ELDER CARE POLICIES AND THE ROLES OF FAMILIES IN CANADA AND JAPAN

BY

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ABSTRACT

Within industrialized nations, the percentage of the population aged over 60 is at an all time high, which has necessitated policy reform. Both Canada and Japan have been reforming social services for the aged, such as health care and pension systems, to adjust to population aging. Along with population aging, elder care has gained significant attention, but little is known about cultural influences on the role of families in elder care. The objective of this case study was to use systems theory in order to compare and contrast public policy and the role of families in elder care in the two countries. Analysis of public opinion showed that Canadians value independence, and family care of frail elders generally involves spouses. Japanese tradition dictated frail elders to receive care at home, generally from a daughter-in-law, but that value is diminishing in post-modern Japan. Guided by four research questions, a content analysis of elder care policies in the two countries showed that in both countries, the government has been trying to shift the responsibilities of supporting elderly people from the government to individuals, and families in both countries are expected to be primary caregivers. Efforts have been made by both governments to enhance support towards family caregivers. However, improvement of the current programs is needed in order to establish a comprehensive support system for them.

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CHAPTER 1: INTRODUCTION

The population of industrialized countries is aging. The proportion of people aged 60 and over has been increasing, and it is projected that the proportion will double in the next 50 years (Sigg, 2002). Many have argued that an aging population will bring economic damage to society and have stated that the future working population will have to sacrifice its income to support the growing number of elderly people (Sigg, 2002). On the other hand, others have suggested that blaming population aging for the problems in social security is not appropriate. Townson (2001) claimed that "the aging crisis is being used as a cover to implement a political agenda" (p. 1). No matter how people view the influence of population aging on society, it is true that population aging has influenced social policies in many countries. According to the Organization for Economic Co-operation and Development (OECD) (1996), policy reforms related to demographic aging started in OECD countries in the early 1980s. Moreover, elder care has received significant attention and has become one of the most important issues in social policy reforms in many countries, especially in industrialized countries (Keating, Fast, Frederick, Cranswick, & Perrier, 1999; Ministry of Health, Labour & Welfare, 2002b).

Like many industrialized countries, Canada and Japan are experiencing population aging, and elder care policies in both countries have been undergoing reforms (Keating, et al., 1999; Ministry of Health, Labour and Welfare, 2002b; OECD, 1996). The direction both countries are taking to reform is to keep frail elderly people at home as long as possible and to keep the responsibilities of supporting elderly people within families, rather than on governments. Consequently, over the past decades, there has been a dramatic increase in the provision and use of home care services in both countries

(Keating, et al., 1999; OECD, 1996). New services, such as day care services for frail elderly people and respite care, have developed so that family caregivers can take a break from ongoing caregiving (Health Canada, 2001; Ministry of Health, Labour & Welfare, 2002b). Despite the similarities in the approach that both Canadian and Japanese governments are taking, the situations families experience differ in each country. Differences in traditions and cultural practices have influenced the development of elder care policies in the two countries.

Although there is a large body of literature on elder care, little is known about how differences in social demands, which are influenced by traditions and cultural assumptions in society, influence policy development in both Canada and Japan. Accordingly, the purpose of this study was to examine and analyze the role of families in elder care in the two countries in relation to differences in social demands, which are influenced by cultural views on elder care.

Several key terms used in this study are defined based on the definition by OECD (1996). *Frail elderly people* is defined as older individuals who have a long-standing limiting physical or mental condition or who are at risk of neglect or injury because of their lower levels of health. *Formal care* is defined as help supplied by any organization including both the public and private sector, whereas *informal care* is defined as care provided by family members, friends, or neighbors (OECD, 1996). The term informal care, rather than family care is used in many Canadian reports and studies. However, the role of neighbors is not emphasized in Canadian literature, and only family and friends are included in the term informal care in most studies and reports (Family Caregivers Association of Nova Scotia [FCgANS], 2001; Keating, 2001; Romanow,

2002). Friends are included in the definition of informal caregiver in Canadian literature because they provide a small amount of care. However, most informal care in Canada, over 80%, is provided by family members (FCgANS, 2001; Ontario Coalition of Senior Citizen's Organizations, 2002). Similarly, the role of friends and neighbors in informal care in Japan has not been identified as significant in the literature. Maeda and Nakatani (1992) stated that the role of family and neighbors in elder care is less important in Japan as compared to other industrialized countries. Therefore, the focus of this study is on *family care*, which is defined as care provided by family members, rather than informal care. In addition to providing care at home, families can provide care for frail elders who live in institutions as a complement to formal care. Nevertheless, the focus of this study is on the role of family caregivers as the primary caregivers, with emphasis on family care provided at home. *Caregiver leave programs* are related to the time away from employment, whereas *caregiver benefit programs* are those which provide financial compensation for caregiving tasks. Therefore, the Compassionate Care Benefit program in Canada is considered as a caregiver leave program rather than a caregiver benefit.

CHAPTER 2: REVIEW OF LITERATURE

This chapter first introduces the theoretical framework used in this study, systems theory, followed by the review of literature. In the literature review, differences in cultural beliefs and traditions between Canada and Japan as well as the history of social development in each country are reviewed.

Systems Theory

When establishing policies, it is necessary for governments to consider not only social changes in the society but also individuals' changes. Systems theory is useful to analyze elder care policies in Canada and Japan as the theory focuses on the interaction among subsystems and their influence on individuals and families. System theorists view understanding human behavior as possible only by examining the context in which families exist (Klein & White, 1996; Whitchurch & Constantine, 1993). A society contains many subsystems (families, bureaucracies, and schools, for example), and each subsystem is interdependent on the others and within the environment. Moreover, in this theory, families are systems that consist of smaller subsystems such as spousal, sibling, parent-child, which in turn relate to suprasystems, such as the community and the society (Whitchurch & Constantine, 1993). System theorists view all actions as being a part of systems. As all parts of a system are interconnected, one person's behavior becomes another person's information, and one change in a system influences all other parts (Klein & White, 1996).

Several concepts of systems theory are useful in examining the way policies and families influence each other. Families make demands on and offer support to the political system (input), and by considering those inputs, the political system establishes

family policies (output) to enhance support toward families (Zimmerman, 1995). Once a new policy is implemented, the government receives feedback as to whether the public likes the new policy or not. Reaction of the public is usually taken into consideration when revising policies. This process is fundamental in public policy development and enables the government "to develop the best policy to respond to [the] increasing family need" (Anderson, 1993, p.354). Systems theory is thus useful in providing a framework for analyzing the development and implementation of family policies, and it will be used in this research.

Differences in Cultural Beliefs and Traditions between Canada and Japan

Public policies on elder care in Japan have been significantly influenced by the cultural belief that elder care should be provided by family members (Kiefer, 1987; Maeda & Shimizu, 1991). As a result of this belief, the development of both nursing homes and home care services for elderly people was significantly delayed. Traditionally, the Japanese view of the aged is one of respect and admiration (Cinelli, McConatha, & McConatha, 1991). This cultural view came from "the indigenous culture of Asian society, particularly respect for age and filial piety derived from Confucian ethics, which originated in China" (Kamo, 1988, pp. 300, 301). Confucian ethics emphasize the importance of public order and demands that individuals sacrifice their own interests to the public good. In addition, filial piety, which is one of the most significant concepts of Confucianism, represents the essential of sacrificing individuals for their parents and ancestors as respect of the family lineage (Kamo, 1988).

On the contrary, independence and individualism are highly valued in Canada, and the freedom of individuals to make their own decisions and to have responsibility for

their own lives is important. In many cases, this freedom is protected by law and reinforced by social policies (Wenger, 1991). Therefore, the rights of individuals are considered to be more important than the rights of families. Although family members rely on each other throughout their lives, many of the decisions of elderly people are influenced by the values of independence and individualism (Wenger, 1991). This difference in beliefs has significantly influenced several aspects of elder care in the two countries and set apart the situations that each country is currently experiencing, as well as the path taken by each government to implement elder care policies. The following are the three key differences that are emphasized in the literature, which might have considerable influence on divergence in elder care policy in the two countries.

Living Arrangements

The most significant difference in the two countries that might have influenced elder care policy is living arrangements. Although the proportion has been decreasing, a significantly higher proportion of elderly people live with their adult offspring in Japan, compared to other industrialized countries (Hirayama & Miyazaki, 1996; Maeda & Nakatani, 1992). In Canada 70% of women and 77% of men live in elderly households, in which all members are aged 65 and over (Statistics Canada, 2002). However this proportion is significantly lower in Japan; only 49.3% of the elderly population live in an elderly household while 47.1% of elderly people live with their adult offspring (Ministry of Health, Labour, & Welfare, 2003a).

The Number of Long-term Care Institutions

In Japan, the number of institutions that provide long term care for elderly people is considerably smaller than other industrialized countries (Kimura, 1996;

Mackellar & Horlacher, 2000). Because of the shortage of long term care facilities, many elderly people were sent to hospitals when they could no longer stay at home, and this pressured health care costs upwards. An aging population has been pressuring health care costs upwards in Canada as well. The difference in the two countries under the similar circumstance is that Japan is still expanding institutional care facilities. The Gold Plan aimed to expand long-term care facilities for elder people as well as to develop a comprehensive home care system (Kosaka, 1996; OECD, 1996; Mackellar & Horlacher, 2000). However, in Canada, the focus on reducing hospital stays of elderly people targets expansion of community based services rather than institutional care (Williams, Barnsley, Leggat, Deber, & Baranek, 1999). This difference in the focus of the two countries may have influenced the current elder care systems.

Attitudes toward Care of the Elderly

Several differences in traditional values between the two countries may have created different attitudes toward elder care in the two countries. First, despite changes in family structure in Japan, there is still a strong belief that elder care should be provided within families (Hirayama & Miyazaki, 1996; Maeda & Nakatani, 1992). According to Sato (2002), Japanese Long Term Care Insurance (LTCI) was established on the assumption that most elderly people have family members who will provide primary care for them. Therefore, although the LTCI was implemented, the Japanese government still relies on families in terms of care provision for their elderly members. Additionally, the Japanese dislike asking for help outside of the family on family issues because traditionally it is considered to be shameful to expose family problems to strangers (Hirayama & Miyazaki, 1996). Even today, a strong belief remains that families should

provide care for their elderly members. Second, in Canada, independence and autonomy are considered to be very important. When affected by illness, most people want to recover their independence (Kiefer, 1987). On the other hand, in Japan, it is considered to be normal for elderly people to be dependent on their offspring once they become weak or ill (Hirayama & Miyazaki, 1996; Kamo, 1988). Parents take care of children when they are young, and the relationship reverses when parents get older. Therefore, the Japanese system does not see rehabilitation as an important part of elder care as it is in Canada (Kiefer, 1987). Thus, families play significantly larger roles in the care of elderly people in Japan as compared to Canada.

History of Canadian and Japanese Attitudes and Policy toward Elders

Policies of both the Canadian and Japanese governments on elder care have been altered with changes in society. First, in both countries, the population is aging rapidly, and the demographic situation is transforming into that of aging societies. In 1921, only 5% of the Canadian population was aged 65 and older (Statistics Canada, 2001). The elderly proportion of the population increased to 8% in 1971 and to 13% in 2000. Moreover, one in every eight Canadians was over 65 in 2000, and by the year 2041 one in every four Canadians is projected to be over 65 (Health Canada, 2001). The situation in Japan is very similar. For instance, in 1998, one in every six Japanese was over 65 and by 2050, one in every three Japanese is expected to be elderly (Ministry of Health, Labour & Welfare, 2002b). With population aging, finances of both governments are strongly pressured because of the increase in health care and pension expenditures (Denton, Feaver, & Spencer, 1998).

Economic situations in both Canada and Japan have also significantly influenced elder care policies. In both countries, policies for elderly people were expanded when the economy of each country was growing, but in the 1980s after quick economic growth ended, both Canadian and Japanese governments changed the direction of aging policies from expansion to retrenchment (OECD, 1996). Currently in both countries, community-based care that uses both informal and formal care is emphasized. Families are thought to be critical as primary caregivers, and the importance of family members in elder care has been emphasized in both countries (Harlton, Keating, & Fast, 1998; Keating, Kerr, Warren, Grace & Wertenberger, 1994; Penning & Keating, 2000). Although the current approach to emphasize home care in elder care is evident in both Canada and Japan, the path taken by each country is different. Differences in customs and traditions in the two countries may have played an important role in each government's decisions in the policy making process. The following section will examine the history of how home care became an important instrument in care provisions for the elderly people in each country.

History of Social Welfare Development in Canada

The Development of the Pension System

Before the 1920s, it was believed in Canada that each person should be prepared for aged life and families should take care of their aged members. However, it became difficult for people to practice this belief because urbanization and industrialization weakened family ties (Novak, 1997). Therefore, the first national pension plan in Canada was established in 1927, though it was not universal. The pension plan was established as a relief for poor elderly, and only those who passed a means test

could receive assistance from the government. The federal and provincial governments each shared half the cost of the plan, and no contribution from pensioners was required. The system was viewed as an income supplement rather than as a pension (Novak, 1997). Later in 1951, with the enactment of the Old Age Security Act, the pension plan became open to all Canadians over 70 years old (McDaniel, 1997). The funding of the plan came solely from the federal government. In the same year, the Old Age Assistance Act established a plan for those who were between 65 and 69 years of age and needed financial support. Unlike the plan under the Old Age Security Act, this plan was funded by both the federal and provincial governments, and a means test was used to examine the financial needs of individuals. These programs were not designed to completely support elderly people but to supplement their incomes. The government intended to encourage people to be responsible for their old age by keeping the amount of support low. In the 1960s, the Guaranteed Income Supplement (GIS) was established in order to assist the poorest elderly, those who could not maintain a minimum level of living.

In 1967, the Canada Pension Plan (CPP) and Quebec Pension (QPP) were launched. Under these plans, all workers make contributions, and contribution rates are determined according to their wages. Although employers and employees each make fifty percent of contributions, self-employed workers contribute both shares (McGilly, 1997). The eligible age for receiving a pension is 65. For those who have already retired, it is possible to start receiving a pension earlier with reduced benefits.

Pension Reform

After the establishment of CPP/QPP, two types of plans were part of the system to support the income of the retired. The Old Age Security (OAS) and the Guaranteed

Income Supplement (GIS) played a role in providing income security so that every retired person could maintain a minimum level of living, while CPP/QPP helped them to maintain the level of living consistent with their pre-retirement income. In the early 1980s, debates about pension reform started, and some changes in the pension system were made during the 1980s. Regarding income security, the amount of OAS continued to be raised with the inflation rate, and the enhancement of GIS led to a decrease in poverty rates for the single elderly. Also in 1985, the Spouse's Allowance became available to all widowed elderly with low incomes. In 1984, changes to the CPP enabled both men and women to deduct years spent on child bearing from pensionable years in order to protect a parental leave period so as not to lower their pension benefits. In addition, a credit-splitting system for divorced couples was established so that each spouse could get equal benefits from the time they spent together. Similar changes, such as survivor benefits and credit-splitting and additional changes to enhance benefits for both full-time and part-time workers, were made in the area of work-related private pension plans. When the federal government altered the Canada Pension Benefits Standard Act in 1985, the situations of many workers were improved (Banting & Boadway, 1997). These reforms broadened the scope of pension plans by giving more benefits to widows, part-time workers, and the elderly with low incomes, but more reforms were needed, especially for assisting homemakers.

Pension reforms in the 1980s enhanced benefits for Canadian elderly people, and the incidence of poverty among the elderly significantly declined. Elderly people were the poorest group in Canada in the post war years, but thanks to the development of a comprehensive pension system, the situation of elderly people was considerably

improved compared to that of young people (Baker, 1993; Banting & Boadway, 1997). Yet, despite the substantial success in improving the income security of elderly people, funding problems started to pressure the Canadian pension system. There were five working people supporting each person aged 65 and older in the 1990s, but analysts have predicted there will only be three working people for each elderly person by 2030 (Sigg, 2002).

Population aging is not the only factor pressuring the pension system. Banting and Boadway (1997) state that the pension system was developed and reformed in a time of strong economic growth, but economic growth has declined over recent years. This decrease in economic growth is the second reason why the pension system is under pressure. To keep the same benefit rates for future elderly people at today's levels, the contribution rate of future working generations needs to be increased. In 1985, the federal government announced that CPP premiums would be increased from 3.8% of earnings to 7.6% by 2011, starting in 1986 (Baker, 1988). Current estimates are that by the year 2030, the contribution rate will need to be increased to 14.2% from 5.6% in 1997 (Banting & Boadway, 1997). Banting and Boadway (1997) suggest two alternatives to the problem. First, Canada can establish a reserve fund by increasing the contribution rate gradually and sharing the burden of future pension costs with the currently working generations. In that way, the contribution rate for future working generations will not need to increase as much as estimated. Another option is to decrease the benefits for future pensioners. Canada has chosen the first alternative. In 1998, contribution rates for CPP were increased for the purpose of building a reserve fund (Gee, 2000).

