover-

eign above society. Instead, there are stable constellations of strategies that operate as social hegemonies either in the form of institutions or of implicit dispositions which form self-evident orientation for the self-definition of individuals and their activities. This becomes obvious when we look at a schedule of a nursing home where most of the daily occurring activities are regulated to a great extent by a fixed timetable (see Table 7).

Table 7: **Regulated activities and treatment according to time (%)**

Activity	Special nursing home for old people (*tokubetsu yōgo rōjin hōmu*)	Nursing home for old people (*yōgo rōjin hōmu*)
breakfast	98.9	98.8
lunch	98.9	98.9
dinner	98.1	98.9
bathing	95.5	95.2
excretion care	87.3	30.2
gymnastics	86.3	93.4
going to bed	81.3	91.0
getting up	70.2	93.0
rehabilitation	66.1	12.8
snack	60.7	32.6
club activities	60.1	61.1
washing themselves	57.3	28.1
cleaning	37.5	55.3
other activities	8.7	7.0

Source: ZSFKK (1986: 105, Table 3/22).

Timetables of nursing homes are commonly discussed in regard to dinner time (which many feel is too early), the frequency of bathing (which is said to be too low) and to excretion care (*haisetsu kaijo*). In most nursing homes, dinner is served between 4:30 p.m. and 6 p.m. In about half of the nursing homes, it is served before 5 p.m. Serving dinner at such an early hour has been criticized, but reasons given for this regulation only make evident how the timetable, in relation to other conditions, allow for no other alternatives. First, the gap between the low number of personnel and the relatively high number of inmates makes it impossible to begin dinner at a later time. Second, cleaning up after dinner takes a considerable amount of time, and again, since the number of staff is insufficient, many of those who are meant to care exclusively for inmates perform

other work, e.g., cleaning up after dinner as well (ZSFKK 1986: 165–167). Some homes, however, have found their own solution, such as a buffet that allows more flexible work time for the personnel and enables inmates to choose what and how much they would like to eat. Even improvements like these, however, disguise the diversity of individual needs. Some of the inmates suffer because they cannot eat anything for thirteen hours between 7 p.m. until 8 a.m., while others would in fact rather start at 4 p.m. because they need help with eating and therefore take longer (Ogasawara 1985: 56).

As mentioned above, excretion care is one of the central problems in the treatment and care of the institutionalized elderly and for the personnel. In regard to excretion care, too, the necessity to adapt individual needs to a strict timetable causes great problems and expresses the "dehumanizing" or "depersonalizing" aspects of the institution (Tobin and Lieberman 1976: 4). To adjust their most basic needs to a timetable made by others leads them feel "treated as objects" (*mono toshite atsukau*) (Yoshida 1980: 22), and many agree that the quality of treatment cannot be exclusively measured by the frequency at which diapers are changed.

Bathing is the most time-consuming care activity that involve personnel help, and bathing days are limited according to the number of staff available. According to national norms, inmates of nursing homes must take a bath more than twice a week. However, according to a national survey in 1977, in every third institution, bathing took place only once a week, and in only half of all homes twice a week. In 1982, almost all *tokuyō* inmates took baths twice a week and in 80% of *yōgo* twice to four times a week. In every fifth *yōgo* however, bathing was only possible once a week. Again, the number of "bathing days" does not necessarily inform us about how often inmates took a bath. In homes with four "bathing days", inmates might be allowed to take a bath only twice a week (ZSFKK 1986: 163). Although taking a shower or washing would take less time and could be done with less personnel, inmates do not consider that a welcome solution since bathing is one of their favorite activities (ZSFKK 1986: 164).[7]

The administrative regulations through control, discipline, and therapy as well as through space and time organize life in a nursing home. For both inmates and staff, life in a nursing home appears to be one "without

[7] Taking part in clubs for the elderly or other individual leisure activities are rather rare. Both became part of the programs which aim at the socialization of the nursing homes and are treated extensively in Linhart's *Organisationsformen alter Menschen in Japan* (1983) and Ben-Ari's *Changing Japanese Suburbia: A Study of Two Present-day Localities* (1991: 125–190).

the right to vote" (*senkyoken no nai seikatsu*), as one of the overworked *ryōbo* said (ZSFKK 1986: 200).

2.6 Conclusions

I have described two types of nursing homes, *tokuyō* and *yōgo*, focusing on their organizational structure. Both institutions, although to differing extents, constitute a rather isolated *Lebenswelt* through strict regulations of time and space, which in turn creates an atmosphere that seriously limits the sphere of action of inmates, intrudes on their privacy, and involves other restrictions of their personal freedom. Inmates deal in various ways with these restrictions and develop different strategies of adaptation and resistance, depending on a number of factors, such as their idea of life in a nursing home before their institutionalization, their reasons for entering a nursing home, the degree to which the decision to continue their life in a nursing home is their own, how they felt about their institutionalization when they entered, and their physical and mental constitutions.

It is precisely the question of strategies of adaptation and resistance that divides academic writing on institutions, methods of analysis, and arguments as well as proposals for reform. The first type focuses on the institution itself, its organizational structure, and its problems and explains the effects of institutionalization on inmates. The weakness of this approach lies in its failure to take into account the reasons for institutionalization and the life histories of inmates prior to their institutionalization. As I have shown, despite their heterogeneity, inmates of *tokuyō* and *yōgo* share a number of characteristics that differentiates them from other elderly who need care. These characteristics include specific features of their life histories, of their personalities and their social backgrounds, their material situations, their physical and mental conditions, and their familial situations, all of which make institutionalization in a nursing home more likely than for other elderly who do not share these characteristics.

The second methodological approach, which is historically speaking a newer one and which appeared in reaction to the first one, puts these before-mentioned features into the center of analysis and tends to underestimate institutional elements in the narrow sense such as the regimentation of time, of activities and treatment, and the regimentation of space, which structures the options for interactions among inmates as well as between inmates and staff. A closer look at the organizational structure of nursing homes, however, shows that such institutional elements have a significant influence on the lives of inmates as well. I have tried to utilize both approaches.

Although it is important to take a few considerations into account – differences between inmates and regional differences between institutions and in the availability of community care services – we can draw the following conclusions: First, the probability of entering a *tokuyō* or a *yōgo* in old age is twice as high for women than it is for men and this gender gap increases with age. Second, to live alone or to have no child(ren), partner, friends, or close acquaintances in old age increases the probability of institutionalization in a *yōgo*. Third, a weak physical constitution, an insecure social situation, and especially poor living conditions increase the chances of institutionalization in either of the nursing homes, although the probability of entering a *tokuyō* when in poor physical health is clearly higher than entering a *yōgo*. Fourth, a stay in a hospital over a long period of time, together with the deterioration of physical condition, increases the probability of institutionalization in a *tokuyō*. Last, we have to keep in mind that it is very rare that only one factor leads to institutionalization. Rather, two or more factors have to come together to lead to institutionalization in a *tokuyō* or a *yōgo*.

Since the beginning of the 1980s, no new *yōgo* have been built, but *tokuyō* increased by about 120 a year (see Table 8).

Table 8: **Number of institutions, personnel, and inmates (1965–1988)**

Year	Institutions		Personnel		Inmates	
	yōgo	*tokuyō*	*yōgo*	*tokuyō*	*yōgo*	*tokuyō*
1965	702	27	— *	—	—	—
1970	810	152	10,466	4,197	60,453	11,573
1975	934	539	14,798	18,005	67,848	43,207
1980	944	1,031	18,318	37,037	66,395	79,499
1981	945	1,165	18,511	41,258	65,944	88,361
1982	946	1,311	18,654	46,111	66,110	97,919
1983	945	1,410	18,560	49,461	66,552	105,459
1984	946	1,505	18,694	52,766	66,707	111,908
1985	944	1,619	18,791	57,262	66,452	118,959
1986	944	1,731	18,686	61,110	66,136	126,332
1987	945	1,855	18,788	65,398	65,826	134,461
1988	945	1,995	18,812	71,248	65,480	143,496

Note: * Up to 1969, neither personnel nor inmates were included in the surveys.
Source: ESKS (1987: 348); KARGL (1987: 94, 375); own calculations based on SŌMUCHŌ TŌKEIKYOKU (1971–1990).

Existing institutions were not extended and the elderly reacted in the following way. Those elderly who had financial resources at their disposal and who decided to enter an institution despite good physical condition, tended to choose a privately-run, more expensive but less restrictive, nursing home rather than a public *yōgo*.

Despite the vehement criticism of the *tokuyō*, which allow hardly any privacy due to their strict regulation of space and time, there is an increasing demand for institutions for the elderly with quasi-medical services which cannot be provided by the family.

3. "Community Care" in Japan

3.1 Preliminary remarks

Although Miura Fumio (1982: 208) claimed in 1982 that the institutions of social welfare had come into being according to social needs and stated optimistically that they would change according to their social function and role, it would be more appropriate to rephrase his "social needs" as "financial considerations of the Japanese government". Only in institutions does the state bear the full cost of caring for dependent adults. From the point of view of public expenditure, institutions are by far the most expensive form of care. These financial considerations ironically concur with two other observations which seem to point in the same direction: First, there is a common wish among Japanese elderly to enjoy old age in their own homes in familiar surroundings and with their families (*rōgo o wagaya de*). Second, they are supported by the criticism of the existing nursing homes as described above.

I will base the following description and critique of the Japanese community care system for the elderly on the assumption that care or nursing is not just one of peripheral phenomena of the social order, but rather a "central crossroad of capital and gender" as defined by H. Graham (1983: 30).

3.2 The socialization of social welfare institutions for the elderly and "community care"

Shisetsu no shakaika [socialization of institutions] or *shisetsu shogū no chiiki-ka* [localization of institutional care] stand for a social policy that had been propagated and slowly taken up by the Japanese administration during the mid-1980s. One of their main foci was smaller collective units, e.g., regions, and the inward-orientation of these units. Within the context of

an explicit de-institutionalization of old age, this liberates the state to a considerable extent from its welfare responsibilities and leaves it to smaller collective units to feel solidarity with those in need, i.e., the indigent elderly. The Japanese state took up this policy at a time when per capita expenses for social security were significantly lower than those of other post-industrial countries.[8] Although in Japan expenses for social security rose from ¥ 288,000 to ¥ 333,000 between the years 1980–1982 and 1985–1987, the per capita expenses equaled only one-third of the Swedish expenses and about half of the French expenses. Even the per capita social security expenses of the United States, Italy, and Great Britain during 1985–1987 with 59%, 29%, and 17%, respectively, were higher than those of Japan (YANO TSUNETA KINENKAI 1990: 325).

Another focus was the restabilization of the social status of women and their place at home, since caring for the elderly (and others in need), whether it is paid or unpaid, whether it takes place inside the boundaries of an institution or in a private home, whether it is done in private or in public, is first of all women's work. Most of the nurses, *ryōbo*, or home-helpers (*hōmu herupā*) are women. Women work in day-care centers. Women organize themselves in volunteer groups and prepare and deliver food. Nursing homes, hospitals, and private homes are cleaned by women. Two-thirds of the personnel of nursing homes are women. What J. FINCH and D. GROVES (1983: 494) concluded in regard to the United States is also true for Japan: "In practice community care equals care by the family, and in practice care by the family equals care by women".

In 1982, the International Association of Gerontology (IAG) – a worldwide organization of scientists who study old age – invited gerontologists from all over the world to develop and formulate guidelines for social policy for the elderly. Among other important recommendations, the IAG insisted that besides rehabilitation centers, day-care hospitals, day-care centers, nursing homes, and institutions for long-term care, comprehensible systems must be implemented to enable the integration of medical and social services as well as of the family and other people and organizations. In this context it should be brought to the attention of decision-makers that traditionally, caregivers are women. On the basis of the changes in the status of women in society, it is necessary to prepare women *and* men for the tasks of caregiving and nursing (IAG 1982: 82). What had been suggested by the IAG was labeled "community care" and taken up by Japanese administrators as well. Gillian PASCALL (1986: 86) comments as follows:

[8] As calculated from the GNP, expenses for social security in 1985/1987 were 8% lower than during the years 1980–1982.

> An ideology that romanticizes caring for the elderly and handicapped seems more improbable than one that romanticizes motherhood. However, the idea of "community care", while less developed than romanticized notions of motherhood, fulfills a very similar function in legitimating minimal state activity in the private sphere of home and family. It also disguises minimal men's activity. […] The notion of "community care" belongs to social policy documents rather than to women. It does not have the widespread allegiance of "maternal deprivation"; nor is it in any sense "needed" to persuade women to look after dependent relatives and friends. Its use has been in justifying low government spending on the elderly and handicapped, and in disguising policies whose real effects are to burden and isolate individuals. […] An expression which appears warmly to encompass everyone disguises the fact that, whether as paid workers or as relatives, it is generally women who do the "caring".

Despite the fact that the Japanese state never really developed a system of welfare institutions for the elderly that could be compared in both quantity and quality to those of Germany or other Western European nations, it took over the rhetoric of "community care" and further radicalized the situation for those who were in need of care as well as for non-professional caregivers in families. It thus restabilized the view that there is no alternative to either total institutions or women caring themselves.