The Development of the Health Care System

The concept of a health care system was first introduced in the British North American Act of 1867, wherein health was deemed a provincial responsibility. Later in 1919, the idea of public funding was introduced, and the system was gradually developed during and after World War II. In 1943, the concept of a federal health care system was proposed, but it was difficult to develop a federal system because of the strong political power that each province had. Although some provinces preferred a federal health care system, others, especially Quebec, favored provincial independence. The reason why some provinces, wealthier provinces in particular, preferred to develop provincial health care systems was because of concern that the federal government would attain too much power over funding and thus control the health care system.

After World War II, each province developed its own health insurance scheme. In 1947, Saskatchewan proposed the first public insurance plan for hospital services, and the other nine provinces and two territories followed and began to develop their own systems. With the federal government's effort to develop hospital insurance plans in all twelve jurisdictions, the Hospital Insurance and Diagnostic Services Act was passed in 1957, and this new legislation promised fifty–fifty cost sharing between provincial and federal governments. All provinces agreed to the plan by 1961, and the foundation of the universal health care system in Canada was established. The four principles of the system were, and still are, are follows: (a) the coverage is universal and comprehensive, (b) services are reasonably accessible, (c) benefits are portable in Canada, and (d) administration is non-profit by a public agency (Chappell, 1993; Lassey, Lassey, & Jinks, 1997).

Later, hospital insurance plans in each province were extended to medical care insurance. Following the establishment of the National Medical Care Insurance Act (Medicare) in 1966, Medicare was established in all provinces by 1971 and in two territories by 1972. The funding system for Medicare was the same as the hospital insurance system; provincial and federal governments each shared fifty percent of the cost. Each province and territory covered half the cost of medical care services and the other half was transferred from the federal government. Similarly, the four principles of the hospital insurance system remained in Medicare (Lassey, et al., 1997). Despite the economic differences among provinces, the medical care system was developed to be comparable from one province to another (Lassey, et al., 1997).

Health Care Reform

Because the funds transfer from the federal to provincial governments was open-ended, efforts were made in each province to maximize financial transfers from the federal government (Novak, 1997). Provincial governments focused health care expenditure on treatment and curative services because the federal government only contributed to the cost of medical and health care services. Therefore, the cost sharing system discouraged the provinces from developing a variety of community-based health services (OECD, 1994). In the middle 1970s, concerns regarding cost sharing between federal and provincial governments began emerging. The federal government started to focus on the more effective use of resources and searched for alternatives to the provision of health care funding. Although the federal government attempted to negotiate with provincial governments to change the funds transfer, the latter were hesitant to bear an increased share of the cost. Therefore, in 1977, the federal government independently

changed the system of cost sharing between itself and the provincial governments. Instead of paying one half of the provinces' expenditures, the federal government started to use a new funding formula, per capita block funding. In this new system, funds transfer from the federal to the provincial governments was not based on how much each province spent on health care, but was based on the population in each province and territory. With the new funding method, the federal government was able to reduce its contribution to provincial health expenditures from almost 50% in 1979 to 38.6% in 1987, and to 24.4% by 1991 (Chappell, 1993). Therefore, it became necessary for each province to use resources more effectively because of reduced federal cost-sharing.

In 1977, when the new cash transfer arrangement was established, it was expected that the federal government's expenditure on Medicare would steadily increase along with the GNP (Chappell, 1993). Increasing health care costs became a concern of the federal government, and it began to search for ways to stop the increase. In 1982, the government set limits to the increase of annual federal contributions to health care (Crichton, Hsu, & Tsang, 1994). Beginning in 1986, the federal government started to reduce the planned increase in the contribution rate to health care in the provinces (Chappell, 1993). In 1987, reducing the national deficit was the first objective in national policy of the federal government and cutting back its contribution to health care became critical (Crichton et al., 1994). The burden of health care costs was put on the shoulders of each province as federal support decreased. With the reduction of cash transfers from the federal government to each province, the federal government's power to control provincial health care systems declined. Indeed, it became difficult for the federal government to maintain comparable health care services from province to province.

In addition to reduced federal power, a new concern arose that each province would change the health care system by adopting additional user fees and extra billing to patients. Therefore, in 1984, the federal government implemented the Canada Health Act. The principles of the previous systems were kept. The Canada Health Act became the standard of the Canadian health care system to keep comparable health care insurance schemes in provinces and territories by setting the regulations for each province to be qualified for full transfer funding from the federal government. After this legislation was passed, creating user fees or additional billing by physicians was prohibited by 1987.

Development of Long-term Care and Home Care

Long-term institutional and home care services in Canada have developed gradually over the last 40 years. Influenced by the rapid economic growth of the country, these services grew rapidly in the 1960s and 1970s in the same way as the rest of Canada's health care system. In 1977, when the funding system changed from cost-sharing to block funding, the federal government extended the funds transfer so that each province could provide more services (Crichton et al., 1994). The funds transfer was extended to more health care services, such as institutional and home care, and each province was able to develop alternative health care services (Lassy, et al., 1997). This extension of transfer funding promoted the recognition of community-based services, and these services dramatically increased at this time. People's desire to remain in their own homes increased, and there was a significant movement of frail elderly people from institutions to the community. Community-based care was developed during this period, and this development encouraged frail elderly people to remain in their community instead of going into institutions (OECD, 1996).

Concern about health care costs also influenced the development of community-based care services. Services, such as home care, were supported by provincial funding agencies in order to allocate the health care budget as effectively as possible without decreasing the quality of care (OECD, 1996). Home care was developed in provinces and territories, and each region has a different system. In most cases, home care started as small urban programs that were developed by voluntary agencies (Dumont-Lemasson, Donovan, & Wylie, 1999). In the 1970s, comprehensive and government-organized home care was developed in some provinces, and other provinces followed this in the 1980s. Today, home care services are provided in all provinces and territories, but service delivery or finance systems differ from one province to another.

According to Keating et al. (1999), "elder care has moved toward center stage on the national policy agenda" (p. 9). To reduce public costs, the Canadian government is trying to promote community care and to keep elders at home as long as possible instead of encouraging them to reside in institutions or nursing homes. In 1994/95, there were about 335,000 people aged 65 or older who received home care services, and this number was almost twice the number of elders who were living in institutions or nursing homes (Statistics Canada, 1998). Canada's spending on home care has grown over the years, especially in the last two decades, when the spending increased more than 21% per year (Williams, et al., 1999). The reason that home care has grown rapidly is partly because the government is trying to cut hospital costs. Informal caregivers such as family members and friends now are considered to be primary care providers, and informal care is regarded to be both better and cheaper than formal services (Harlton, et al., 1998).

There is growing evidence that home care is able to contribute to cost control and to improve the quality of both patient care and patient life compared to the care provided in hospitals or institutions (Romanow, 2002). The need and demand for home care services will increase in the future for several reasons: "continuing trends for early discharge from hospital," "the overall cost effectiveness of home care," "a growing elderly population that wants access to home care," and "increasing pressures on informal caregivers" (Romanow, 2002, p.176). Despite the growing attention to home care, under the current Canada Health Act, it is not considered to be a medically necessary service. Therefore, each province and territory has its original home care plans. Types of home care services and costs for the services vary across the country. Moreover, there is a variation in eligibility requirements, and conditions in which people are qualified for certain services differ from province to province. Therefore, several recommendations were made in the Romanow report as the first step to establish a comprehensive home care program in Canada. Additionally, the First Ministers' Accord on Health Care Renewal, which is the new health care plan, promised the expansion of home care programs in the nation (Health Canada, 2003b).

History of the Social Welfare System in Japan

Before the End of the Second World War

The first legislation for supporting the elderly in Japan was issued in 1874. The Relief Order (Futsukyu Kisoku) aimed to give supports to elderly people aged 70 years or older who had no relatives and gave those elderly public relief (Maeda, 2000). Support was minimal: A very small amount of money, enough only to maintain basic life, was given as relief. Moreover, this order did not include institutional care. In 1932, an

improved order, the Public Relief Law (Kyugo Ho) was enacted. Under the new law, eligibility was eased, the age limit was lowered from 70 to 65, and institutional care was included. However, this law was still very limited compared to modern social welfare policies of other countries, and the number of residential institutions where care was available was critically short of the demand (Maeda, 2000). These policies were put forward in order to keep people from poverty and crimes, which in turn retained peace and order in society (Adachi, 2000).

During World War II, some social polices were started in order to develop a high quality military force (Adachi, 2000). The first step in construction of a public retirement pension system was taken in 1941. Eligibility was very limited, and only those who contributed to the war effort in important ways, such as workers in mining, manufacturing, and other industrial workers, were eligible for the plan (Maeda, 2000). Although there were some social security policies in Japan before the end of World War II, "the idea of social welfare had never existed until it was introduced to Japan via the direct order of GHQ" (General Headquarters of the Supreme Commander of the Allied Forces), which supervised Japan for several years after World War II (Adachi, 2000).

Post World War II (1945-1954)

After World War II, the GHQ directed several reforms; it democratized the economy and liberalized education. Along with restructuring society, new principles of social security were developed. Japanese citizens' rights to "maintain the minimum standards of wholesome and cultured living" and the state's use of "endeavor for the promotion and extension of social welfare and security, and of public health" were stated as the basic principles of Japan's social security (Ministry of Health & Welfare, 1996).

In the social confusion after the war, maintaining everyday life was not easy for most people. There was not enough food available for the whole nation, and many people suffered from hunger and lack of proper nutrition. Therefore, emergency relief was extended in order to support all citizens at a minimum level of living. Contagious diseases such as cholera and tuberculosis became serious problems, and the prevention of the spread of these diseases was one of the most important tasks for the nation. In addition, the lack of medical facilities and the absence of a medical system became critical, and effort was made to improve medical care. In this period, the emphasis of social welfare was on social assistance to provide necessities to citizens (Ministry of Health & Welfare, 1996).

Development of Universal Insurance and Pension Programs (1955-1964)

Japan's economy developed quickly following the confusion after the end of the war, and the citizens' level of living improved. As the living standard of people improved, not only social assistance but also social insurance became significant to protect people from going into poverty (Ministry of Health & Welfare, 1996). The development of the economy brought new welfare systems, and in 1961 both the National Health Insurance and National Pension were implemented.

Before the development of the National Health Insurance, about 30 million workers such as the self-employed and farmers were not included in either the medical insurance system or the pension system (Ministry of Health & Welfare, 1996). National Health Insurance was formed to cover those workers who were not covered by the original insurance plan, and it gave all citizens universal medical coverage. The achievement of universal medical insurance increased the demand for medical care, and

the increased demand pushed the development of medical facilities. As a result, in this period Japan's medical facilities were expanded rapidly.

In addition to the development of universal insurance and pension systems, new services to improve the life of elderly people started to be developed at this time. Services in long-term care in nursing homes for the elderly who needed personal care were established during this period (Ministry of Health & Welfare, 1996; OECD, 1996). The government started to emphasize the social and humanistic aspects of the lives of the people, and various public services to improve social life began to be developed. As a result, services for the elderly in such areas as health, education, and recreation were established. Japanese public services thus were expanded, modeling those of Western Europe and North America (Maeda, 2000).

Expansion of the Welfare System (1965-1974)

Japan's economy continued to develop rapidly, and in 1968, the GNP of Japan was second in the world. Along with the rapid growth of the national economy, the levels of benefits for medical insurance and pensions were increased because the government had sufficient finances to increase benefits for citizens. However, rapid economic growth also resulted in negative consequences. For example, industrial wastes polluted water, and income inequality was created among citizens. These problems generated demands for improved social policies, which became the major concern of politicians (Palley & Usui, 1997).

In terms of the health care system, the benefits of medical insurance were increased. Advanced medical treatment and drugs became available to citizens, and needs for medical care increased. In 1973, free medical care became available to elderly people

aged 70 and older. At this time, equal distribution of medical services to all parts of the country became difficult because the population started to shift to urban areas and depopulation of rural areas began. Although new laws were enacted to establish medical schools in every prefecture, this policy did not have significant influence on solving inequalities between urban and rural areas.

Regarding the pension system, benefits were revised several times in the early 1970s to meet the changes in the living standards that were improved by economic growth. Attitudes toward support for elderly people were altered along with changes in society, such as an increase in the number of nuclear families and in women's labor force participation, and many citizens started to be concerned about old age. In the area of politics, the main question was how much the pension benefit should be increased rather than if it should be increased (Palley & Usui, 1997). After several revisions, in 1973 pension benefit levels were set at about 60% of the average pre-retirement salary of the insured (Ministry of Health & Welfare, 1996).

Reexamination of the Welfare System (1975-1984)

After the oil crisis that occurred in 1973, Japan's economic growth changed from rapid to stable growth. The government decided not to increase tax revenue but to control national expenditures in order to adjust to economic change. Therefore, in the 1980s, large revisions in medical insurance and the pension system were started (Ministry of Health & Welfare, 1996).

In the area of medical insurance, the critical factor that pressured expenditure was a free medical care policy for the elderly, which was enacted in 1973. After the new legislation, health expenditures for the elderly increased dramatically, and the

phenomenon of elderly people's use of "the hospitals as social salons" was created (Ministry of Health & Welfare, 1996, p.19). Many elderly people went to hospitals not because they needed medical care but because they used hospitals as a place for socialization. To prevent elderly people from overusing the free medical system, the Health Insurance Law was revised in 1984, and 10% co-payments became the responsibility of all participants.

Another problem that worsened the finances of the health care system was the increased number of elderly that stayed in the hospital for a long time. In 1993, the average length of hospital stays in Japan (41.9 days) was more than four times that of the United States (8.8 days), and considerably longer than various European countries such as France (11.7 days), the United Kingdom (12.3 days), and Germany (15.8 days) (Kosaka, 1996). This problem was related to the fact that the number of nursing and personal care homes for the elderly in Japan was far fewer than needed. Moreover, home care delivery services were also insufficient, and many elderly people who needed personal care did not have any place to stay other than the hospitals. Under the circumstances, the Japanese government started to pay attention to the fact that there were not enough facilities for elderly people and began to develop a new type of health service facility for the elderly, which provided both medical and personal care services (Ministry of Health & Welfare, 1996).

Regarding the pension system, a discussion about raising the pensionable age started around 1980. The government recognized that although more than 80% of companies had a mandatory retirement age of 60 or older, almost 70% of those companies had extended employment and reemployment systems, in which retirement

aged workers are able to continue working (Ministry of Health & Welfare, 1996). After this recognition, in 1994 the government decided to increase the pensionable age from 60 to 65 at the beginning of the 21st century. The idea of increasing the pensionable age was seen as preparation for the future with an aging society in which the number of elderly aged 80 and older would be significantly large.

During this period, quality of life started to gain attention from Japanese people. In terms of elder care, emphasis shifted from institutional care to home care in order to support people to be able to live in a familiar environment as long as possible (Ministry of Health & Welfare, 1996). Therefore, several services such as respite care and day services programs began to develop. Additionally, the number of home-helpers who carry out personal services for frail elders was increased. However, in-home care was traditionally not seen as important in Japan, and home care services were provided only for low income families. It was the government's responsibility to determine whether an individual needed home care services. Therefore, individuals did not have control over deciding the need for home care services for themselves (Sato, 2002).

Pension Reform

Along with the increase of the proportion of elderly people in the population, the objective of the pension system shifted from increasing pension benefits to maintaining the stable system by creating a balance between contributions made by working generations to benefits consumed by retired people. In Japan, the pension system is reviewed and changes are made to try to improve the system every five years. The critical factor pressuring the system is the lack of reserve funding to support increasing numbers of elderly people. The pension system in Japan originally started as one in which

contributors paid part of their salary toward transfer payments from the government but has changed to a system for individuals to save money in order to support themselves after retirement. As time passed, the system became pay-as-you-go, and current benefits are financed by current contributions ("Public Pension," 2000).

The Japanese pension system consists of two tiers: National Pension (NP) and Employees' Pension Insurance (EPI). NP is a universal system to which contributions are mandatory for all residents aged 20 to 59 and is managed by each prefecture. EPI is only for public workers and workers in private companies with more than five employees. Although the government does not fund any portion of the EPI scheme, it is managed by the federal government, and management costs are paid by the government (Ogawa & Retherford, 1997). Because NP had a large number of people who both were close to or at retirement age and had contributed little or nothing to the system, the system was strained; a funding problem emerged. Therefore, enrollment in the NP for those who belonged to EPI became obligatory in 1986.