> It does seem necessary to explain the widespread failure to "share" care, to support women who do caring work, to found any real middle way between the total institution and the woman alone. A conspiratorial interpretation would suggest that such policies are "meant" to keep women in their place. But the idea of the state as a coherent entity with a coherent policy on women's place is not very compelling. I would argue that policies for "sharing" care involve a threat to traditional notions of the family and woman's role, and that the fear of undermining women's commitment to caring work lies near the surface. The quantity and cost of such work, especially in an era of increasing dependency, must reinforce wariness about drawing it into public expenditure. Thus, the interest of government departments in maintaining traditional family patterns is a pervasive underlying element, if it does not amount to a policy for women (Pascall 1986: 96).

Community care programs should on the one hand dissolve the polarity formed by the state and the family, and on the other hand develop a social

network that integrates all members of a regional community in one way or another. Consequently, information pamphlets of local governments of rural municipalities and prefectures appeal to the solidarity of the community, thus attempting to mobilize a solidarity that restabilizes society as a whole, since "the more people work themselves up to a rage in regard to conflicts that developed out of the community, the less they will question the basic institutions of this society" (Sennett 1983: 390). A look at the information pamphlets on the policies of a city or prefecture can further illustrate how appeals to the solidarity of smaller collectives in society function. Two examples, of which one is taken from the "Charter of Kanazawa's citizens" (*Kanazawa shimin kenshō*) and the other from the "Charter of Yashiro's citizens" (*Yashiro jūmin kenshō*), make the following appeals:

> We who love Kanazawa, […] let's hold out our hands to each other in order to build our city" (Kanazawa-shi Fukushi-bu 1987: 5).
>
> We, citizens of Yashiro, let's build families full of cheerfulness and warmth. In mutual agreement and friendship we shall do our best to create a region full of love and order with the youth who carries the future on their shoulders. We shall support their dreams (Yashiro-chō 1974: 1).

The pamphlet of Yashiro even communicates the hope that "social solidarity" will increase the sense of morals (*dōtokushin*) (Yashiro-chō 1974: 18). A myriad of other examples could be quoted which illuminate the rhetoric of "community care" for the elderly by referring in specifically appealing ways to the family, regional solidarity, and the education of the region's youth. In regard to the education of youth, the then Prime Minister Kaifu Toshiki stated in a speech given in parliament on March 2, 1990:

> The stagnating birth rate poses a lot of questions concerning the future of this country. Focusing on tomorrow, we must strengthen in our youth the wish to have children (Arioka 1990: 51).

Pointing in the same direction, the president of the Japan Federation of Employers' Associations, Suzuki Eiji, went a step further and suggested that men should cut their time playing golf or mahjong and instead spend more time with their wives (Arioka 1990: 51). These thoughts are commonly underpinned by forecasts on the number of elderly, which for 2015 will reach about a quarter of the total population (Sōmuchō Tōkeikyoku 1989: 25). Hence, the view that Japan's youth should procreate at a higher rate in order to balance the population pyramid is widely shared among policy-makers (Eijingu 1989: 2). Women themselves, however, have differ-

ent views of procreation. In a 1990 *Mainichi Shinbun* survey, 80% of 5,000 women said that they consider child bearing a private matter and that they do not see a reason to change their opinion in response to the government's policy (Arioka 1990: 52).

While "institutionalized social welfare" had dominated during the 1970s, Japan's social policy of the 1980s shifted its priority toward community care or, more precisely, toward "welfare at home" (*zaitaku fukushi*). The ambivalence of this development becomes clear when considering that already at the beginning of the 1980s, the building of *yōgo* stagnated, while community care programs were not yet fully organized but only propagated as a cheaper solution. From a strategic point of view, this development seems to complement policies taken up in another area of social welfare, namely welfare for the disabled. Until 1984, the budget for the welfare of the disabled had been increasing every year. In 1985, however, the budget was abruptly cut based on the suggestions of the Commission on Administrative Reform to the Prime Minister. These suggestions included the following paragraph:

> […] [W]elfare measures must be reduced to the minimum level, by retaining only those measures that are truly indispensable for the welfare of the population, while fully safeguarding the private sector's free activities in the field of welfare services (Nishida 1991: 139).

The cuts concerned first of all institutions such as rehabilitation centers and other institutions for stationary care. The turn concerning welfare institutions for the disabled complements the propagation of community care programs for the elderly: away from institutions and toward care services that can be performed at home. Despite extensions of community care programs and facilities, the total budget was cut considerably. Instead of setting new priorities for social welfare for the disabled, the government sought to cut the budget and reorganize it to the advantage of those areas which support "independence and self-help" (Nishida 1991: 143). Furthermore, it slashed government outlays for the welfare of the disabled, mainly those for facilities and institutions, while forcing local governments to bear greater financial burdens for ensuing their welfare (Nishida 1991: 150).

Private initiatives were welcomed in the welfare for the elderly sector as well. Many of them met the criteria for relatively open institutions and offered quite good services. However, their geographic distribution was uneven, with a good supply in urban areas and a poor supply in rural areas where they are needed most because of the unbalanced dissemination of the elderly (see Lützeler (1997) for demographic details). Further-

more, they failed to provide services at a price that was affordable for many elderly and very often only accepted elderly in good physical condition (GETREUER-KARGL 1990b: 157). Organizations such as Kōseikai in Tōkyō, which built apartments especially equipped for elderly, received ¥ 10 million at first and then ¥ 10,000 to ¥ 20,000 per month. Similar organizations required the entire inheritance in case the person concerned dies (KIM 1991: 14).[9] In a survey on behalf of the then Prime Minister Takeshita Noboru, more than half of the respondents said that the high costs of private institutions would be unfortunate, while only a fifth said that they met their needs (NAIKAKU SŌRI DAIJIN KANBŌ KŌHŌSHITSU 1987: 150–151). That – as late as in 1987 – two-thirds of the respondents in another survey held in Saitama Prefecture did not even know what "community care" was must be taken as a further indicator for the insufficiency of the system at that time (NAIKAKU SŌRI DAIJIN KANBŌ KŌHŌSHITSU 1987: 212).

This policy was not specifically Japanese. The Italian movement *Psychiatria Democrazia*, which was organized in 1973, was probably the first organization that called for the opening of total institutions (there, psychiatric wards) and served as a model for many other similar movements in other European countries with similar institutions (METZGER 1980: 825). The governments of Great Britain and the United States also propagated community care at a time when social welfare networks were not sufficiently developed (SCULL 1988: 80). The same is true for former West Germany where the construction of new nursing homes slowed down considerably after the implementation of new laws concerning social welfare for the elderly which, on the one hand, humanized the existing institutions, but, on the other hand, almost stopped the creation of new beds (HUMMEL 1982: 45). Swiss gerontologists developed a model for the *nouvelle geriatrie* and demanded that geriatric hospitals must be "open to the outside world, a part of intensive collaboration of physicians, a network for care at home, other social and medical organizations, and prevention policies" (GILLIAND and FRAGNIÈRE 1988: 25–26).

[9] On a similar program in the city of Musashino (suburban Tōkyō), see LINHART (1995: 36–37).

3.3 Socialization policies and programs

Ambulant care services that were offered at *tokuyō* and *yōgo* were meant to open up these institutions. Other services were provided for use at home to postpone institutionalization as long as possible. Since 1979, day services (*dē sābisu*) were offered in day-care centers which were usually built as extensions of *tokuyō* or *yōgo*. So-called short stays (*shōto sutei*) at nursing homes were possible for over-64-year-olds who needed care for up to seven days and had to be applied for at the local bureau for social welfare. Costs for a short stay varied depending on whether the person was put there for "private" (more expensive) or "social" reasons. Social reasons included illness of the caregiver, births, weddings, funerals, accidents, and responsibilities at school. All other reasons, including the need for the caregiver to rest, were considered private (KKSFK 1988: 25). However, in 1989 there were still only 4,274 beds available for this service. Short-stay services included bathing, eating, physical training, or training for caregivers on how to take care of elderly at home. In 1987, there were 57 *tokuyō* that offered training on caring for the senile elderly. The training is done by *ryōbo* (Kōseishō 1988: 290).

Such services as cleaning of laundry, food catering, and bathing were also provided at home (Getreuer-Kargl 1990b: 57; Oberländer 1997: 96–97). They were, however, not available on call but only on certain days at certain times. For example, municipal *tokuyō* and *yōgo* in the city of Itami offered food catering only on Tuesdays and bathing only on Fridays between one and three o'clock (Itami-shi 1986: 9). Apart from the inconvenience of limited availability, day-care centers also presupposed that there was a person available to take the elderly from their home to the institution and back. It goes without saying that this was considered the responsibility of female caregivers and thus relieved them only temporarily and partially.

Short-stay services presented quite a few problems to both the institutions and the people at home involved. Table 9 shows which were the main problems when formerly relatively closed institutions such as *tokuyō* and *yōgo* tried to establish themselves as day-care centers. The most pressing problems were the lack of staff, of financial resources, and of material equipment. These insufficiencies are seen most clearly in the context of bathing or rehabilitation training but also when means of transportation were needed.

Table 9: **Problems concerning the socialization of nursing homes (%)**

Nature of problems	Special nursing home for old people (*tokubetsu yōgo rōjin hōmu*)	Nursing home for old people (*yōgo rōjin hōmu*)
a number of problems	25.0	45.0
lack of personnel	24.3	40.0
overwork	8.1	10.0
lack of financial resources	29.7	6.0
lack of material equipment	10.8	24.0
accidents	2.7	–
traffic/transport	–	6.0
training of volunteers	8.1	–
lack of professionals	8.1	–
other	8.2	14.0

Source: Miura (1982: 257, Tab. 3/25).

The policies for the socialization of nursing homes as described above did not have a significant effect on those who were already institutionalized, but they bore the potential to postpone the institutionalization of other elderly.

Since 1971, homehelpers could be requested if the elderly person at home was physically or mentally disabled or the caregiver did not feel able to continue at home alone. The maximum amount a homehelper could be serviced was two to three hours on not more than two days of a week between 9 a.m. and 5 p.m. (KKSFK 1988: 21). Until 1982, only households with low incomes were qualified to apply. Since then, such services could be requested for a rather low fee of about ¥ 650 per hour (Kōseishō 1990: 237). However, there were far too few homehelpers available (Hosaka 1988: 56). In 1987 there were 17,486 homehelpers for 60,237 households with elderly and 22,539 other households that were qualified to apply for them (Sōmuchō Tōkeikyoku 1989: 591). In 1989, their number had doubled and reached 31,405 (Kōseishō 1990: 236). Bedridden elderly could lease special beds and mattresses, bath tubs, air cushions against bedsoreness, urinals, emergency telephones, and other expedients for daily use.

Social Welfare Centers for the Elderly (*rōjin fukushi sentā*) had three functions. They informed the elderly of the region on all sorts of questions, advised them on health issues, and offered facilities for recreation. In 1987, there were 1,884 of these centers in operation (Kōseishō 1988: 236).

Volunteer organizations mainly consisting of middle-aged women offered similar services but had difficulty recruiting new members. In

1988, 3.39 million people were active in various ways in volunteer organizations for the elderly. The most well known were the "Visitors of Friendship and Love", the "Group to Create a Better Life for the Aged", as well as a group called "Tearing Down the Wall between Able-bodied People and the Disabled" (Nakamura 1991: 14).

4. Concluding Remarks

In this paper I have attempted to describe the turn in social policies for the elderly in Japan that took form during the 1980s prior to the "Gold Plan" and the introduction of the long-term care insurance. The announcement of the Commission on Administrative Reform in 1983 that national social policies were to be reduced to a minimum and at the same time private initiatives and activities were to be supported was ironically met by the severe criticism of *tokuyō* and *yōgo* articulated at academic and administrative meetings and in discussions among the personnel and inmates of the existing institutions for the elderly as described in the first part of this article. The rapidly rising costs for the care of the elderly and the rising number and proportion of old people brought about a new orientation of the bureaucracy in dealing with financial and social questions. This orientation turned into the aggressive revival of the role of the family in regard to social policy for the elderly.

Public care institutions for the elderly, as the *tokuyō* and *yōgo* depicted in this article, were thus increasingly criticized. This critique was superficially co-opted by political decision-makers, but did not for another ten years lead to substantial reforms of the institutions in matters that went beyond superficial rearrangements. Improvements by way of government interventions were of a gradual nature and could only be recognized on the level of organization. Instead, the criticism served as a powerful rhetorical tool for encouraging community care programs which were cheaper for the state, and put the financial burden on smaller political units, such as prefectures and municipalities, as well as on the families who pay for these services. The co-option of the above-mentioned critique allowed decision-makers to demonstrate moral superiority and thus enabled them to organize their own rejection of the old institutions in contrast to the enthusiasm with which they propagated the new system.