After the increase in pension benefits during the 1970s, in the 1980s the government recognized the necessity of adjusting the system, realizing that Japan's population aging was proceeding at the fastest rate in the world. Therefore, it became necessary to reform the system by increasing contributions by working generations and by cutting benefits (Horlacher & Mackellar, 2000). In 1986, contributions to the system were increased, and a minimum 40 year work requirement for receiving full pensions was set (Horlacher & Mackellar, 2000). In addition, in 1994, a gradual rise in the eligible age for receiving pensions was proposed, to start in 2001 and to be completed by 2013 (Horlacher & Mackellar, 2000; Ogawa & Retherford, 1997).

The most recent pension reform took place in 1999, and more changes were made. Because of the hardship of the current economic situation in Japan, contribution requirements to NP were not increased, but some flexibility was introduced, including acceptance of delayed payments for students and reduction of contributions for low-income people. In contrast, revision of EPI constricted the system. Six new conditions for EPI were introduced as follows: (a) Starting in April 2000, new recipients' benefits were reduced by 5%. (b) Wage-indexing of benefits, which took place once in every five years, was eliminated. (c) Beginning in 2013 (2018 for women) and finishing in 2025 (2030 for women) the eligible age for receiving full benefits will be raised from 60 to 65. (d) For those who are 65 to 69 years old, a new earnings test for setting the amount of EPI benefits will be developed: If a pensioner has a monthly income, then if combined earnings and EPI benefits are more than 370,000 yen [83.5 yen = $1 Canadian], EPI benefits will be cut by 50% of the excess amount. (e) Pensioners who still have jobs will be required to contribute to EPI until 70 years of age. These people receive benefits from EPI and NP and contribute to EPI according to the amount of salary they make. (f) Net contributions will be increased to 17.35% of basic monthly salary and 1% of bonuses to 13.58% of total earnings that include bonuses, starting in October 2000 ("Public Pension," 2000). According to one estimate, these new provisions will result in a 33% reduction in pension costs ("Public Pension," 2000).

Health Care Reform

Compared to other industrialized countries the Japanese health care system is thought to be inexpensive because only 7% of GDP is used for the health care system, as compared to 14% for the United States and an average of 10% for other developed

countries ("Public Pension," 2000). The proportion of national income distributed to health care was increased from 3 to 6% between 1965 and 1982, was stable in 1982 (Campbell & Ikegami, 1995; Ogawa & Retherford, 1997), and had risen only to about 7% by 1995 (Horlacher & Mackellar, 2000). However, health care expenditure for the elderly has risen steadily, from 4% of total health care expenditure in 1975 to 31% in 1995. Moreover, a projection estimates that by 2025 health care expenditure for the elderly will be half of the total health care expenditure (Horlacher & Mackellar, 2000).

There are four health care schemes in the Japanese health care system and they can be divided into two groups. The first group is the Employees' Health Insurance System (EHI), and it encompasses employment-based plans. Under the EHI, one plan is managed by the federal government (EGHI) and covers workers in small and medium companies. The other plan under the EHI is managed by an individual company (EGCI) and covers workers in big companies. The second group is the National Health Insurance System (NHI), which covers the self-employed, farmers, and people without jobs. The NHI consists of two plans: municipality-managed (NMHI) and association-managed (NAHI). The latter covers such associations as lawyers, doctors, and artists. Co-payments differ among the plans. Insured persons under EHI are required to pay 10% of medical care costs, whereas their dependents are subject to pay 20% for in-patient care and 30% for out-patient care. Under NHI both insured persons and their dependents have to pay 30% of medical care costs (Hoshino, 1996). Medical care that is covered under these insurances includes physical examinations, prescriptions, medical supplies, treatment, hospitalization, surgery, nursing care, and transportation (Kosaka, 1996).

The critical issue in the Japanese health care system is that each plan has a considerably different age composition of the people insured. NMHI has a significant number of older members, and its financial foundation is weaker than the other plans (Hoshino, 1996; Ogawa & Retherford, 1997; Okamoto, 1996). In 1993, under NMHI 16.8% of members were aged 70 years or older, compared to 5.1% for EGHI and 2.9% for EGCI (Hoshino, 1996). The reason for this situation is that the retired, who have belonged to either EGHI or EGCI before their retirement, generally switch their plans to NMHI after their retirement. Therefore, it is unavoidable that NMHI has more low-income and elderly people than other plans (Hoshino, 1996). As a solution to this problem, the Elder Health Care System was implemented in 1982 and contributions to this new system from all workers who belonged to other plans became mandatory. These contributions from other insurers started to be pooled to fund increasing health care costs for the elderly; this pool now can and does fund 70% of health care costs for elderly people (Hoshino, 1996; Okamoto, 1996).

Although the new plan to support funding for the health care costs for elderly people was established, problems related to population aging still remain. This reserved funding from different plans solves a "horizontal" problem of the health care system in which different plans have significantly diverse financing foundations. This policy does not solve the "vertical" problem of the health care system, that of intergenerational differences regarding contributions (Okamoto, 1996). The current elderly population is receiving more benefits than what it has contributed to both the pension and the health care systems, but current contributors to those systems will probably have the reverse result (Okamoto, 1996).

Preparation for the Aged Society (1985-Present)

As the age composition of the population changed in Japan, the federal government formulated the Gold Plan (the Ten Year Strategy to Promote Health Care and Welfare for the Elderly) in 1989. The main object of the Plan was to establish long-term care services for the elderly in order to encourage individuals to be independent as long as possible (Ministry of Health & Welfare, 1996). The Gold Plan was based on a belief that if people could receive better supports and services from public programs, the health status of citizens would be improved (OECD, 1996). Payments for the services under the Gold Plan were little or nothing, and fees were funded by both local and central governments (Ogawa & Retherford, 1997).

Major objectives of the Gold Plan can be divided into two groups: services and education. Services included development of home care services for elders, such as home helpers, short stay services, and day care centers, as well as an increase in the number of intermediate nursing homes (OECD, 1996). In addition, establishment of comprehensive elder care facilities to provide both health care and long-term care was proposed and implemented. The necessity of increasing the number of nursing homes and long-term care facilities for elderly people was emphasized in the Plan because elders had a greater than average length of hospital stays, which placed increased pressure on health care costs. Elderly people tended to stay in hospitals for the purpose of long-term care rather than in nursing homes. Reasons for extensive hospital stays were not only the lack of nursing homes but also the difference in costs between hospitals and nursing homes. According to data presented in 1997, co-payments for hospitals (60,000 yen) were

cheaper than those for nursing homes (39,000 yen) although hospital stay cost were much higher for the government (Mackellar & Horlacher, 2000; Ogawa & Retherford, 1997).

In terms of education, a research fund to encourage studies and projects on in-home elder care was established. Promotions, such as enhancing after-stroke rehabilitation services and health care information to decrease the number of individuals who are bedridden, were proposed and implemented. Moreover, a campaign to encourage images of healthy and productive aging was included.

In 1994, the Gold Plan was revised to meet expanded needs, and the New Gold Plan became the foundation of long-term care services for elderly people (Maeda, 2000). Despite many reforms designed to cut back and control health care expenditures for elderly people, the Japanese health care system continued to have financial problems because the cost of health care for the elderly had been growing much faster than the national income growth rate (Hoshino, 1996). Therefore, structural reform of social security began, and the establishment of a long-term care insurance system was set as the first objective. The government stated that long-term care is currently the major issue for post-retired Japanese people (Ministry of Health & Welfare, 1996). In 1997, the number of people who required long-term care was two million, and by the year 2025, the number is predicted to be more than double that at over four million.

As the first step of the structural reform of social security, Long-Term Care Insurance (LTCI) was established in 1997 and implemented beginning in April 2000 (Ministry of Health & Welfare, 1996). The government intended to separate long-term care costs for elderly people from health care costs with this new insurance (Hoshino, 1996; Okamoto, 1996). The aims of the LTCI were (a) to restructure the existing system

that was divided into health, medical, and welfare services and to create a comprehensive system for long-term care for elderly people; (b) to launch a system that was easily understandable for users in terms of its costs and benefits; and (c) to facilitate sharing the costs of long-term care for the elderly among society as a whole. This plan enabled private companies to enter the elder care system and encouraged people to choose any services available including both public and private sector by increasing the number of helpers and facilities for long-term care.

People insured under LITC can be categorized into two groups, people aged 65 and older and people aged 40 to 64. The contribution rates for the insured are decided according to their levels of income to ease the burden of low-income people. Individuals are expected to pay 10% of fees and food costs for institutionalized care. However, there are upper limits for the service fees, and these limits are lower for people with low incomes (Ministry of Health, Labour & Welfare, 2002a).

Several types of services related to elder care were increased due to the government effort. The number of full-time home helpers increased from 31,405 in 1989 to 59,005 in 1994. The number of centers providing day services increased from about 1,000 in 1989 to over 5,000 in 1994 (OECD, 1996). In addition, data reported in 2002 indicated that the LTCI resulted in increases in both the number of long-term care facilities and the usage of those services (Ministry of Health, Labour & Welfare, 2002a). According to a survey conducted by the Ministry of Health, Labour and Welfare (2002a), roughly 86% of respondents replied that they were "satisfied" or "nearly satisfied" with the services provided under the LTCI, and many replied that the family burden of elder care was lightened due to the LTCI. Thus, with the Gold Plan and establishment of the

LTCI, more services became available to elderly people and their caregivers, and the support system for caregivers was expanded. Before the LTCI, it was the government who determined the needs of frail elders receiving long-term care services, but due to the LTCI, these services became available to anybody who needed the services (Sato, 2002).

Changes in society pressured the traditional philosophy of filial piety into modernized ideas in Japan. Japanese people started to realize the importance of selfhood by getting higher levels of education and recognizing the cultural influence of Western industrialized countries (Maeda, 2000). The sense of selfhood caused many people, including both young and old generations, to prefer living as nuclear families, rather than living with two or three generations together. Moreover, many young people started to have jobs in industry or government instead of agriculture, and these people began to move to places where jobs were available for them. As young people started to move, it became difficult for older people to live with their children, and this resulted in the increase in nuclear families (Ministry of Health, Labour & Welfare, 2002b). These familial changes made it difficult for modern families to carry out tasks for elderly caregiving (Barusch, 1995). Therefore, it became necessary for the government to implement a new elder care policy to support family caregivers in order to stop the decline in family caregiving. Thus, the government announced the Gold Plan with the hope of reducing the number and the length of hospital stays of the elderly by promoting education and enhancing services for elder care in nursing facilities and at home (Kosaka, 1996). At the same time, the government attempted to shift some responsibilities for elder care to families by enhancing home-based care for the elderly (Ogawa & Retherford, 1997). Additionally, LTCI was implemented with the expectation that this new insurance

will encourage families to stay in the field of caregiving for their elderly members instead of depending on public services.

Current Direction of Elder Care Policy and Related Research

Changes in the age composition of the population and the approaches to providing care for the elderly evident in both Canada and Japan have led policy makers to adjust policies in order to form a support system for informal caregivers who play multiple roles in the provision of care for the elderly. The OECD (1996) highlighted the importance of balancing the needs of elderly people and the government to keep frail elderly people at home with the needs of family caregivers to maintain normal family functions such as preserving sufficient income, caring for children, and maintaining well-being of family members. Moreover, policy makers have realized that supporting informal caregivers by extending social policies is crucial in order to keep the informal caregivers in the caregiving field, and several interventions to support informal caregivers have been developed (Noelker & Bass, 1989).

Although the current emphasis in Canada and Japan is on informal caregiving, numerous studies have focused on the relationship between formal and informal caregiving. Most research on the linkage between formal and informal care has attempted to identify the relationships between the two sources of care. According to Penning and Keating (2000), a substitute model was prominently supported by the literature until quite recently. It was assumed that there was no collaboration between formal and informal caregivers because when formal care was available, informal caregivers tended to reduce their involvement in caregiving (Denton, 1997; Penning & Keating, 2000). Placing an elderly member of the family into an institution indicated that the family was unwilling or

incapable of caring for the frail elder (Penning & Keating, 2000). However, findings of past studies lacked consistency and conclusiveness, and some researchers argued that there were not enough empirical data supporting the substitute relationship between formal and informal caregiving (Denton, 1997).

Since the 1990s, partnerships between formal and informal caregiving have been emphasized. This complementary model emphasizes how the best care "emerged from caring partnerships, a collaborative effort in which services are provided by people with varying informal and formal relationships to a senior" (Penning & Keating, 2000, pp. 77-78). In terms of care for the frail elderly, the literature illustrated the current belief that it should be the informal caregiver that comes first, and that formal care should be used only to assist informal caregivers when the care requirements become heavier, or family resources for the care are insufficient (Penning & Keating, 2000).

Despite the large body of literature on elder care and the linkage between formal and informal caregiving, little is known about how traditions and cultural beliefs influence this relationship. Kiefer (1987) declared that Japanese family caregivers tend to seek less outside help in elder care compared to those in Western nations. Also, how formal and informal caregiving work together is still unknown. Additionally, there is a gap between policy makers' beliefs about what is needed to support informal caregivers and the actual demands of informal caregivers (Harlton, et al., 1998).

Research Questions Addressed in the Current Study

In order to address this gap in the literature, this study examined the influence of traditions and cultural assumptions on the role of families in the field of elder care in Canada and Japan. The objective of the study was to compare and contrast public policy

and the role of families in elder care in the two countries. Research questions answered in this study were as follows: (1) How do differences in traditions and social demands influence elder care policies in each country? (2) What role does each government expect families to take in care provision for frail elderly? (3) How does each government support frail elders and family caregivers? (4) Based on the similarities and differences identified in the case study of the two countries, what recommendations for policy can be made? A case study using the two countries was conducted.

First, in order to answer research Question 1, historical changes in each government's policy toward elder care was reviewed. Furthermore, beliefs and public opinion of people in each country with regard to elder care were analyzed. Second, in order to answer research Question 2, information on each government's expectations of families was analyzed through examination of public documents. Moreover, the elder care system in each country was analyzed with particular focus on the level of state involvement and the expectations that each government puts on family caregivers in care provision for the elderly. Third, to answer research Question 3, existing elder care policies that support family caregivers in the two countries, including long-term care, home care, caregiver leave, and caregiver benefits programs were reviewed. Finally, to answer research Question 4, current public issues in the elder care system in each country were compared and contrasted in order to make recommendations for change.

CHAPTER 3: METHODOLOGY

Significance of the Study

Understanding diverse policies on elder care can facilitate improving the situation of both elderly people and their family caregivers in Canada and Japan. A comparative analysis of elder care policies in the two countries is important as the population in both countries is aging rapidly and both governments have emphasized home care when reforming elder care policies. Barusch (1994) declared "the knowledge from other cultures will enhance policy development and program design by expanding the realm of possible approaches and possible consequences" (p. 34). Moreover, Heidenheimer, Heclo and Adams (1990) affirmed that the assessment of one situation against another could enable researchers to gain a better perspective on current situations as well as the options and constraints that exist. The comparative analysis the present study undertakes could enhance policy development as well as program design and implementation in the two countries.

Research Design and Procedure

Case Study

From the various research methods available, the case study method was selected. The case study method is a way of examining "a contemporary phenomenon within its real-life context" (Yin, 1989, p. 23) and is appropriate when the investigator has little or no control over the questions being asked (Yin, 1989). The core concept of the case study method is that researchers can appropriately obtain data needed to do the research by intensely exploring a single example. However, the focus of a case study is not always a single case. The method more often exemplifies several cases with unique contexts or

specific backgrounds. This study focused on two countries, Canada and Japan. Case studies allow researchers to understand great details and accurate information about particular cases (Rothe, 2000). However, the case study method does not provide enough bases for generalization (Yin, 1989). Considering this limitation, this study did not aim to generalize but focused on description and explanation of the cases with a view to making recommendations.

Social Policy Analysis

Several policies are in place to provide care for elderly people in both Canada and Japan, and some policy instruments are used in each country. Policy instruments are tools by which governments attempt to put policies in effect (Howlett & Ramesh, 1995). Several kinds of policy instruments are shown in Appendix A. According to Howlett and Ramesh (1995), in theory, there is more than one instrument that can be used to accomplish most policy objectives. Additionally, in a technical sense most instruments can be substituted for one another. However, in practice the choice of instrument is a complex matter because "different instruments involve varying degrees of effectiveness, efficiency, equity, legitimacy, and partisan support, which affect their appropriateness for a particular situation" (Howlett & Ramesh, 1995, p. 83). Therefore, the challenge of the government in public policy-making is to choose the instrument or combination of instruments that is most appropriate to carry out the task. When choosing the instrument, the government needs to take into account both the limitations and capabilities of each instrument in addition to the political consequences of its employment (Howlett & Ramesh, 1995). Several factors have influenced the government's instrument choice in elder care in both Canada and Japan. This study examined the instruments used in each

country, focusing on how each government saw families as a source of caregiving for their elderly people.