The propagated community care programs did hardly take any form at all, although there were significant regional differences. Interaction between institutions and communities barely took place and certainly had no influence whatsoever on the isolated *Lebenswelt* of the inmates.

The half-hearted and partial realization of these programs did not go hand in hand with the reform of existing institutions. Especially in regard to the isolating character of *tokuyō* and *yōgo* there were hardly any improvements for the institutionalized elderly.

Another alarming feature of the developments during the 1980s and their consequences is the fact that most of the caregivers were women. Through community care programs or rather the lack of their functioning, women's status as caring, nursing, and in any case emotionally, privately, and socially active persons was reinforced. This can be seen as a side effect of the retreat of the Japanese state from its responsibility to take care of its citizens, therefore encouraging private initiatives and activities.

The smaller political entities – prefectures and municipalities – reacted with a massive propagation of a common feeling of solidarity for the welfare of the community. For the families, this development meant that women were more or less left alone with the problems and difficulties that caring for elderly people involved.

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Bioethical Public Policy and the Making of the 1997 Japanese Long-Term Care Insurance Law

Kimura Rihito

1. Introduction

An epoch-making new law, *Kaigo hoken-hō* [Long-Term Care Insurance Law], passed the Japanese Diet on December 9, 1997. The law came into effect and was fully implemented on April 1, 2000. Some media referred to this new law as *kōteki* [i.e., public] *kaigo hoken*, drawing on the public and social elements of the new long-term care system, in which around 50% of the expenses are "publicly funded" by central and local governments.[1] In international publications, *Kaigo hoken-hō* is usually translated as "Long-Term Care Insurance Law", emphasizing the concern for public care and replacing the traditional family-supported care system. Tremendous efforts were made by Japanese citizens as well as by the government to prepare this new system as it became the new foundation for institutional and functional care for the elderly.

Beginning in the early 1990s, extensive public discussions and wide coverage in the media took place calling for a need to address care requirements of the elderly as traditional family-supported care slowly became obsolete and difficult to maintain due to an increasing number of nuclear families. The new law was a response to the social re-evaluation reflecting the reality of an aging society in Japan. This realization drew attention to the necessity of an integrated system of welfare policy for the elderly, and an official recommendation was proposed for the establishment of a publicly funded long-term care insurance system by the Rōjin Hoken Fukushi Shingikai (Senior Citizens' Health and Welfare Council) on April 23, 1996.

The Ministry of Health and Welfare, the government body responsible for formulating the new law, worked hard to stress the positive elements and introduced the law on November 29, 1996. However, many individuals, from welfare professionals to local governments officials, continued

[1] See *Kaigo hoken-hō*, Articles 121–128. The publicly funded share is split; 25% is paid by the central government, and 12.5% is paid each by the prefectural governments and the municipalities. According to Tochimoto (1997: 126–127), this sharing system is different from the one adopted in Germany.

to be skeptical about the implementation of the law and future plans for the care of elderly people under this new system (*Yomiuri Shinbun* 13.12.1997: 29).

This paper will analyze the background leading up to the enactment of *Kaigo hoken-hō*. It will raise some critical aspects of the law, examining thereby the socio-cultural context of Japanese society from a bioethical point of view. Moreover, it will suggest that there were several positive consequences that emerged during the process of public policy-making leading to the enactment of this law.[2]

2. SHIFTS IN WELFARE POLICY LEADING TO *KAIGO HOKEN-HŌ*

During the 1990s, there were ongoing debates to establish some integrated system to provide care for the elderly in Japan. The White Paper issued by the Ministry of Health and Welfare (KŌSEISHŌ 1997a: 171–191) indicated that the need for proper elderly care is constantly regarded as one of the greatest tasks of an "aging society" (*kōreika shakai*) as Japan enters into the 21st century.

The reasons for proposing the *Kaigo hoken-hō* were as follows: First, with a rapid increase in the number of elderly, the number of people who will need care will also naturally increase. As people live longer, the level of care required will be more intense and long-term. Second, the change in the "traditional" role of the family in caring for the elderly has made it now more difficult to support the elderly than before. The general public is aware of this insecurity and expresses its concern about being able to meet the care requirements of the elderly. Third, care of the elderly could mean an excessive financial and physical burden for many families. Fourth, close to 80% of the Japanese people surveyed want to see the establishment of a new unified system of assisted care for the elderly. Many complained that limited access in the traditional system made it difficult to choose an individual style of service and care (KŌSEISHŌ 1997b).

The aim of the new law can be summarized as follows: First, regardless of family situation and income level, elderly people should be entitled to utilize home care services and institutional services according to their own needs and wishes. In addition, the independence of the elderly should be fully supported by this new system. Second, the two existing

[2] This paper was originally written based on the presentation made by the author at a conference hosted by the German Institute for Japanese Studies in 1997. Minor changes were made due to the enforcement of *Kaigo hoken-hō* in April 1, 2000.

systems – the elderly welfare system and the national medical insurance system for the elderly – should be integrated in the new law in order to create a unified care system for all elderly people above the age of 64. Third, the law should encourage the private sector to play an active role as a service provider. Traditionally, these services were supported by the public and semi-public sectors. Fourth, the idea of "care management", a new notion in Japanese health care, should be introduced in order to provide a variety of services required by the elderly (IHARA and AMAIKE 1997: 2–3).

It could be said that *Kaigo hoken-hō* introduced shifts in the traditional concepts of social welfare that can be viewed positively, but with some notable reservations. The following phrases indicate some symbolic changes in this new system of care for the elderly.

"From status to contract"

This phrase was originally coined by a legal historian named Sir Henry S. MAINE (1888: 165). He used this phrase to explain changes in the legal status of individuals in society from ancient to modern times through social trends. Indeed, in this sense, the *Kaigo hoken* Law denotes an actual shift of the individual elderly from "status to contract".

The former *Rōjin fukushi-hō* [Law for the Welfare of the Elderly], promulgated in 1963, provided "administrative measures" (*sochi*) for the care of the elderly. These measures made arrangements for various welfare services such as homehelp services, day-care services, and short-stay services for the elderly. It included the provision or rental of special equipment such as wheelchairs, canes, or hearing aides for daily use. *Sochi* was also used to admit elderly persons into institutions. S*ochi* was mainly determined by local authorities. Legally as well as administratively, the request for services or institutionalization was not regarded as a claim or right of an elderly person (see OGASAWARA *et al.* 1997: 52–53). In order to receive the benefits of *sochi*, personal information regarding family relations, income, and other private data had to be disclosed. The elderly who required *sochi* were treated as "objects" that had to be taken care of by the social welfare system. In *Rōjin fukushi-hō*, tax monies were used to provide for disadvantaged people. However, people were reluctant to obtain this "status" which was accompanied by the stigma of being cared for by a policy intended for the poor.[3] The new *Kaigo hoken-hō* abolished this

[3] See *Rōjin fukushi-hō* [Law for the Welfare of the Elderly], Chapter II (*Fukushi no sochi*), Article 10, Section 3 (11.07.1963). A health and welfare activist and member of the House of Representatives, Ms. Ishige Eiko, points out the negative notion of *sochi* and proposes a "Citizen-Type of Welfare" as a new

notion of *sochi*. By establishing a mutual support system that includes compulsory payment from those aged 40 years or older, a shift from state obligation in a particular individual category (*status*) and as an administrative object to more individual care (*contract*) can be seen in this law.

"From family to society"

For many years, care and social assistance provided by the Japanese welfare system had negative connotations and faced difficulties because of the traditional emphasis on family care. Those who received welfare services were categorized as poor and lacking family support. Thus, people were reluctant to have "recipient status" and become "objects" of socialized welfare service. Until recently, families living in cities and – even still today – in rural areas were responsible for the care of their elderly members (KIMURA 1988: 175–186). It was shameful for many elderly to receive public welfare services, particularly if they lived alone and were separated from their family.

A series of feature articles on elderly life published in the *Asahi Shinbun* (16.12.1997: 26; 17.12.1997: 34) reported strong ethical and moral sentiments of the elderly against utilizing social welfare services. Those interviewed expressed the more traditional notion that "parents should be cared for by their children's family members, particularly by the wife of the eldest married son". However, in reality, changes in the composition of the nuclear family and the move to urban areas have made it difficult, both in urban and rural communities, to care for elderly family members. Moreover, demographic data reveal that there has been a rapid increase not only in the number of elderly parents but also in the number of elderly children.

The new law stresses the idea of insurance as a mutual assistance framework. It attempts to remove the stigma and reluctance of being a care recipient. All citizens beyond the age of 40 are required to pay premiums from their income. This premium funds a part of the cost of care that may be required after an individual reaches 65 years of age. This is a practical solution to deal with a possible increase in the number of elderly citizens who may not be cared for by his or her family.

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model to provide welfare services by conscious citizen's mutual support and participation (ISHIGE 1997: 256–278). By contrast, even though *sochi* has quite a negative connotation and some bureaucratic, administrative implications, AIZAWA (1996: 79) holds that there have been some cases where the contents of *sochi* services had been gradually forced to change due to claims made by local citizens.

According to the "Report on the Survey Concerning Aging" issued by the Prime Minister's Office in January 1998, 38% of middle-aged people (40–59 years of age), and 46% of the elderly (beyond 60 years) responded that if a family member were to become bedridden, he or she should be cared for by the family. By contrast, 47% of middle-aged people and 31% of the elderly expressed the need to utilize public welfare services, and in some cases institutions, to care for a bedridden family member. In the case of care for healthy elderly, only 9% of middle-aged people and 10% of the elderly responded that he or she needed to be institutionalized (Sōmuchō Chōkan Kanbō Kōrei Shakai Taisakushitsu 1998). This suggested a growing interest in utilizing public welfare services within a home environment rather than institutionalization.

The new law recognizes the changes in the traditional concept of family by shifting the responsibility of elderly care from *"family to society"*. The new insurance system has transformed the negative notion of welfare service. Government surveys suggest that the attitude of the public towards receiving welfare services is already shifting toward a more positive direction.

"From state to individual"

According to the *Kaigo hoken-hō*, each individual will be supported in his or her care by community-based local agencies. The emphasis is on each individual to utilize community-based care services after consulting a care manager, and to prevent the government intervening in care services by requiring the application of *sochi*, as mentioned above. Moreover, the law encourages the use of private sector organizations in the community, usually business-oriented welfare services. This new option provides many Japanese citizens with the opportunity to employ services that were previously too expensive.

The shift from welfare as a state obligation to a more individual choice of care providers can be viewed as a positive development. However, critics like Sakai Sonoko (1997), a social worker at one of the Elderly Home-Care Support Centers in Tōkyō, worries about the downgrading of elderly care as a result of the new insurance law system. While this law signifies a dramatic change in Japanese welfare legislation, there is also the possibility of a decrease in the quality of care for the elderly due to both a lack of human resources for care services and the difficulty of determining a standard criteria to evaluate the level of care requirements.

"From bureaucrats to the people"

Traditionally, bureaucrats in Japan have been viewed as paternalistic and unsympathetic to individual citizens. The official statement issued by the Ministry of Health and Welfare read that as soon as people understand the new long-term care system of a mutually assisted insurance mechanism that is supported by local governments and communities, elderly citizens will eagerly claim their rights and utilize this system in a positive way. However, in order for this objective to be realized, there must be a change in the mentality and attitudes of welfare bureaucrats as well as of people in the local community. They must become more compassionate and less paternalistic as this law shifts the concept from receiving welfare to the people's right to utilize care services.

"From tax to cost-sharing insurance"

In order to share the cost of caring for the elderly the new law transfers the expenditure from taxes to insurance. Thus, the major problem people will encounter with this new system is trying to meet costs that are expected to rise in the future. Although people will have to pay premiums for this insurance, they may not be able to tap into this service unless certain criteria are met. Even individuals classified in the standard-care category after an evaluation process have to pay 10% of the total cost as a user fee. This means that for this new insurance system, citizens must now pay an insurance fee and a user fee in addition to their taxes.

Cost-sharing for the benefit of elderly care is generally viewed as a good idea. However, due to the different level of services available based on different criteria in each local community, there is the fear that *hoken atte mo kaigo nashi*, meaning "an insurance system exists but no services are available". Special efforts must be made to ensure that cost-sharing insurance will not disadvantage others.

3. A Bioethical Approach to the Long-Term Care Insurance Law

Bioethics is an interdisciplinary subject related to issues of value judgments regarding life and death in the natural, social, and human environment (KIMURA 1986: 248–249). The field of bioethics interweaves traditional disciplines such as biomedical sciences, ethics, law, philosophy, religion, and public policy. Grassroots movements in the 1960s dedicated to civil rights, women's liberation, consumer protection, patient's dignity, and other human rights issues were the creative forces behind the forma-

tion of bioethical ideas. It is important to examine *Kaigo hoken-hō* within this socio-cultural context.

The following bioethical implications can be analyzed in order to study the new law: (1) the public policy perspective; (2) the human rights perspective; (3) the equality perspective; and (4) the "do-no-harm" perspective (KIMURA 1987).