Data Sources

Data sources for this study were documents such as annual reports, white papers, policy statements, and study reports. Documents from each federal government, written within the last 25 years, were used in order to examine the expected role of families in elder care in each country. In addition to documents, public opinion polls from the two countries were examined in order to understand the differences in public opinion with respect to elder care. No direct contact to policy personnel or recipients was made.

Data Sources for Documents

Numerous government reports and independent studies have appeared, indicating the importance of familial care for frail elderly people in Canada. At the national level, social policies related to elder care are mainly implemented by Health Canada. Health Canada has a division called "Division of Aging and Seniors," which plays the role of federal leadership in areas relating to aging and seniors. "The Division serves as a focal point for information and [as a] center of expertise" (Health Canada, 2003a, p.1). Additionally, the Division conducts and supports research and education activities in order to provide advice and support on policy development. The Division contains the "National Advisory Council on Aging" (NACA), which provides assistance and advice to the Minister of Health regarding matters related to population aging in Canada and the quality of life of seniors. NACA reviews the needs and problems of seniors and makes recommendations to the government. As well, research is conducted by NACA in order to improve the situation of seniors. NACA also "selects the best policy and program

alternatives and develops its position on the issues under study," as well as monitors policy development in Canada and abroad (NACA, 2004, p.5). Since Health Canada directs the development of policies related to elder care, governmental reports used in this study were collected mainly from the Health Canada website. In addition to study reports from the Division of Aging and Seniors and NACA, reports by other groups or individual researchers that are found in the Health Canada website were also used in this study in order to examine opinions from a variety of sources.

The Cabinet Office and the Ministry of Health, Labour, and Welfare are the two places in which policies related to elder care in Japan are implemented. In 1995, the federal government enacted "The Basic Law on Measures for the Aging Society." This new law aimed to review social policies relating to employment, pension, medical care, welfare, and education, as well as the social involvement and living environment of seniors, in order to prepare for an aging society. Later in 1996, "General Principles Concerning Measures for the Aged Society" was formulated by the Cabinet Office. In this document, the two offices, the Cabinet Office and the Ministry of Health, Labour, and Welfare, were named as the two major bureaus that had the responsibility of promoting policies for the aged society in Japan. The document promised close coordination between the two bureaus as well as coordination with other relevant government bodies (Cabinet Office, 1996). Therefore, public reports and documents examined in this study were mainly collected from the website of the Cabinet Office and the Ministry of Health, Labour, and Welfare. Besides documents from the federal government, statements made by an advocacy group, the Women's Association for a

Better Aging Society (WABAS) were included in the analysis in order to understand the situation of families from a different viewpoint from the government.

Data Sources for Policies

Most policies related to elder care in Japan are implemented through the federal government, whereas some are implemented through provincial governments in Canada. In order to examine provincial policies in addition to those of federal, data for examining existing policies that support frail elders and their caregivers in Canada were searched from various sources, including Health Canada, Manitoba Health, and the Seniors Policies and Programs Database (http://www.sppd.gc.ca/default_e.html), which includes existing policies related to seniors in all provinces and territories in Canada. Similar policies in Japan were obtained from the federal government's websites. For each policy and program, details such as (a) the goals and objectives, (b) forms of benefits or services delivered, and (c) entitlement (eligibility) rules were collected.

Long-term and home care programs in Canada vary across provinces, whereas they are universal across the nation in Japan. Therefore, the Manitoba Home Care Program was compared to Japan's LTCI, which includes both long-term and home care. Long-term care and home care programs in Manitoba were analyzed as examples of these programs in Canada because the community care system in Manitoba is considered to be one of the most extensive in the country (OECD, 1996). Also, the Manitoba Home Care program is the oldest, province-wide, comprehensive, and universal program in Canada (Thompson & Motuz, 1982).

Data Sources for Public Opinion Polls

The details of public opinion polls used in this study are as follow. A survey, conducted by POLLARA (2002), was prepared for the Commission on the Future of Health Care in Canada (Romanow Report). Complete survey questions and results used in this study are shown in Appendix B. The data for this survey were collected by two methods: (1) on-line questionnaire and (2) a small portion of mail-in workbooks. The survey was posted on-line between May 16, 2002 and September 30, 2002. A total of 509 surveys were completed on-line during this time. However, because respondents could withdraw from the on-line survey at any time, the overall participation rate varied on a question-by-question basis. There are several reasons why the results of this survey cannot represent Canadians as a whole. First, participants were not randomly selected. All participants voluntarily participated in the survey. Also, there was a possibility of having multiple responses made by the same participant in this survey.

POLLARA (2002) stated that due to the nature of the data, it was not possible to conduct tests of significance. However, this study used the survey results only to examine the overall differences between the two societies, Canada and Japan. The survey results by POLLARA (2002) may not represent the Canadian population as a whole, but they provided a useful contrast to study attitudes toward elder care in the two societies.

A national survey on elder care was conducted by the Cabinet Office in 2003 in Japan. The data were collected through direct interviews by trained interviewers between July 24 and August 3, 2003. A sample of 5,000 people was selected with stratified random sampling, and 71.3% (3,567) of the 5,000 participated in the survey. The purpose of the survey was to understand opinions on elder care across the nation and

to reflect those opinions in policy development. Complete survey questions and results used in this study are shown in Appendix C.

Data Analysis

In order to answer the four research questions stated earlier, several aspects of elder care system in each country were examined. Evidence for the first three research questions will be presented in Chapter 4. Furthermore, a discussion of the findings for each research question will be presented in Chapter 5. Also in Chapter 5, the fourth research question will be addressed. Table 1 summarizes the data analysis procedure.

Research Question 1

First, in order to investigate the first question, historical changes in each government's policy on elder care were reviewed. This first step provided a background of each government's policy on elder care in order to demonstrate the influence of tradition on the development of elder care policy in each country. It also helped to show how each government changed expectations of families over time.

Second, beliefs and public opinion of people with regard to elder care were provided from the results of an opinion poll in each country. The poll results helped to answer the first research question, which aimed to understand differences in traditions and social demands in public opinion on elder care. A Canadian and a Japanese opinion poll were compared in this study.

Research Question 2

Analysis of public documents was conducted in order to clarify the second research question, the expectations that each government has on families. Documents, such as

Table 1: Data Analysis Procedure

Research Questions	Data Analyses
Research Question 1: How do differences in traditions and social demands influence elder care policies in each country?	**1**. Review of the historical change in each government's policy toward elder care (provided in Chapter 4). **2**. Examination of beliefs and public opinion of people in each country with regard to elder care (provided in Chapter 4).
Research Question 2: What role does each government expect families to take in care provision for frail elderly?	**1**. Document analysis related to information of each government's policy and expectations of families in elder care (provided in Chapter 4). **2**. Analysis of the instruments used in the current elder care system in each country (provided in Chapter 4).
Research Question 3: How does each government support frail elders and their family caregivers?	**1**. Analysis of the current programs supporting frail elders and their family caregivers in each country (provided in Chapter 4).
Research Question 4: Based on the similarities and differences identified in the case study of the two countries, what recommendation for policy can be made?	**1**. Examination of results from comparing and contrasting the two countries (provided in Chapter 5). **2**. Examination of current and emerging issues related to each care policy (provided in Chapter 5).

annual reports, white papers, and health reports, were examined with regard to how care was provided by families for their frail elderly members.

Instruments used in each country were also analyzed to investigate the second question and to illustrate the expectations that each government has on families in elder care. Policy instruments were categorized into three groups: voluntary, mixed, and compulsory (see Appendix A for more details). The role of families as an instrument

(Howlett & Ramesh, 1995) of the elder care system was illustrated by examining all instruments used in each country.

Research Question 3

Existing elder care policies related to support to family caregivers such as long-term, home care, caregiver leave, and caregiver benefits programs in each country were reviewed in order to answer the third research question. Analysis of these programs followed, in part, Chambers' (1993) process of policy analysis. There are six characteristics that Chambers (1993) identified as important to understand social policies and programs: (1) "goals and objectives, (2) forms of benefits or services delivered, (3) entitlement (eligibility) rules, (4) administrative or organizational structure for service delivery, (5) financing method, and (6) interactions among the foregoing elements" (p.77). However, in this study, the first three elements were analyzed because the last three did not relate to the focus of this study; the first three were helpful to identify how each government supports families in elder care. Furthermore, several evaluation criteria (see Appendix D for the details) for each of the six operating characteristics were classified by Chambers (1993). These criteria were used in a brief evaluation of each program in order to examine each government's support toward elderly people and their family caregivers. For example, goals and objectives of a program or policy were analyzed with such evaluative criteria as clarity and measurability. Forms of benefits and services were analyzed using such criteria as target efficiency, cost effectiveness, and complexity of administration. However, the emphasis of this part of the analysis was on the description of each program rather than on the evaluation.

Research Question 4

Current issues in the elder care systems in Canada and Japan were identified from the examination of elder care policies and the system in each country. Furthermore, the comparison of these results illustrated several emerging issues in the two countries. Based on these issues identified in this study, recommendations for policy were made in order to answer the fourth research question. Because it was necessary to compare and contrast the results from the two countries before discussing this question, this research question was addressed in Chapter 5.

Verification of the Data

Several strategies were employed in order to ensure the validity of the data. First, data were collected through multiple sources including documents such as annual reports, white papers, and policy statements (triangulation of data). Second, all data used in this study, including documents and opinion polls, were available to the public and should be easily obtainable by anyone. The validity of research is established when the research process is made visible and auditable. Therefore, an audit trail that will enable other researchers to reconstruct the entire process was provided. Lemieux (1996) declared that the audit trail must provide "sufficient contextual information" and description of "the rationale for coding of data into patterns and themes" (p. 47). The audit trail of this study included raw data, data reduction, and analysis processes. Records of data used in the description of policies as well as criteria and measures used in analysis and evaluation of the policies were kept. In addition, documentation of which criteria were used in which part of the evaluation was kept. Since all data used in this study were documents that are open to the public, it was not necessary to go through human ethics review.

CHAPTER 4: NATIONAL CASE STUDIES

This chapter will examine the elder care system in both Canada and Japan, and it will use systems theory as the lens through which to view the two countries. As the theory states that examination of the context is necessary in order to understand individual behavior, elder care contexts in the two countries will be examined in order to understand the role of families in each country. Several factors that have influenced the current elder care systems and programs in each country will be examined.

The first three research questions will be addressed in this chapter by examining evidence from each country. Data analysis for the first research question will consist of two elements: historical changes in government policy toward elder care and beliefs and public opinion of people in each country with regard to elder care. The examination of the second research question will also include two elements: information on each government's views and expectations of families, and the current elder care system in each country. The third research question will be investigated by the examination of existing elder care programs, which support frail elders and their family caregivers in the two countries, including long-term and home care programs, as well as caregiver leave and caregiver benefits programs. Examination of Canadian evidence for each research question will be followed by the Japanese evidence. The focus of this chapter is on the analysis of evidence from each country, and the comparisons and contrasts of the two countries will be provided in the following chapter. Because the last research question requires the comparison of results from the two countries, it will be addressed in Chapter 5.

Canada

Historical Changes in Government Policy toward Elder Care in Canada (Research Question 1)

The following section will examine how the Canadian government changed its policy toward elder care over time. Examining historical changes in governmental policy toward elder care is helpful in understanding the influence of cultural traditions on elder care policy, which relates to the first research question.

Canada's elder care system is currently managed by a mixture of both the federal and provincial and territorial governments. According to Alexander (2002), the federal government's policy toward supporting the elderly has periodically changed in its history. Two areas, income security and housing programs, are a continuing concern of governments, and they form a basis for independence of elders in Canada (Alexander, 2002). Recent demographic trends in society and governments' deficits of health care funding increased attention paid to community-based services.

Health and welfare were traditionally conceived as local responsibilities, and it was not until the Great Depression that national pressure to share the responsibility of helping the unemployed and the unemployable, which were mostly the elderly, emerged. However, the federal government's support was limited to hospital and medical care at the beginning. In the 1960's, under the influence of economic growth, the federal government commissioned the first study in the nation on the elderly and their needs. The study, which was done by the Special Committee on Aging, emphasized the importance of supporting the independence of the elderly and made several recommendations. Some of the issues identified by the Committee, such as "inadequate income security, the lack

of coordinated planning, ageist social attitudes, and the lack of adequate human resources training in the field of aging," are still relevant today (Alexander, 2002). In 1966, the Canada Assistance Plan (CAP) was implemented with the hope that it would promote independence of poor persons by improving provincial programs. The federal government shared one half of the costs for welfare in each province and territory. Various services for elderly persons such as rehabilitation, homemaking, and homes or residences for the aged, were supported by the CAP.

The federal government's support for long-term care was enhanced when the Established Programs Financing (EPF) began in 1977. Support for long-term care was included in a new program, Extended Health Care Services (EHCS). With the EPF arrangements, the federal government provided insured health services, extended health care services (EHCS), and post-secondary education. Long-term care facilities and home care services developed rapidly after the federal government extended its support to long-term care. The federal government changed the cash transfer system again in 1996; The CAP, the EPF, and the EHCS were replaced by a new system, the Canada Health and Social Transfer (CHST). Under the CHST, funding for health, welfare and post-secondary education were combined into one block funding, and provincial governments could freely decide its allocation. Although the federal government stopped targeted funding for long-term care, provinces kept a strong interest in long-term care as an alternative to costly acute care. In current reports, there is no targeted funding for long-term care, but the federal government has been increasing support for caregiver and disability tax credits (Alexander, 2002).

Beliefs and Public Opinion on Elder Care in Canada (Research Question 1)

The results of a Canadian opinion survey will be presented in this section in order to understand public opinion on elder care in Canada. Understanding the current social demands is important to understand the first research question, "How do differences in traditions and social demands influence elder care policy?"

The POLLARA (2002) survey revealed strong support by Canadians toward home care. Approximately eight in ten respondents agreed that the government should expand health care spending in order to establish a national home care program. As well, a majority of the respondents (79%) agreed that a national homecare program should cover not only medically necessary services but also social support services, such as meal preparation and house cleaning because providing these services at home will probably reduce hospital use. In addition, 73% of the respondents said that it should be the government rather than the family who should take the responsibility for providing home care, and the government should provide as much formal care as needed in order not to put burden on families. Similarly, three-quarters of the respondents agreed that increased support for unpaid caregivers by the government is needed through such programs as tax breaks, respite care, and day hospitals.

Summary of Canadian Findings for Research Question 1

Since independence is highly valued in Canadian culture, the government has been emphasizing supporting elders in two areas: income security and housing programs. These are considered to be the foundation of independence for Canadian elders. Both health and welfare were traditionally considered as a local responsibility in Canada, and the federal government's support in these areas did not start until the Great Depression.

The federal government did not extend its support for long-term care services until after welfare programs were enhanced. When the country's economy was growing rapidly in the 1960s and the 1970s, the federal government expanded support for elders in welfare and health care services, including long-term care. Long-term care facilities and home care services were rapidly developed at this time, and comprehensive long-term care services were established provincially. Implementation and management of long-term care programs are currently up to each province and territory in Canada.

Although the survey mentioned above is not representative of the Canadian population as a whole, the results showed a strong public demand for the enhancement of governmental support for elder care. The public expectation of the government to enhance home care services and support for informal caregivers became clear from the results of the survey. Particularly, public support for establishing a national home care program appeared to be strong, as 80% of respondents agreed with the idea. Provincial disparity in long-term and home care programs became noticeable with the increase in attention on community-based care, and the need for national long-term and home care programs became visible.

Expected Family Role in Elder Care in Canada (Research Question 2)

The following section will review various governmental and non-governmental reports in order to examine the second research question, "What role does each government expect families to take in care provision for frail elderly?" Close examination of these reports will help us to understand the expected role of families in elder care and the situation of family caregivers in Canada.