3.1 Public policy

The public policy perspective is often used to analyze the bioethical aspects in making new laws regarding such issues as organ transplants, the definition of brain death, and guidelines for genetic testing. It emphasizes the importance of law-making that includes public debate rather than traditional top-down decision-making procedures of bureaucrats and politicians. How did *Kaigo hoken-hō* utilize this new approach?

From the time *Kaigo hoken-hō* was proposed in the House of Representatives (139th Session) on November 29, 1996, there was considerable discussion in the general public on the long-term implications of this new policy. One criticism was that the law focused too heavily on *elderly* persons who need care, but not enough on someone who might become disabled or require care services at a younger age. According to the law, individuals are required to pay a compulsory premium from the age of 40. However, in principle, benefits can only be provided after undergoing a qualifying evaluation by an expert and after reaching the age of 65. Younger individuals, who become ill or disabled, may receive benefits only in exceptional cases. Therefore, this law could be viewed as unjust from the perspective of the younger generation.

During the year 1997, the public debate focused on the most basic element of the system, i.e., whether benefits should be funded by the insurance or taxation systems. If the principle of mutual support is fundamentally important, it would appear that a taxation system is better suited because it is fairer. However, without much exchange of opinion with the public, policy-makers adopted the insurance system as the better choice. The main reason behind this outcome was that political parties wanted to refrain from raising taxes in face of general elections.

While attempts were made by the public to become involved in the policy-making of the new system, the Long-Term Care Insurance Law became a victim of political compromise. And thus, a great opportunity to reconsider fundamental notions of public policy with regard to mutual care for needy people was lost. The government insisted that persons covered under the Welfare Law for the Disabled would not be integrated into the Long-Term Care Insurance Law. This was a disappointing deci-

sion made by the government as care should be provided as a commitment of the community regardless of age and generation. It should have been based on the needs of disabled people and their families, and not by what is considered convenient for the government.

3.2 Human rights

The human rights perspective can be used to analyze legislation to determine if a certain law will have positive or negative implications regarding the dignity and rights of the people. In the Long-Term Care Insurance Law, key expressions such as "support", "care", "welfare", "choice", "service", "mutual support", "cost-sharing", and "independence" are repeated throughout the text. But there are no words that indicate the "rights" of the person in need of services. This law still bears the sense of obligation and paternalistic welfare-state attitude traditionally observed in Japanese bureaucracies. If it is important to support the independence of the elderly, as it is specifically stated in this law, policy-makers must first recognize the entitlement of elderly persons to have access to various services as an extension of their constitutional rights.

3.3 Equality

The equality component is essential to judge how the law applies to each individual. The possibility of inequality in services is a reality in *Kaigo hoken-hō* because of differences in the circumstance of local communities. For example, a care manager of a particular community may recommend plans for specific elderly care, but home care or institutional care may not be available due to a lack of human resources. This unequal and unethical situation may result in the creation of a new type of social welfare recipient; one which migrates from one local community to another in search of better services.

Another problem relating to equality is the gender issue. Japan is traditionally a strong male-oriented society where an estimated 85% of family caregivers are still women. Ironically, some Japanese feminist groups rejected the idea of cash payment for full-time care provided by family members at home. They felt that such a cash payment could work against women, confining them to the home and depriving them of their social, business, and professional opportunities.[4] Moreover, the final de-

[4] See KŌSEISHŌ (1997c), no. 2, chapter 4: *Kazoku kaigo ni tsuite, (2) genkin kyūfu ni shōkyokuteki-na iken* [On Family Care, (2) Negative Opinions Toward Cash Payment for the Care Services]. OKIFUJI (1997: 61, 210) argues that one of the

cision not to provide cash payment to full-time family caregivers also deprives some family members of receiving full-time care.

The equality principle is clearly in violation of this law. Equal care should be available to all who require services. In addition, if in reality women continue to be the core caregivers in the household, financial assistance should have been provided in order to address the inequality of gender roles.

3.4 "Do-No-Harm"

"Do-No-Harm" is also regarded as one of the criteria in making value judgments on issues related to bioethics. "Do-No-Harm" is a fundamental principle for health care professionals to serve the needs of the client. However, one of the main concerns of this law is that those who have paid insurance premiums may not necessarily receive care services later in life. Ordinarily, insurance means that those who pay premiums to protect them against future setbacks will receive benefits when he or she requires them in the case of sickness, injury, or unemployment. In this definition, the new law is not an insurance policy. This law takes advantage of healthy citizens who expect to receive proper services when they require them. Citizens do not realize that the Long-Term Care Insurance Law does not automatically guarantee them care and it imposes a barrier of qualifying standards. It is not even clear whether an appeal for care can be filed within a particular time limit. In fact, the insurance designed to cover their future needs actually harms prospective recipients with uncertainty.

An additional problem in caring for the elderly can be seen in the traditional arrangement where many hospitals admit elderly patients who encounter difficulties in living alone. This hospitalization for the elderly often occurs due to a lack of vacancies in appropriate elderly institutions and is called "social hospitalization" (*shakaiteki nyūin*). Hospitalization, in this case, is not meant to cure a disease, but rather to care for an elderly patient in an institutional setting. This leads to a great drainage of medical resources (Kōseishō 1997a: 175). With the implementation of the Long-Term Care Insurance Law, these patients will eventually have to be discharged. This will cause tremendous problems not only to elderly patients, but also to their families. Therefore, this new system can actually "harm" the intended beneficiaries without providing for a proper structure to prepare for the care of these elderly.

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negative impacts of the delay in long-term care policy in Japan is the problem that men do not recognize care issues as men's issues. Today, in 85% of all cases women provide "family care".

4. The *Kaigo hoken-hō* in the Public Policy Process: The Citizen's Positive Role in Making Proposals

The bioethical public policy perspective mentioned above played a vital part in the making of the Long-Term Care Insurance Law. There was a high degree of open debate and public policy-making with regard to this law. The debate on *Kaigo hoken-hō* caught the attention of the public because it was believed to have implications in political, economic, social, and family settings as Japan entered the 21st century. This section will examine how the activities of civic action groups contributed to the process of making this law.

The media was an active participant in the debate of *Kaigo hoken-hō*. By and large, coverage of topics related to elderly citizens was covered in the "Social" or "Family and Women" feature sections. However, articles written to support or criticize *Kaigo hoken-hō* also appeared on the front pages of national newspapers. The topic topped the news on radio and television programs with reports on the political, economic, financial, and government issues surrounding this bill.

As the legislative body, the Diet held a series of special sessions, inviting experts from Welfare and Health Committees to speak on issues related to long-term care. Moreover, special public hearings were held in cities outside the capital region. The subject evolved into one of the most crucial political issues in Japan integrating all existing systems for welfare and medical care in local communities.