Expected Family Role

The role of informal caregivers has been influenced by several factors including current reform in the Canadian health care system. Some argued that the recent changes in health services have strained the ability of the informal support network (FCgANS, 2001; NACA,1999b). The emphasis in health care has shifted from institutional to community-based care. Along with de-institutionalization, early discharge and short stay have increased the demand for home care, which in turn has shifted the responsibility of caregiving toward informal caregivers. According to an estimate by the Ontario Coalition of Senior Citizen's Organizations (2002), family and friends provide 85% to 90% of home care. A similar estimation was made by the Family Caregivers Association of Nova Scotia (2001) that approximately 80% of the care needs of elderly people are provided by informal caregivers. Additionally, it was estimated that family caregivers save over $5 billion a year in costs for the health care system and they provide the work equivalent of more than 276,000 full-time employees (FCgANS, 2001). Thus, informal caregivers are an integral part of the Canadian health care system.

Nevertheless, resources and services for informal caregivers provided by the current health care system are not enough to respond to the increasing demands and needs of caregivers (FCgANS, 2001; NACA, 1999b, 2002). There is growing concern about how much burden long-term caregiving can put on the shoulders of caregivers. Although some studies found positive outcomes of caregiving, most studies emphasized the significance of negative consequences of elder care (Biegel & Schulz, 1999; Hooyman, Gonyea & Montgomery, 1985; Keating, et al., 1999). Much attention has been paid to the psychological consequences, and past studies have found that depression, anxiety,

loneliness, guilt, and frustration are typical psychological impacts of caregiving (Biegel & Schulz, 1999; Brody, 1990; England, 2001; Haggan, 1998; Keating, et al., 1999). England (2001) suggested that caregiving can cause emotional damage, which in turn can lead to caregivers' exposure to adverse events. Physical consequences such as sleeplessness and headaches were also found in past studies (Brody, 1990; Keating, et al., 1999). To improve the current situation of informal caregivers, several recommendations to expand the support for informal caregivers were made by various organizations (Canadian Caregiver Coalition [CCC], 2002, 2003b; FCgANS, 2001; NACA, 2002).

For example, the CCC stated several recommendations to the government in its policy papers. The CCC is an association that aims to unify the voices of caregivers and addresses their needs across Canada. The CCC consults and lobbies policy makers to promote the needs of caregivers and to improve the support system for them (CCC, 2003a). In a 2002 policy paper, the CCC emphasized three main points as recommendations to the federal government: (a) to recognize caregivers as essential partners in home and community care systems, (b) to ensure that caregivers are able to receive sufficient support, such as health, social, and financial support, and (c) to provide comprehensive services to individuals who need care at home or in the community (CCC, 2002). The CCC made several more recommendations in a 2003 policy paper, of which the main two were: (a) to increase public awareness in terms of the needs of caregivers and issues facing caregivers, and (b) to increase support for caregivers in order for them to be able to balance work and caregiving commitments (CCC, 2003b).

Some of these recommendations from groups and associations supporting informal caregivers were reflected in the final report by the Romanow Commission,

which reviewed the current health care system in Canada and made recommendations in order to improve the existing system. In addition to the Romanow Commission report, the following will examine sections related to elder care in the two other reports, The First Ministers' Accord on Health Care Renewal and The Liberal Task Force on Seniors, which also examined the existing health care system and stated proposals to improve the current health care system in Canada.

Romanow Commission Report

The Romanow Commission was established to conduct public hearings across Canada on the health care system. The final report was made after extensive research by Commission staff, which included studying existing reports, consulting with various health policy experts, and hearing voices from provincial government officials and many Canadians (Romanow, 2002). The Commission discussed expanding home care services in the nation. Because of the trend in shifting some health care services from institutions and hospitals to homes, it became important for the federal government to consider containing home care services under the Canada Health Act as "medically necessary" services (Romanow, 2002, p.172). However, because of the lack of a current federal mandate, it is not possible to include all home care services under the Canada Health Act. According to the report, expansion of resources and services in three areas, mental health, post-acute care, and palliative care, are considered to be critical to improve current home care services. The reason why expanding acute care services was recommended is that recent history suggested a lack of resources for treating people with mental illness in the community. Expansion of post-acute care services was thought to be necessary because without adequate resources, early discharge of patients from the hospital will only shift

the burden of care from hospitals to patients' families. As well, palliative care services were recommended for expansion because accessibility for these services was limited despite the belief that home was the best place for palliative care. Therefore, these three areas of home care were recommended for inclusion under the Canada Health Act as the first step in health care reform (Romanow, 2002).

Furthermore, the importance of recognizing the role of informal caregivers was stated, and a proposal to provide direct support to informal caregivers was made in the Romonow Commission report (Romanow, 2002). The report of the Commission declared that informal caregivers should be able to take time off from work in order to provide necessary care at home. Therefore, a proposal was made and implemented in 2004 so that caregivers would be able to receive support through Employment Insurance benefits when their family members needed care at critical times.

The First Ministers' Accord on Health Care Renewal

The First Ministers' Accord on Health Care Renewal was formulated in 2003 by provincial health officials. A vision, principles and an action plan for health care renewal were stated in the accord. In order to improve the quality, accessibility, and sustainability of the Canadian health care system, provincial and territorial governmental officials engaged in examining the current health care system and studying needs for reform. Regarding family care, the accord discussed direct support for informal caregivers. The report suggested the establishment of a compassionate care benefit through the Employment Insurance Program and job protection through the Canada Labour Code for those who need a temporarily leave from their jobs in order to provide care for a "gravely ill or dying child, parent or spouse" (Health Canada, 2003b, p.3).

The Liberal Task Force Report on Seniors

The Liberal Task Force Report on Seniors was created by a political party, the Liberal Party, which formed the federal government at the time. This Task Force studied issues related to the living conditions of Canadian seniors. Its report included opinions and concerns of not only academics and professionals who work with seniors but also seniors and seniors' representatives from all over the country. In response to previous recommendations on family care, the Compassionate Care Benefit was launched on January 4, 2004 for people who need time away from their work in order to provide care or support to "a family member who is seriously ill with a significant risk of death" ("The Liberal Task Force Report on Seniors," 2004, p.14).

Current Canadian Elder Care System (Research Question 2)

This section will examine the Canadian elder care system using *a spectrum of policy instruments* developed by Howlett and Ramesh (1995) in order to investigate the second research question, "What role does each government expect families to take in care provision for frail elderly?" According to Howlett and Ramesh (1995), the family is one of the voluntary instruments, which requires the lowest level of involvement of the government. Examination of policy instruments is useful to identify what role the government is taking in the current elder care system, which in turn will explain the government's expectation of families in elder care.

As mentioned earlier, a complex mixture of federal and provincial policies and programs exist in Canada's elder care system. Both caregiver leave and caregiver benefits were implemented and administrated by the federal government, and the benefits that each caregiver receives from these programs are equivalent to one another across the

nation. Caregiver leave is a regulation, which falls under the category of compulsory instruments, whereas caregiver benefits are subsidies, which fall under mixed instruments (Howlett & Ramesh, 1995).

Regarding long-term and home care services, since the first province-wide comprehensive home care program was established in 1974 in Manitoba, various home care and long-term care services have been provided across the country. Because long-term care policies are implemented by provincial and territorial governments, the Canadian long-term care system consists of complex policies and programs. Each jurisdiction has a unique history and uses different terminology for its long-term care, making comparisons difficult (Alexander, 2002).

Examining Manitoba as an example, the Manitoba Home Care Program fits the category of a compulsory instrument (Howlett & Ramesh, 1995). The Manitoba Home Care Program was implemented and is managed by the provincial government. Services for the program are provided directly by local governments, and each region has a coordinator. This program can be categorized as a "direct provision" of the government, which falls under compulsory instruments (Howlett & Ramesh, 1995). Compulsory instruments require the highest amount of government involvement as compared to voluntary or mixed instruments, and they confer strong authority on the government to do whatever tasks it chooses. Compulsory instruments are highly coercive and leave little discretion to the target individuals (Howlett & Ramesh, 1995). Therefore, in Manitoba, the level of governmental involvement in elder care is relatively high.

Although there is a comprehensive home care program in the province, informal caregiving provided by the family or friends is also important. According to Chappell

(1993), informal caregiving is used more than formal caregiving regarding elders. It has estimated that about 80% of care for frail elderly people is provided by informal caregivers in Manitoba (OECD, 1996). Thus informal care plays a significant role in the life of elderly people even though they also receive formal care. Formal care services, such as long-term institutional and community care programs are generally intended to complement informal care rather than replace it (OECD, 1996). Therefore, voluntary instruments are also important elements of the policy instruments used in elder care in Manitoba.

Summary of Canadian Findings for Research Question 2

Examination of various reports clarified the critical role that families play in elder care provision in Canada. Informal caregivers now provide over 80% of care needs of elderly people in the country (FCgANS, 2001; Ontario Coalition of Senior Citizen's Organizations, 2002). Because the government has been emphasizing community-based care, the pressure on families has been increasing. In the current elder care system in Canada, different levels of instruments are mixed. By examining Manitoba as an example of Canadian provinces, we can see that the level of the government's involvement in elder care is relatively high. The province provides the comprehensive long-term and home care programs in addition to the federally managed caregiver leave and benefits programs. However, families provide 80% of elder care and play a critical role in elder care provision.

Although informal caregivers make a large contribution to elder care, they do not receive enough public support. Both public opinion polls and government reports show a need for an increase in understanding informal caregivers' needs and enhancing support

services and programs for them. Examining three different major governmental reports, it appeared that the recognition of the importance of families in elder care was acknowledged. Enhancing support toward family caregivers was addressed in these reports, and the federal government started to expand help toward family caregivers by establishing a new program, the Compassionate Care Program.

Current Policies in Canada (Research Question 3)

This section will examine current Canadian programs supporting frail elders and their family caregivers in order to find answers to research Question 3, which aims to understand how the government supports both groups. In each program, three characteristics, *objectives, eligibility rules, and forms of benefits or services delivered*, which were identified as important to understand social policies and programs by Chambers (1993), will be described.

Long-term Care in Canada

Provincial governments are the principal authorities in administrating and financing health care in Canada. The federal government does not have direct responsibility for health care services except services for First Nations People and the armed forces (OECD, 1996). Although each province and territory has its own health care scheme and services, the federal government sets a standard for health care under the Canada Health Act so that each system is comparable to the others. The federal government has influence over provinces and territories because the federal government shares the financial burden for provincial and territorial health care systems. However, long-term care has received very limited funding from the federal government, and it is not as universal and uniform across the nation as the other areas of health care (Heavens

& Bray, 1996). The federal government's influence is only on the broad eligibility and administration of long-term care (OECD, 1996). These services are delivered at the community level across the nation, and there is significant variation in long-term care services.

Home Care in Canada

Home care, like long-term care, is delivered in each province, and eligibility rules and types of services available in each province differ from one province to another. The lack of a national standard for home care has been a concern for many people, and the demand for establishing a common standard across the nation has been repeatedly expressed in various reports and studies (FCgANS, 2001; Health Canada, 1999; NACA, 1999a; 2002). A report by Health Canada (1999) reviewed all home care programs in each province and territory in Canada. The report stated three general objectives of home care programs across the nation. They are as follows: to provide (1) "a substitution function for services provided by hospitals and long-term facilities," (2) "a maintenance function that allows clients to remain independent in their current environment rather than moving to a new and more costly venue," and (3) "a preventative function, which invests in client service and monitoring at additional short-run but lower long-run costs" (Health Canada, 1999, p. 10).

The Health Canada report (1999) also demonstrated the similarities and differences in home care programs across the nation. In terms of similarities among home care programs, critical findings were a common base of services and similar basic criteria for eligibility. Nursing, personal care, and home making services were found to be available in all provinces and territories. Possession of provincial and territorial health

insurance, residence in the jurisdiction, assessment of unmet needs, safety considerations in the home, and obtaining client consent are essential for eligibility across the nation.

Among various differences found by Health Canada (1999) were differences in the arrangement of charges to clients, the range of professional services available, and the models of service delivery. Regarding user charges, methods in income and assets testing, priority for low income clients, the use of flat rates per hour, and the use of third party insurance by the client all differ according to rules in each province and territory. Moreover, there is variation in available professional services, such as nursing and therapy services, among provinces and territories. For example, in some provinces, home care providers are all public workers, whereas in other provinces, they are a mix of public and private sector workers (Health Canada, 1999).

Long-term/Home Care in Manitoba

Long-term care can be received in either long-term care facilities or individual homes, and in Manitoba, both long-term and home care are managed under the Manitoba Home Care program. There are two objectives under the Manitoba Home Care program, as follows: (1) "To ensure provision of effective, reliable, and responsive home health care services for Manitobans to support independent living in the community" and (2) "to ensure co-ordination of admission to facility care when living in the community is not a viable alternative" (Manitoba Health, 2001, p.1).

The Manitoba Home Care Program is available to Manitobans of any age who require assistance with daily activities or services to remain at home. There is no premium or service charge; services are paid primarily with provincial taxes, with a small subsidy from the federal government (Manitoba Health, 2001). However, the total cost of

home care services for a client must be less than that of equivalent care at a nursing home (except in temporary circumstances) ("Lessons to be Learned," 1992). To determine the needs of each client, one assessment instrument is used for both care in homes and nursing homes. This instrument evaluates the informal supports available to each client in addition to their medical, social, and psychological state. Services for each client are determined based on the assessment of need. Home care services are provided by regional health authorities under the Manitoba Home Care Program.

Evaluation of the Manitoba Home Care Program. The objectives of the Manitoba Home Care Program appear to be compatible with the federal government's strategy of promoting seniors living in communities and reducing the use of facilities. Using Chambers' (1993) evaluation criteria, these objectives are clear, and they articulate the specific meaning of the mission. However, the eligibility rules are very broad. Although program rules stated that the services are available to any Manitoban who needs assistance for daily life, every client has to go through a needs assessment in order to receive services. Additionally, those who want to receive services in personal a care home need to go through a means test. It assesses informal care available to each client and specifies how much formal care each client is qualified to receive. Thus, services for each client are determined by the government, and each client receives different services according to the result of these evaluation. Therefore, the adaptability across users is low. The cost of the program is easily controlled by the government since it decides the amount of service that each client receives. From the family caregivers' points of view, however, they may not receive enough services and may be experiencing stress because their needs are not considered in the assessment of the clients' service needs.

Caregiver Leave (Compassionate Care Benefit)

Following recommendation #35 made in the Romanow report (2002), the federal government launched the Compassionate Care Benefit in January 2004. The stated objective of the program is to support individuals so that they can provide necessary care for frail members at home (Romanow, 2002). In order to be eligible for the program, caregivers have to have (1) more than a 40% decrease in weekly earnings from work and (2) accumulation of at least 600 insured hours in the last 52 weeks or since the start of the last claim for the benefits. Beneficiaries are able to obtain 55% of their usual earnings from Employment Insurance up to a maximum of six weeks while they take time away from work to provide care for their family members. With this new benefit, caregivers in all provinces and territories who have to be absent from work in order to provide care or support for a family member who is "gravely ill with a significant risk of death within 26 weeks" are able to take time off work and receive benefits from Employment Insurance (EI) (Health Canada, 2004).

Evaluation of the caregiver leave program (Compassionate Care Benefit). As stated in the objective, the Compassionate Care Benefit was made to support family caregivers. This new program is a step in the right direction of expanding support for family caregivers. However, the compassionate care benefit is available to a limited group of people such as full-time employees. It omits unpaid caregivers who need support, such as seniors, part-time employees, and self-employed workers. The program also does not cover those who provide care for the disabled, aged, or chronically ill unless the care recipients are at a significant risk of dying within six months. Although intended to provide support for family caregivers, the majority of caregivers that the

Compassionate Care Benefit is intended to support remain ineligible to receive any benefits from the program (Armstrong & O'Grady, 2004).

Caregiver Benefits

Several kinds of financial compensation programs for caregivers are available in Canada. These programs can be categorized into two: direct and indirect financial compensation programs. Indirect financial compensation programs are implemented by the federal government, and thus they are universal across the nation. Direct financial compensation programs currently implemented in Canada are all provincial programs; therefore, variation exists among these programs in relation to their stage of development and policies.

Indirect financial compensation programs. There are four kinds of tax credits that are available for caregivers who provide care for their family members (Finance Canada, 2002). The first two, the Infirm Dependent Credit and the Caregiver Credit, are available for family caregivers. The objective of these credits is to provide tax relief to those who provide in-home care for their family members (Technical Advisory Committee on Tax Measures for Pension with Disabilities, 2004). The Infirm Dependent Credit is available for caregivers who support adult children or relatives with mental or physical infirmities. Those eligible for the infirm dependent credit are relatives, such as parents, grandparents, brothers, sisters, aunts, uncles, nieces or nephews. To be eligible for the credit, dependent persons must be assessed by a physician as having a severe and prolonged mental or physical impairment.

The Caregiver Credit was introduced in 1998 and is available to caregivers who reside with, and provide in-home care for, a parent or grandparent aged 65 or older, or a

relative such as an adult child, brother, sister, niece, nephew, aunt, or uncle with infirmity. In 2004, both credits (the Infirm Dependent Tax Credit and the Caregiver Credit) reduced the supporting individual's federal tax up to $605. These credits are available only when the dependent's net income is low. When the dependent's net income exceeds $12,921, the credit starts to decrease, and the credits are no longer available when the dependent's net income reaches $16,705 (Technical Advisory Committee, 2004). Caregivers residing with, and providing in-home care for, a frail relative are able to claim either the Infirm Dependent Credit or the Caregiver Credit (Finance Canada, 2002).

Third, family caregivers can receive an unused portion of the Disability Tax Credit. The unused portion of the Disability Tax Credit can be transferred by a disabled person to a spouse or to supporting relatives. This credit is available to those who are restricted from performing at least one of their basic activities of daily living and who are determined by a physician as having a severe and prolonged impairment. For 2004, the credit reduced eligible individuals' or their caregivers' federal tax by up to $1,038 (Technical Advisory Committee, 2004).

The last tax credit that family caregivers may receive is the Medical Expenses Credit. Caregivers can claim the medical expenses their dependent relatives incur. To be eligible for this credit in 2004, the applicants' total expenses must exceed $1,614 or 3% of their net income. The credit equals 16% of the qualifying medical expenses (Technical Advisory Committee, 2004). Entitled medical expenses covered are items such as medical equipment and devices, payments to health practitioners and care attendants as well as costs of travel for special treatment. A dependent person may hire a family member (excluding spouses), and claim the cost as long as pay roll deductions have been

completed and a federal income tax receipt has been issued (Canada Revenue Agency, 2003).

Direct financial compensation programs. In addition to the indirect financial compensation programs, there are several direct financial compensation programs; these are implemented by provinces. First, Self-Managed Care Programs are "the purest form of cash and counseling programs available in Canada" (Keefe & Fancey, 1998, p.59). The objective of these programs is to provide individuals more options and control over the kinds of home care services they receive. Eligibility rules vary across the provinces. Under these programs, individuals are able to purchase and manage home care services they receive through direct funding from the government. If the client is intellectually disabled or unable to take on the responsibility of managing his or her own care services, several provincial alternatives are available for appointing case managers. Most of the provinces have a self-managed care program or are in the process of piloting or developing the program. As with the disparity in home care services, there is variation among programs in the provinces (Keefe & Fancey, 1998).

Besides the Self-Managed Care Program, Quebec and Nova Scotia have a direct financial compensation program. Quebec provides payments to caregivers for respite care. Caregivers receive up to $600 per year from the province for purchasing respite care services. The program allows caregivers to hire other relatives or non-relatives to provide respite. The Home Life Support Program in Nova Scotia provides a monthly allowance to an informal caregiver of a person over 65 years. The allowance is provided by municipal governments, and both care receivers' and caregivers' incomes are tested for eligibility.

This program is available only to caregivers whose family income is below or near the poverty line (Keefe & Fancey, 1998).

Evaluation of caregiver benefits programs. Tax credits are made to support family caregivers, and The Infirm Dependent Credit and Caregiver Credit state this as their objective. However, the amount of the credits may not be adequate to provide significant support for families. Research suggests that tax relief hardly provides sufficient compensation to assist family caregiving (Keefe & Fancey, 1998). Regarding the Medical Expense Tax Credit, the minimum care expenses, which families are required to spend in order to be eligible, may be a barrier for low income families wanting to apply for the benefits.

Direct financial compensation programs have been developed provincially, and there has not been a national policy with regard to these programs. These programs enable family caregivers to have more control and options in care provision. However, since these programs are relatively new in Canada, more research is needed to understand the effectiveness and the influence of direct financial compensation programs (Keefe & Fancey, 1998).

Current Issue: Need for a National Long-term/Home Care Program

Canadian long-term care consists of complex mixture of the public and private sectors. Under the Canada Health Act, long-term care is not an insured service. The five principles of medicare do not apply to long-term care (Alexander, 2002; Keefe, 2002; Pitters, 2002). Therefore, regarding long-term care, Canada has two-tier health care. Canadians are expected to make extra payments such as user fees and co-payments in long-term care. For example, most provinces except Manitoba require their clients to pay

user fees for home support services (Keefe, 2002). Also, most seniors in long-term care facilities spend a portion of their Old Age Security (OAS) on user fees for the facilities (MacLean & Klein, 2002).

In addition to funding systems, service delivery systems in Canada also have a public-private mixture. There is variation in the public-private balance in home care services and residential care services across the provinces and territories. Regarding home care, in most cases the provincial governments contract various extra services, such as non-profit, for-profit, and voluntary agencies, to provide a wide variety of services required by clients in addition to providing direct services (Keefe, 2002). Regarding residential care facilities, fifty-one percent of facilities for seniors in Canada were owned by the private sector (Alexander, 2002).

There are several issues related to the public-private mixture in health care systems. First, low-income seniors will be significantly influenced by the rising costs of out-of-pocket expenses (MacLean & Klein, 2002). Second, as the share of the private sector increases in long-term care service delivery, quality control, especially in the for-profit private sector will be important (Nahmiash & Reis, 1992). National standards are needed in order to control these issues.

Summary of Canadian Findings for Research Question 3

Major programs supporting frail elders and their caregivers in Canada were reviewed in this section. Policies and programs related to elder care are implemented by each province and territory in Canada, and there is a variation in programs and services available to individuals across provinces. Provincial differences in long-term care, home care, and caregivers' benefits programs suggest inequality in situations and in experiences

of families across the nation. In order to improve the current situation and to establish a comprehensive support system for families, national standards for long-term and home care as well as for caregiver benefits are needed.

Japan

Historical Changes in Government Policy toward Elder Care in Japan (Research Question 1)

The following section will examine how the Japanese government changed its policy toward elder care in order to understand the first research question, "How do differences in traditions and social demands influence elder care policies in each country?" As was done in the Canadian section, the influence of cultural traditions on the development of elder care policies and changes in expected family roles in elder care will be shown by examining historical changes in governmental policy toward elder care.

Prior to the 1960s, responsibility for elder care was entirely on families, and there was no support system for a family providing care for an elderly member in Japan. The focus of the government at this time was on the development of the economy and establishment of very basic social services, such as public transportation and the water system (Maeda & Nakatani, 1992). After systematizing the social services to meet basic human needs, people started to pay more attention to the social and humanistic aspects of their lives. In 1963, the Law of Welfare of the Elderly (LWE) was enacted, and this law became the foundation for supporting elder people in Japan. Although from the 1960s the government began to create several programs to support family caregiving at home, in-home nursing services took a long time to develop (Maeda & Shimizu, 1991).

The federal government in Japan continued to rely on the family as a major source of elder care throughout the 1970's and 1980's. However, as the rapid increase of the aging population started to attract great attention in Japan, social policy reform in elder care began to be emphasized by the Japanese government (Campbell, 2000). In politics, policy reform to enhance support for the elderly population was used to gain votes for elections in the 1970s. In 1973, free medical care for the elderly aged 70 and over was introduced (Campbell, 2000; OECD, 1996). The logic behind this free medical care was rapid economic growth. There was a perception in society that wealth among the younger population at the time should be shared with the elderly who sacrificed their time as youth in the war (Palley & Usui 1997).

Free medical care for the elderly had a significant impact on traditional family caregiving. Families who declined to provide care for their elderly members had become problems, as they started to rely on hospitals rather than providing elder care at home (Campbell, 2000). Hospital use by the elderly population grew dramatically and the increase in health care expenditures became a critical issue. Health care costs for elderly people aged 70 and over grew by 466% between 1973 and 1986 (Palley & Usui, 1997). This problem is related to the fact that the number of nursing homes and personal care homes for the elderly in Japan was far less than the demand. Moreover, home care delivery services were also insufficient, and many elderly people who needed personal care did not have any place to stay other than the hospitals (Kimura, 1996). As a result, free medical care for the elderly was abolished and a 10% co-payment was introduced in 1982.

In the late 1980s, the government started to enhance home care services in order to reduce hospital use by the elderly population. Around this time, the government recognized family caregiving as an important factor to control health care expenditures. Additionally, the government realized the necessity of improving home care services in order to support family caregiving at home. The government introduced the Gold Plan in 1989, and the establishment of the Long-term Care Insurance (LTCI) was set as the main objective (Ministry of Health, Labour & Welfare, 2002a).

Beliefs and Public Opinion on Elder Care in Japan (Research Question 1)

The results of a Japanese opinion survey will be presented in this section in order to understand the current beliefs and public opinion on elder care in Japan. Understanding the current social demands is critical to understand the first research question, which aimed to examine the influence of social demands on elder care policy.

A national survey on elder care conducted by the Cabinet Office (2003b) revealed that 73.5% of the respondents were concerned about providing care for their family members when their family members become frail. Additionally, respondents were asked what their main concerns regarding providing care at home were, and four main issues were revealed. The first concern was physical stress from providing personal care such as feeding and bathing, pointed out by 62.5% of the respondents, followed by psychological stress (57.9%), lack of freedom due to constant care obligations (52.5%), and economic strain (50.3%). On the other hand, 68.1% of the respondents were worried about themselves being a burden on their family members when they become frail. When asked about the responsibility of providing care for parents when they become frail, 48.6% of the respondents said "it is an obligation for children to provide care for their frail

parents," while 36.1% said "children should not be obligated to provide care for their parents" (Cabinet Office, 2003b). Regarding the question on what the government's focus should be in order to improve the elder care situation in the country, expansion of home care services ranked as the top demand (60.5%), followed by the increase and improvement of institutions such as personal care and nursing homes (49.7%), and increase in support for family caregivers (46.3%).

Summary of Japanese Findings for Research Question 1

The Japanese government did not start providing support for elderly people until the 1960s, and prior to the 1960s, the responsibilities for elder care were entirely on families. Although the government set the foundation for supporting elders by enacting the LWE in 1963, the responsibilities of elder care were still on families through the 1970s and 1980s. The government began to increase supports for elders when a rapidly aging population started gaining attention. Supports for elders, especially in health care, were dramatically increased during rapid economic growth periods, but when the increase in health care expenditures became uncontainable, the government began to cut services to reduce health care costs. Around the same time, the decline in the capacity of families to provide elder care became evident, and the Japanese government finally began to get involved in the elder care field in the late 1980s. The government recognized the importance of enhancing long-term care services in homes and in facilities, and the enhancement of such services became the recent focus of the Japanese government.

The results of the survey revealed strong concerns related to the provision of elder care among the Japanese public. Not only were the respondents concerned about providing elder care for their family members, but also they were worried about

themselves becoming a burden on their family members when they become ill. High concern for family care for elderly people appears to substantiate the Japanese tradition of providing elder care within families. Similarly, almost half the respondents pointed out that the provision of care for frail elderly parents was the children's duty. Although the abilities of families to provide elder care has been identified as decreasing, the survey results indicated that there are still strong remnants of cultural beliefs and traditions in Japan with regard to family care for frail elderly members.

Expected Family Role in Elder Care in Japan (Research Question 2)

In this section various governmental and non-governmental reports will be reviewed in order to examine the second research question, which aimed to understand the expected role of families in elder care. Expectations of the government of families and the situation of family caregivers in elder care in Japan will be revealed by the close examination of these reports.

Expected Family Role

Because elder care is considered to be the responsibility of families in Japan, most reports from the government contain a section where family care is discussed. There is no question in those reports that family care plays a significant role in elder care provisioning in Japan. However, the recent reports pointed to the decline in the capability of families to provide care to frail elders. Several reasons for the decline of families' ability to provide care for their elderly members were reported, including increased longevity, changes in living arrangements, and increases in the participation of women in the labor force (Maeda & Nakatani, 1992).

As people's average life span continued to grow, the length of the caregiving period became longer, resulting in family caregivers feeling increased burden (Ministry of Health & Welfare, 2000). Regarding living arrangements, the number of traditional three-generation households has been decreasing, and more elderly have started to live without having a younger generation in the same household. When frail elderly people live with their family members who can provide care, they have their caregivers with them 24 hours a day, but the separation in living arrangements made it impossible for family caregivers to provide full-time care. Additionally, an increased number of women who were traditionally the main providers of family care now have jobs outside the home, and fewer women are available to provide care for their frail elder family members (Cabinet Office, 2002; Ministry of Health & Welfare, 2000).

The Women's Association for a Better Aging Society (WABAS) advocates the needs and voices of women who provide care for family members across Japan. The association conducted research to understand the situation of female family caregivers and the issues they face. They focused on female caregivers because the majority (85%) of current family caregivers in Japan are women, and 90% of individuals who leave the work place in order to provide care for their family members are women (WABAS, 2002). Based on the results from their research, the WABAS promoted the necessity of a comprehensive support system for family caregivers, and the association played a propelling role for the enactment of the LTCI Act in 1997 (WABAS, 2002). The association continues to conduct research and to presents its views on how to improve the support system for female family caregivers, particularly on how to improve the system of the LTCI. For example, the WABAS suggested making changes in fees and in the

premium system and simplifying service application procedures in order to make the system user-friendly. Additionally, recommendations were made to increase the number of health professionals, health programs, and health departments focusing only on seniors as well as to enhance programs for seniors to enjoy activities and sports (WABAS, 2001).

Because families' abilities to provide care for their frail elderly members have been declining, the major concern of the government in recent years has been how to maintain the tradition of families being the primary caregivers for elderly people. The government launched the LTCI in 2000 to support family caregivers to stay in the elder care system, and the LTCI continued to be expanded in order to provide support toward family caregivers who are facing ever increasing demands from their frail elderly family members (Cabinet Office, 2002). After the enactment of the new law, "the Basic Law on Measures for the Ageing Society," in 1996, the Cabinet Office formulated "General Principles Concerning Measures for the Aged Society" that outlined basic policy guidelines to respond to an aging society (Cabinet Office, 2001). The principles were revised in 2001. The 2001 document stated that revisions were made in order to support seniors' independence and family roles, and to maintain the balance between self and public support to prepare for the coming aged society. With respect to elder care, the focus of the government was on effectual operation of the LTCI, which was launched the previous year. Since the LTCI is the core of recent elder care policies in Japan, most current reports from the government focus their attention to issues related to the LTCI.

Annual Report of the Ministry of Health and Welfare

The 2000 Annual Report of the Ministry of Health and Welfare spotlighted policies for an aging society. In terms of elder care, the report focused its attention on the

implementation of the LTCI. Contrary to the increasing caregiving demands on families, capacities of families to provide adequate care for their frail family members are declining (Ministry of Health & Welfare, 2000). Therefore, the LTCI was established in order to support family caregiving. Public assistance in the field of elder care was originally limited to low income families. The Old Age Welfare Act in 1963 theoretically changed this situation and enabled every elderly person to receive support from the government when support is needed regardless of his or her income level. However, before the LTCI was established, support from the welfare system was limited to those who had low-incomes and who did not have families (Brodsky, Habib, & Mizrahi, 2000). After the LTCI, supports were extended to any family who needed support regardless of the family income (Ministry of Health & Welfare, 2000).

Annual Report of the Cabinet Office

In 1996, the Cabinet Office launched an annual report that focuses on the situation of the aging society and the issues related to it. The Annual Report on the Aging Society by the Cabinet Office provides (1) annual information on the status of the aging society and policies for the aging society that were implemented in that year, and (2) policies for the aging society that will be adapted in the next year (Cabinet Office, 2002, 2003a). This annual report is based on the Basic Law on Measures for the Ageing Society. The 2002 annual report reported that the proportion of seniors living alone will increase in the future, and it expressed concern for seniors who live independently without a family member who can provide daily support for them. Similarly, the 2003 report stated the proportion of seniors living alone or living with spouse only has greatly increased. To support those who live alone, the 2002 report promised to promote local networking for

daily life support as well for emergencies. Although the proportion of seniors who live independently has been increasing, many seniors who are in need of care are still likely to live in three-generation households in Japan (Cabinet Office, 2002). The report suggested the importance of reducing burden of family caregivers by providing relief to them. In order to provide better support for family caregivers, enhancement of services, such as home care, day services, and care in facilities, were promised in both the 2002 and the 2003 annual reports. In addition to the development of services, the report assured promotion of the LTCI as well as the improvement of service quality. Thus, the current focus of the Japanese government is on the LTCI, and the LTCI is the foundation of the Japanese elder care system.