However, even more remarkable was the formation of a citizens' social action group in order to support the fundamental idea of long-term care insurance. A group was established in 1996 that called themselves *Kaigo no Shakaika o Susumeru Ichimannin Shimin Iinkai* (Ten Thousand Citizens' Committee to Realize a Public Long-term Care System; abbreviated in the following as KSSISI). The name of the group, KSSISI, reflects the purpose of this organization. The founding members planned to gather 10,000 citizens to join this committee with a membership fee of ¥ 10,000. They suggested that this national organization would raise a fund worth ¥ 100 million to support activities that allowed ordinary Japanese citizens to put forward suggestions for the law regarding the care of the elderly. As of February 10, 1998, KSSISI claimed 2,320 members of which around 60% were women, 37% men, and 3% associations. It made tremendous efforts to put forward concrete and positive proposals to the new law. Among other things, the group presented policy alternatives, it submitted recommendations, administered surveys on elderly care, dispatched questionnaires to Diet members on the proposed law, and collected resources, documents, and drafts related to the law.

In the founding statement of KSSISI, the emphasis was on the citizens' input to influence law-making procedures and to present positive proposals on various points such as the following: 1) citizen's participation in the policy-making process to plan for care-related infrastructure; 2) assurance of receiving services by setting a target age in order to avoid the situation of compulsory insurance payments without receiving benefits; 3) insurance fee payments from age 20; 4) deletion of the provision stating "necessity of care caused by the aging process" and expansion of benefits to all people with disabilities including younger people; and 5) the establishment of a Care Insurance Managing Council consisting of an equal number of male and female representatives of the insured in order to protect the human rights of the insured. This council was also willing to provide an "ombudsman" function so that it would have the power of "investigation, recommendation, and public disclosure" (KSSISI 15.09. 1996: 7–8).

KSSISI received a great deal of attention during the first two years of its establishment. They appeared in the news whenever symposiums, seminars, and general assemblies were held. One remarkable feature of this process was the publication of newsletters that carried valuable information on survey results, data, and proposals. In issues 1 to 7 (including an extra issue published immediately after the passing of the bill in the Health and Welfare Committee of the House of Councilors on December 2, 1997), the group put forward very positive proposals and even exerted strong pressure to consider amendments in the final process of law-making (KSSISI 02.12.1997: 2–3).[5]

On May 22, 1997, the House of Representatives passed the Long-Term Care Insurance Law that included the following amendment: "Local municipalities should be given the necessary administrative discretion in order to get feedback from the insured whenever they make a plan or intend to change services provided by the care insurance policy" (KSSISI, 01.06.1997: 1–3).[6] The actual content and meaning of "administrative discretion" was suggested as: "1) the establishment of a planning policy committee, consisting of experts from the fields of health, medicine, welfare, and insurance; and 2) a public hearing or briefing including the

[5] Concretely, it was decided to include the phrase "policies and other necessary measures to secure the system for providing health and medical services", relating to the responsibility of central and local governments, in Article 5.

[6] This amendment endorsed public participation in reflecting the insured's opinion when the municipalities need to establish or change its care insurance service plans. The idea of "citizen participation in the care planning process" may be considered as one of the fundamental proposals made by the KSSISI.

insured should be held" (Kōseishō Kaigo Hoken Seido Jisshi Suishin Honbu 1998: 35).

This amendment shows the actual influence of KSSISI's movement. Its role in the public policy process for the new care insurance system cannot be denied. The entire process of making *Kaigo hoken-hō* gave new hope to many citizens as government bureaucrats and politicians seriously considered KSSISI proposals for amendments. KSSISI's role as a citizen's public policy-making body was, for the first time in Japan, accepted by government policy-makers, candidates for the Diet at the time of the 1996 general election, and by the Japanese people in general.

5. Concluding Remarks: Disappointments and Hopes for the Future

The public debate that surrounded the making of *Kaigo hoken-hō* was in many respects the first of its kind in Japan. However, many Japanese have not recognized the importance of addressing bioethical concerns in the public policy-making process. Democratic efforts were made through nationwide public hearings held in certain prefectures, such as Okayama, Fukushima, Hokkaidō, and Niigata, organized by the Welfare Committee of the House of Representatives, and in the prefectures of Yamanashi, Kōchi, Ōita, and Aichi, organized by the Health and Welfare Committee of the House of Councilors. The most encouraging approach of public participation was the formation of special citizens' interest groups on the care issue.

Nonetheless, citizens' groups were unable to influence the legislators on the fundamental issue regarding which people are entitled to receive care. The *Kaigo hoken-hō* clearly stipulates that citizens are eligible for benefits according to the care category in which they are classified. They must have certain symptoms of disability or a condition caused by the "aging process". It is important to note that the original draft of the law did not have such a restrictive wording of *kōrei ni tomonatte shō-zuru* [caused by the aging process] but had a more inclusive *kaigo o hitsuyō to suru hito* [those who need care]. In spite of the efforts to keep the original wording in the law, the law was passed using the more restrictive phrase. KSSISI and the majority of the public consider this phrase ridiculous. There was also concern about the serious implications this phrase may have for those who require care because they suffer from symptoms or disease unrelated to the aging process.

While problems existed in the making of *Kaigo hoken-hō*, this was one of the first instances where the public experienced direct participation in the

democratic political process by submitting concrete proposals and amendments to the law. Because of an increasing number of people in need of care, many citizens felt direct connection to the issue as it related to their own life within the community. This law-making process led to changes in the idea of mutual caring, the family, welfare, and medical services. This new trend in Japan will have positive implications in realizing the global agenda "Health for All in the Year 2000", which was initiated by the World Health Organization (WHO) of the United Nations.

In order to determine the necessary level of care for people in need, international comparisons should be made and concerted efforts initiated to address these issues. In many cases, new approaches to solve difficult problems can be found by investigating and looking at the issues from different socio-cultural and bioethical perspectives. This is not meant to discourage traditional values that emphasize care in the family and community as some societies move towards socializing care for the disabled. Rather, it is important to note that Japan is attempting to enter a new era of care and support with additional mechanisms influenced by bioethical guidelines brought forth within the course of a public policy-making process.

Continuous cooperation is necessary for all participants in the public policy process to address national, generational, and gender disparities. In addition, there is a need to respect the autonomous decision of those people who need care. Participation by citizens including those in need of care, the commitment of health care professionals and policy-makers are critical when making public policies based on bioethical beliefs of building communities where humane care is fully realized.

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