Current Elder Care System in Japan (Research Question 2)

In this section, the current Japanese elder care system will be examined with regards to instruments used in the system in order to examine the second research question; "What role does each government expect families to take in care provision for frail elderly?" The analysis of the instruments follows *a spectrum of policy instruments* developed by Howlett and Ramesh (1995). By examining policy instruments used in the current elder care system, roles that the government and the family are taking in the current system will be clear.

The LTCI is the fundamental policy of the current elder care system in Japan. Before the LTCI, the government utilized mainly voluntary instruments, especially families, in the field of elder care, except the direct service provision for those who did not have families or who did not have enough income to support themselves. Voluntary instruments need little or no involvement by the government, and they are cost effective

(Howlett & Ramesh, 1995). Therefore, voluntary instruments are preferred in many societies, and governments often deliberately choose not to do anything about a recognized public problem when they think that the problem can be best solved by the market, by the family, or by voluntary organizations (Howlett & Ramesh, 1995). Although the government provided some supports for family caregivers, such as tax deductions, equipments loans, and housing support, support for families was minimal before the LTCI (Maeda & Nakatani, 1992). Thus, the responsibility of elder care was largely placed on families in Japan, and the level of governmental involvement was relatively low until the LTCI was introduced.

However, the LTCI (2000) changed the concept of providing support in the field of elder care and enhanced governmental support so that ordinary people, regardless of their income or existence of families, could receive support from the government (Campbell, 2000). Furthermore, the government began to employ new instruments in the elder care system with the LTCI. With the LTCI, mixed instruments, such as information, subsidies, and user fees for home care, began to be included in the system in addition to the previously existing instruments. Also, the caregiver benefit program, which is categorized as a subsidy, was introduced as a complementary support with the LTCI. Mixed instruments require more government involvement than voluntary instruments (Howlett & Ramesh, 1995).

Around the same time as the introduction of the LTCI, a regulation related to caregiver leave was implemented in 1999. This regulation falls under Howlett and Ramesh's (1995) category of compulsory instruments, which require a high level of government involvement. Thus, introduction of mixed and compulsory instruments in the

elder care system demonstrated that the government became conscious of needs and became willing to take more responsibility to improve the system in the nation.

Summary of Japanese Findings for Research Question 2

Families have been traditionally the major provider of elder care in Japan. Governmental support for frail elders and their family caregivers was minimal, and responsibilities of elder care were mostly on families. However, several changes in society, such as an increase in longevity, in women's labor force participation, and in the number of nuclear families, has led to a decrease in families' capacity to provide elder care in Japan. Therefore, the Japanese government began to increase support for family caregivers in order to encourage them to keep providing elder care for their frail family members. Supports for family caregivers were considerably increased with the launch of the LTCI.

The LTCI changed the concept of public support for family caregivers, and families became eligible for support from the government regardless of their income. With the launch of the LTCI, the government began to employ new instruments in elder care including both mixed and compulsory instruments, which require higher levels of government involvement. Thus, the involvement of the Japanese government in the elder care field has greatly increased with the implementation of the LTCI. However, as stated in various governmental documents, families are still the major source of elder care, and governmental programs and services for frail elders and their family caregivers are intended to assist family caregivers instead of replacing them.

Current Policies in Japan (Research Question 3)

In this section, current Japanese programs supporting frail elders and their family caregivers will be reviewed in order to understand the third research question, "How does each government support frail elders and family caregivers?" In each program, three characteristics, which were identified as important to understand social policies and programs by Chambers (1993), will be examined: *objectives, eligibility rules, and forms of benefits or service delivered.*

Long-term/Home Care

The federal government has the authority to form policies on health and social services in Japan. Once a plan is outlined, a law and, if necessary, a budget including the level of subsidy, are prepared and enforced by the federal government (OECD, 1996). Along with measures which are formed by the federal government, prefectures and municipalities implement programs and provide supervision to service providers. However, standards of services, which are supported by the national budget, are determined by the federal government (Ministry of Health, Labour & Welfare, 2002a). Long-term and home care services in Japan are covered by the LTCI.

There are three main objectives of the LTCI. These are as follows: (1) to restructure the existing system that was divided into health, medical, and welfare services and to create a comprehensive system for long-term care for elderly people, (2) to launch a system that was easily understandable for users in terms of its costs and benefits, and (3) to facilitate the sharing of the costs of long-term care for the elderly among society as a whole (Ministry of Health, Labour & Welfare, 2002a).

There are two eligibility rules under the LTCI, and eligible people can be categorized into two groups. First, all people aged 65 and older are eligible for this insurance (Category 1). Second, people aged between 40 and 64, who are insured by health care insurance, are also eligible for the LTCI (Category 2) (Ministry of Health, Labour & Welfare, 2002a). All frail elders in Category 1 who require support and long-term care can be covered by the LTCI. People in Category 2 who become bedridden, have dementia, or are frail because of age-related diseases are also covered. In order to receive support from the insurance, an individual's needs must be assessed by the local authorities.

Following the screening judgments, municipalities will provide a long-term care or support requirement certification to an individual. Individuals who received a long-term care requirement certification are able to use both services at facilities and in home. Beneficiaries are categorized into five groups (level 1 to 5) according to their needs. Each level has a limit in regards to the amount of care services the individual can receive under the insurance (level 1 setting the lowest limit and level 5, the highest) (Ministry of Health, Labour & Welfare, 2002a).

After the needs assessment, a care plan for each client is created by care managers, and each client still has the right to decide what types of services to receive as well as which service providers with whom to deal. People under the LTCI are required to pay premiums, and the price varies according to the category and the income level of the individual. The LTCI does not cover all the costs for services, and care recipients are required to pay a 10% user fee. When clients use services that are not in the care plan created by care managers, they are first required to pay 100% of the user fees instead of

the usual 10%. They can then claim the remaining 90% from the LTCI after they pay the full service fees. However, the user fee and premium can be waived when the family cannot afford the service (Ministry of Health, Labour & Welfare, 2002a).

Evaluation of the LTCI. The LTCI was established with a strong intention to solve elder care related issues in Japan. The government promised to build a stable system in which delivery of services is client-oriented, costs and benefits of the services are clear to clients, and clients are able to receive high quality services (Ministry of Health, Labour & Welfare, 2002a). In Japan, where families were traditionally expected to take nearly 100% of care responsibilities for frail elderly members, the introduction of the LTCI was a great step forward for the government to start providing support for family caregivers.

Regarding eligibility rules, the LTCI is available for any senior who pays the premium and needs support in daily living. The LTCI considers economic burden on low-income families, and fees such as the premium and co-payments for service costs are decided based on the income level of each user. With respect to service delivery, whether frail seniors and their families receive enough needed services is questionable because the amount of services each client is able to receive is decided by the government with an assessment test.

Caregiver Leave

The law on childcare and caregiver leave came into effect in 1999. The objectives of this law are to promote the welfare of employees who have to balance work and caregiver roles, and to support economic development of the nation by keeping workers in the labor force. Eligible family members include spouses, parents, children, and spouses' parents. The law allows individuals to take only one leave per care receiver.

This law allows caregivers to have a maximum of three months leave (six months for public workers), and it allows caregivers to keep their jobs while they have to leave work temporarily in order to provide support for their family members. The law prohibits employers from dismissing their employees from work while caregiving. There is no income support system established under the law, and employers do not have to provide any salary for caregivers during their leave period. It is up to the arrangement between the employer and the employee whether any benefit or salary will be provided during the leave. However, Employment Insurance provides 40% of usual income during the leave. When individuals receive a certain amount of benefits or salaries from their employer during their leave, the benefit from EI is reduced (Ministry of Health, Labour & Welfare, 2004).

Evaluation of the caregiver leave program. Although the stated objective of this program is to support family caregivers in balancing the two roles required at work and at home, limited eligibility makes it difficult to provide support to a broad range of people. Eligibility is limited to those who have full-time jobs. Also, since employers do not have to provide any benefits to their employees during the leave, only those who are eligible for EI have income security unless they are able to make an arrangement for receiving benefits from their employer. Additionally, EI only covers 40% of usual income, and family caregivers still have to endure the financial burden that comes with caregiving.

Caregiver Benefits

Both indirect and direct financial compensation programs exist in Japan. Indirect financial programs consist of tax credits, whereas the direct financial program consists of cash payments for family caregivers, which is called Payments to Family Caregivers.

Indirect financial compensation programs. There are two kinds of tax credits; one is for caregivers of elderly people and the other is for caregivers of elderly, who are bed-ridden. The objective of these tax credits is to reduce the burden on caregivers. Both programs are available to those who provide in-home care for their elderly family members who are aged 70 years and older (National Tax Administration Agency, 2004). There are several categories of program benefits based on the relationship between the caregiver and the care recipient, and on whether the recipient is categorized into the special care needs group. The basic credit for family caregivers is 480,000 yen (CAD$5,932). Additional credits, which are based on categories, will be added to the basic credit (see Appendix E for more details).

Direct financial compensation program. Payments to Family Caregivers were started in 2001 as part of a plan to support low income families. The objectives of this benefit are (1) to reduce the financial burden on family caregivers, (2) to support the frail elderly in maintaining at home, and (3) to improve the situation of the frail elderly so that they would be able to receive better care at home (Ministry of Health, Labour & Welfare, 2000). This benefit is available only to a very limited number of people. First, the eligible care receiver must be categorized at level 4 or 5. Second, the eligible familiy must be recognized as a low-income family, who is exempt from the Citizen Tax. Finally, a family would be eligible only if it has not used any services, except short stay less than a week, from LTCI in the previous 12 months. Eligible individuals receive a money transfer of 100,000 yen (approximately CAD$1,250.00) per year (Ministry of Health, Labour &Welfare, 2000).

Evaluation of caregivers benefits programs. Japanese tax credits for caregivers appear to be valuable for family caregivers. There are no income tests for eligibility rules, and caregivers are able to receive credits regardless of their income as long as they are taxpayers. The amounts of credits are significantly higher compared to Canadian tax credits for caregivers. The issue here is that these credits cannot be helpful for spousal caregivers who are retired and for those who do not pay taxes.

Regarding the direct financial compensation program, although the objectives state that the benefit is to ease the financial burden on family caregivers, the program is not intended to support a broad range of caregivers. The program has very strict eligibility rules, and it supports only low-income families with frail elderly who need high levels of care. The influence of the program on improving the family caregiving situation is minimal because the program targets very few caregivers. Thus, it can be said that unlike in Canada, direct financial compensation programs hardly exist in Japan.

Current Issues in LTCI

With the introduction of the LTCI in 2000, the Japanese government established a national comprehensive support system for individuals and families for elder care. Although services available to individuals, especially in-home services, have been increasing since the implementation of the LTCI, there are several areas that need to be improved. In 2003, three years after the LTCI was launched, four problem areas were identified by the government, and plans to improve the LTCI were proposed. First, the lack of programs and services on prevention and rehabilitation were addressed. In addition to rehabilitation services, the current program provides supports for those who are at risk of needing care yet are still able to maintain their independence in order to

prevent them from being dependent. Despite these programs, the number of dependent elderly people who need care in daily living has been rapidly increasing (Ministry of Health, Labour & Welfare, 2003b). Prevention and rehabilitation programs are important in order to support the elderly in keeping their independence. Expansion of these services, specifically development of programs that provide more information on prevention and rehabilitation, was promised.

The second issue was the rapid increase in the number of people applying for residential care facilities (Ministry of Health, Labour & Welfare, 2003b; Sato, 2002). Although the main objective of the LTCI was to increase home-care services and the use of home care services has dramatically increased after the LTCI was implemented, the number of people applying to residential care facilities also has significantly increased. Before the LTCI, it was the government that controlled both the provision and the use of services in elder care. However, the LTCI enabled individuals to have options as to what care services they wanted to receive without consulting the government, as long as they were classified as needing care services with the eligibility assessment. Therefore, the government explained that people who do not need to be in care facilities started to apply for care facilities, trying to make reservations for future needs. In fact, only thirty percent of those who applied for care facilities actually needed to be admitted to the facilities. However, Sato (2002) argued that the reason why applications for care facilities increased after the introduction of the LTCI was that the cost for individuals is cheaper for institutional care than it is for home care, considering the comprehensiveness of the services clients could receive at facilities. In order to promote home care services, plans were developed for enhancing home care services in such area as (1) providing more

respite services to informal caregivers, (2) developing services in which clients are able to receive security in home care services at any time during the 24-hour day, and (3) encouraging collaboration between care at home and in facilities (Ministry of Health, Labour & Welfare, 2003b).

Third, the lack of efficient services for elderly people with dementia was identified as a problem. Although 50% of the people who were classified as needing care had dementia, care services for them have not been thoroughly developed. There are no specific plans for care or care standards for people with dementia. Additionally, not enough information is provided for family caregivers on providing care for family members with dementia. A plan was proposed in order to educate and support family caregivers by establishing networks with communities and professionals and integrating the family caregivers in the networks (Ministry of Health, Labour & Welfare, 2003b).

The last issue in the current LTCI is related to the quality of services provided under the LTCI. Problems in the care needs assessment method, care management, and low quality of services were recognized (Ministry of Health, Labour & Welfare, 2003b). Regarding the care needs assessment method and care management, lack of efficiency in the assessment was identified. In relation to the quality of services, the lack of information on service providers was identified as problematic. Because the LTCI let non-governmental organizations such as non-profit and for-profit corporations enter the field of elder care as service providers, the choices by individuals as to where they will receive care were enhanced. It was hoped that competition among service providers, which was assumed to start with the entrance of corporations to the elder care field, would encourage keeping the quality of care services high (Brodsky, et al., 2000).

However, there was not enough information available for individuals on service providers with regard to the quality of their services, and the number of service providers was not enough for individuals to make choices. As a result, although the government set a standard for the quality of services for all service providers, the quality was not well secured in the market (Ministery of Health, Labour & Welfare, 2003b). To solve these problems, plans to improve the care need assessment and service standards were proposed as well as plans to improve training in human resources in elder care. In order to improve the quality of services, two ideas were recommended: (1) to evaluate all service providers and (2) to impose penalties on those who provide a lower quality of service than the service standard (Ministry of Health, Labour & Welfare, 2003b). Thus, several issues were identified in the current LTCI, and proposals to improve the system were made by the government.

Summary of Japanese Findings for Research Question 3

Unlike Canadian programs, programs supporting frail elders and their caregivers are standardized by the federal government in Japan. Japan now has a comprehensive long-term and home care system in which frail elders are able to receive support from the government regardless of their income. In addition, supports for family caregivers are provided with caregiver leave and benefits programs. However, these programs provide supports for a limited number of people. The caregiver leave program targets only those who have employment insurance, whereas tax credits assist only taxpayers. People who need governmental support the most may not be receiving sufficient services under the current programs. Improvement of these programs as well as services under the LTCI are

necessary to provide comprehensive supports for family caregivers who are experiencing increasing pressure from elder care.

Chapter Summary

This chapter examined the Canadian and Japanese elder care systems in light of the theoretical framework of systems theory. As the theory emphasizes the importance of context in understanding individual behavior, elder care contexts in the two countries were examined in order to understand the role of families in each country. Canadian evidence for each research question was examined, followed by the Japanese evidence. See Table 2 for a summary of findings for each research question.

In both countries, governmental support for elders started by providing support for poor people who could not support themselves or who did not have families assisting them. Canadian long-term and home care services were rapidly developed in each province and territory in the 1970s when the federal government extended health care transfers. However in Japan, the federal government relied on families to provide care for elderly people until the issue of population aging became apparent in the late 1980s. At the same time, the Japanese government recognized the decline of the capacity of families to provide elder care and began to develop support for frail elders and their family caregivers. The current emphasis of both governments is converging, namely, families care for their own frail elders with governmental cost sharing support programs. However, as pressures on families to provide elder care increase, public opinion in both countries appears to demand enhancement of governmental supports. Improvement of the current programs is necessary for each government to form a comprehensive support system for family caregivers. In Chapter 5, findings from each country will be compared

Table 2: Findings for Each Research Question

Research Questions	Findings
Research Question 1: How do differences in traditions and social demands influence elder care policies in each country?	The strong tradition in Japan of providing family caregiving for their frail elderly members delayed the development of elder care policies in the country as compared to Canada.
Research Question 2: What is the expected role of families in care provision for frail elderly?	Families are the major source of care provision in both countries, and both governments currently emphasize the importance of the family role in elder care.
Research Question 3: How does each government support frail elders and their family caregivers?	Both governments gradually started to enhance programs to support family caregivers in elder care. In addition to comprehensive long term and home care, several support programs such as caregiver leave and caregiver benefits were established in both countries.
Research Question 4: Based on the similarities and differences identified in the case study of the two countries, what recommendation for policy can be made?	Improvement of the current programs is necessary for each government to form a comprehensive support system for family caregivers who are facing increasing pressure.

and contrasted, and similarities and differences between the two countries in various aspects of the elder care system will be provided as will a discussion of the results from Chapter 4.

CHAPTER 5: DISCUSSION

As the proportion of elderly people has been rapidly increasing in industrialized countries, elder care has become a significant issue in public policy development in both Canada and Japan. In both countries over 10% of the current population is 65 years and older (12.8% in Canada and 19% in Japan) (Statistics Canada, 2004; Statistics Bureau, 2003). This study compared and contrasted the role of families in elder care in the two countries. A case study of the role of families in elder care in each country was conducted in order to answer the following four research questions: (1) How do differences in traditions and social demands influence elder care policies in each country? (2) What role does each government expect families to take in care provision for frail elderly? (3) How does each government support frail elders and family caregivers? (4) Based on the similarities and differences identified in the case study of the two countries, what recommendations for policy can be made?

In this chapter, the first three questions will be discussed, comparing results from the two countries. Next, the fourth research question will be discussed with an examination of emerging issues. Finally, implications and limitations of the study as well as future research suggestions will be discussed.

Research Question 1: How Do Differences in Tradition and Social Demands Influence Elder Care Policies in Each Country?

Historical changes in governmental policy toward elder care and current beliefs and public opinion on elder care in each country were examined in order to answer the first research question, which aimed to understand the influence of cultural traditions and social demands on elder care in each country. Some similarities between Canada and

Japan can be seen in paths taken in relation to elder care. Both governments have been altering their elder care policies in order to adjust to changes in their societies. As systems theory states, changes in one sub-system influences the whole system, and changes in governmental elder care and within families have influenced each other. In both societies, policies on seniors expanded with the rapid growth of the economies during the 1960s. Supports for elders began as assisting poor people in both countries and were enhanced to include health care and income support for frail elders. However, as the growth of the economy slowed, both governments' policies toward elder care policies changed.

Modernization of society is linked with the standardization of family life, a concept Cheal (1991) calls a "normal family" (Cheal, 1991). In modern society, as individualism started to be highly valued, individual identity and autonomy became more important than group identity. Several alternatives to normative marriage with children began to appear in the 1960s, especially in Western countries. The roles that families and each family member take have been becoming more individualistic (Cheal, 1991).

The influence of Western modernization and individualism changed Japanese society as well. The situation surrounding elder care was significantly altered. Family structure gradually shifted from a base in strong intergenerational relationships to emphasis on the nuclear unit. Additionally, the role of women who cared for elderly parents started to change in Japan. Women's participation in the labor force has increased steadily (Ogawa & Retherford, 1997). The number of married women who have professional jobs has also increased, and these women with professional jobs are not likely to quit their jobs to care for their elderly parents (Maeda, 2000). Therefore, the individualism that was developed and cultivated in industrialized society changed the

roles of families and their members, which in turn altered elder care situations in both Canada and Japan.

As societies became industrialized, a variety of alternatives to individual life style appeared, and family life became complicated. Post-modernists suggest that deconstruction of traditional values is needed in order to understand contemporary society. For example, elder care, which was traditionally considered to be a normal task in family life, is not considered to be a part of normal family responsibility in post-modern societies.

Although public opinion polls in Canada and Japan were conducted using different methods, the results highlighted some similarities and differences in public opinion in the two countries. First, in both countries, the majority of respondents, 80% in Canada and 60.5% in Japan, believed that it is necessary for governments to expand and improve the home care system in each country (Cabinet Office, 2003b; POLLARA, 2002). Similarly, an increase in supports for informal caregivers was requested in both countries. These results clearly indicated public demands for the government to increase support for families with regard to elder care.

In contrast, differences were observed related to beliefs in family caregiving. The proportion of people who were concerned with providing care for their frail family members is much higher in Japan (73.5%) as compared to Canada (24%) (Cabinet Office, 2003b; POLLARA, 2002). Results suggested that Japanese families are under more pressure to provide family care for their elderly members compared to Canadian families. In fact, while nearly half the respondents in the Japanese opinion survey said that it is an expected duty for children to provide care for their frail parents, in the Canadian survey

approximately three-quarters of respondents said the government rather than families should be responsible for providing care for their frail family members (Cabinet Office, 2003b; POLLARA, 2002). Differences in tradition appear to have played a significant role in beliefs about provision of care for elderly people in the two countries. Obviously, the belief that providing care for their frail elderly members is a family duty remains stronger in Japan than in Canada. However, it is important to note that the Canadian survey results do not necessary represent opinions in the whole country since random selection of respondents was not used.

When families' capacity to provide care for their frail family members declined, the governments of Canada and Japan realized the necessity of taking action in order to help families with elder care. Therefore, both governments gradually started to enhance programs to support family caregivers in elder care. In addition to comprehensive long term and home care, several support programs such as caregiver leave and caregiver benefits were established in both countries.

Research Question 2: What Role Does Each Government Expect Families to Take in Care Provision for Frail Elderly?

Information on each government's views and expectations of families and the current elder care system were analyzed in order to investigate the second question, which aimed to understand the governmental expectations of families. Although there are similarities in the paths taken with regard to elder care, different approaches were observed in the development of elder care policies in the two countries. In Japan, until the LTCI was introduced in 2000, voluntary instruments, especially families, were the main source of elder care, and the involvement of the government in the field of elder care was

relatively low. While comprehensive home care services started to develop in Canada during the 1970s, similar policies did not become accessible to most Japanese until the LTCI was launched in 2000. It appeared that Japan's strong tradition of providing family caregiving for its frail elderly members delayed the development of elder care policies in the country.

It is also the case that there are cultural differences in the perception of stress created by caregiving (Biegel & Schulz, 1999; Fry, 2000; Martin, 2000). Fry (2000) examined cultural differences in elder care and claimed that "caregiving is [a] cultural response" to support elders who have difficulties with daily activities (p. 771). The traditional belief that elder care should be provided within families significantly influenced the government's expectation of families in elder care in Japan. Elderly parents traditionally lived with their adult offspring, and family members provided constant elder care at home (Kiefer, 1987; Maeda & Shimizu, 1991). From a traditional Japanese point of view, the use of formal care services carried a stigma regarding exposing family problems to outsiders, and the Japanese people preferred to provide elder care within families (Hirayama & Miyazaki, 1996; Kamo, 1988). Therefore, the government expected families to take the principle responsibility for elder care, and the development of long-term and nursing facilities as well as home care services for elderly people was delayed in Japan (Maeda & Nakatani, 1992; Maeda & Shimizu, 1991).

Because of strong beliefs regarding family caregiving, the Japanese government did not have to be involved in elder care until the decline of families' abilities to provide care became evident. Nevertheless, in post-modern Japan, the cultural beliefs and attitudes toward elder care have altered, and the capability of families to provide elder

care has declined (Campbell, 2000). As explained by systems theory, changes in society and in families pressured the Japanese government to enhance supports for elder care. Consequently, a variety of programs supporting frail elders and their family caregivers have developed in Japan, and the level of the Japanese government's involvement in the current elder care system became comparable to that of the Canadian government.

Currently, the federal governments of both Canada and Japan have been promoting community-based care in each health care system, and the improvement of home care services is the current focus of elder care. As the public in both countries demand (Cabinet Office, 2003b; POLLARA, 2002), both governments have proposed improvement in home care services in order to enhance support for frail elderly persons and their caregivers. Families are the major source of care provision in both countries, and both governments currently emphasize the importance of family roles in elder care. While the Canadian government has been trying to shift the responsibilities of elder care to families, the Japanese government has been faced with a dilemma. Although families have been the major source of elder care, a decreasing number are able and willing to do so. Therefore, the Japanese government has been increasing supports for family caregivers in order to keep the tradition of family care.

Research Question 3: How Does Each Government Support Frail Elders and Family Caregivers?

Several current programs supporting frail elders and their family caregivers, such as long-term care, home care, caregiver leave and caregiver benefits programs, were reviewed in order to examine research Question 3, which tried to capture the current governmental support system in each country. A close examination of two specific

programs, long-term and home care services, shows that families can receive help via public health insurance (Canada) or long-term care insurance (Japan) regardless of income level. Additionally, the range of these services provided by each country is comparable, from personal care such as cooking, feeding, and bathing to nursing care.

Although there are some similarities in long-term and home care services, there is a fundamental difference between the two countries. Japanese long-term and home care services are provided under the LTCI, which is a national comprehensive program, whereas Canadian services differ by province and territory. In Canada, strong provincial autonomy prevents the federal government from establishing a national home care program. However, because the current focus of elder care is on the enhancement of home care services, the idea of establishing a national home care program has repeatedly discussed in several governmental reports and non-governmental reports (FCgANS, 2001; Health Canada, 1999, 2003b; "Liberal Task Force Report on Seniors," 2004; NACA, 1999a; 2002; Romanow, 2002).

Establishing a national home care system could improve the current home care situation in Canada in several ways. In the current system, equity and availability of home care services are not ensured across the country. Additionally, current funding is neither specified nor consistent from the federal government to provinces and territories. Funding for health, welfare and post secondary education is combined into one block fund, and it is up to each province and territory to allocate funding, which leads to differences in long-term and home programs across the nation. Establishing a national home care program could enable the federal government to create independent funding

for long-term and home care programs as well as ensuring equity in accessibility, availability, and delivery of the services across the nation

Nevertheless, several issues need to be carefully examined when establishing a national home care program. First, it is necessary to study differences in demand from people in each province and territory, and to compare current provincial and territorial programs. Demand for long-term and home care services might differ considerably by area or region. In order to guarantee equity in the services, hearing different voices and considering regional disparity is indispensable. Second, there are various family caregiver compensation programs in Canada, which are associated with long-term and home care. Only a few provinces provide direct financial compensation to family caregivers, and there are variations in the rules and the amount of compensation provided among the provinces. These family compensation programs also need to be examined, and effort to reduce differences among provinces is important in order to ensure equity for family caregivers across the nation. Establishing a national home care program and a national standard for a family compensation program could improve the situation of family caregivers in Canada.

While the caregiver leave programs in both countries are comparable, significantly different approaches have been taken in caregiver benefits programs, especially in family compensation programs. While a few provinces in Canada, such as Quebec and Nova Scotia, have direct financial compensation programs for family caregivers, there is no such program in Japan except the one that supports low income families. In the process of establishing the LTCI, one of the issues debated the most was whether to provide financial compensation for family caregivers (Brodsky et al., 2000).

The direct financial compensation method was not included in the Japanese system because the development of formal services was chosen as the top priority and cash allowances were not considered to be large enough to support a household budget. Additionally, there was a concern that cash allowances would lead to a flood of applicants for benefits. The Japanese government counted on a low number of initial applicants at the beginning of the program since the government wished to slowly phase in the program (Campbell & Ikegami, 2000).

Keefe and Fancey (1998) point out that financial compensation programs for family caregivers signify the recognition of the value of caregiving work. Since family caregiving was a strong tradition in Japan, the assumption that caregiving is a normal family task appears to still remain strong in Japan. Palley and Usui (1997) argued that recent policies in Japan are "designed to use families and community as the building blocks of Japanese services to the elderly" (p. 376). It is assumed that every frail elder needing care has at least one family member who can provide it (Sato, 2002). However, as families continue to change their roles, the Japanese government should not count on the traditional behaviors. The government may need to expand the support system for family caregivers including direct financial compensation programs, for them to keep assisting frail members.

Research Question 4: Based on the Similarities and Differences Identified in the Case Study of the Two Countries, What Recommendations for Policy Can Be Made?

By comparing and contrasting results, policy recommendations can be made in line with research Question 4. Both Canada and Japan have some elements from which the other country can learn and thereby improve. However, there are components that

both countries are missing in their current systems. First, in the assessment of long-term and home care needs, both countries assess only the needs of clients and disregard the needs of their family caregivers. Despite the central role that families play in providing care for the elderly, assessment of caregivers' needs is rather limited (Montgomery & Feinberg, 2003). In Canada, only the availability of family caregivers is included in the assessment, but the needs of family caregivers are not considered, whereas in Japan, in the new system under the LTCI, the availability and needs of family caregivers are no longer taken into account. The United Kingdom (UK) is one of the few countries to evaluate caregivers' needs. The UK system includes the needs of family caregivers when assessing clients' needs by measuring the amount of voluntary contributions that caregivers are willing to make to support their frail family members (Montgomery & Feinberg, 2003). In the current systems both in Canada and Japan, in which governments are encouraging families to take more responsibility for elder care, considering the needs of family caregivers and integrating families in the system is critical.

Second, as both Canadian and Japanese governments promote family care as the key source of long-term and home care, it is imperative to ensure the quality of care provided by family caregivers. The stress of family caregivers has been emphasized in the literature, and numerous studies have investigated the impact of caregiver stress. Although several kinds of stress, such as psychological, physical, and financial, were identified, psychological stress has been demonstrated to be a significant outcome of caregiving (Biegel & Schulz, 1999; Brody, 1990; England, 2001).

Although research supports the idea that family care is better in quality as compared to formal care (Keating, et al., 1999), quality of care provided by family

caregivers is not always adequate or safe. In order to ensure the quality of family care, policies and programs that focus on training and education of family caregivers are needed. In Canada, several reports indicated the lack of training and education programs for family caregivers (CCC, 2002; FCgANS, 2001). The Family Caregivers Association of Nova Scotia (2001) demanded information and education programs on how to provide care for family caregivers in addition to counseling services for them. In Japan, although the current focus on elder care is on enhancing formal services, demands for training and education for family caregivers will likely increase. Thus, developing educational and training programs and enhancing skills of family caregivers is essential if the governments of both Canada and Japan expect families to continue playing the primary role in elder care.

Implications of the Study

This research illustrated the mix of diverse policies in Canada and Japan as well as each government's expectation of families as a primary source of home care. Examination of existing elder care policies in each country not only helped to understand the current system, but also highlighted several elements missing in the elder care system in each country. In addition to long-term and home care programs, both countries have programs for caregiver leave and benefits. However, eligibility rules for these programs are restricted and the benefits of these programs are minimal. Although several programs that attempt to provide support for family caregivers do exist in both countries, they are not enough to provide significant support for family caregivers. Enhancement of these programs is needed in order to provide sufficient support for family caregivers. For example, the eligibility rules in caregiver leave programs in both countries need to be

reconsidered because under the current strict rules, the programs will not be beneficial to many caregivers. Also, the benefits of the programs are quite low in both countries at 55% of the average EI insured earnings in Canada and 40% of the average EI insured earnings in Japan. However, the maximum EI benefit in Canada is set at $413 per week. Family caregivers might be hesitant to use the program because the amounts of benefits are set at a relatively low level. The governments of both countries need to improve policies and programs to support the increasing number of family caregivers so that families will be willing to continue providing support for their frail family members.

Comparison of the two countries provided an example of different ways to approach common goals for providing support and care for the elderly. Many factors may influence the differences in the approach, but results from the comparison of public opinion polls between the two countries suggested differences in cultural traditions in elder care. While the belief that elder care should be provided by families still remains strong in Japan, in contrast, many Canadians appears to expect governments to take the responsibility rather than families. This difference in beliefs may have influenced the development of policies in the two countries. Direct financial compensation programs, which are considered to be a way of recognizing the value of family care (Keefe & Fancey, 1998), have been developed more in Canada than in Japan. In the current system, the Japanese government chose to enhance formal care services rather than providing financial compensation to family caregivers. Although there is a debate regarding financial compensation versus community support, there is not one single program that can provide sufficient support for caregivers in elder care tasks and in reducing their stress. Support systems for family caregivers need to contain a diverse range and mix of

services, and the interrelationship between formal and informal caregivers is crucial. Keefe and Fancey (1998) pointed out the significance of providing a different combination of services to caregivers who provide different types of care and who have different levels of dependents. A study found that whether or not choices exist in caregiver tasks is a significant factor influencing the levels of stress and disruption for family caregivers (Decima Research Inc, 2002). Thus, giving a variety of options to family caregivers is important so that caregivers are able to choose services they would like to receive.

This research focused on the role that Canadian and Japanese families are expected to take as well as governments' support systems toward them. The results of this study can provide information for policy makers to understand the situations of family caregivers in each country and the difficulties they face in fulfilling this role. Elder care systems in both countries need more development in order to establish comprehensive support systems in which family caregivers are able to provide the care needed by their frail elderly members. Although, influenced by several factors such as differences in cultural traditions, politics, and economics, different approaches were taken in the development of elder care policies in the two countries, several similarities were found between the current systems in the two countries. Since both countries have put their emphasis on the combination of formal and informal care, there is potential that the future direction of both countries would converge. Examining more than one country or one case provides valuable information from which each country can learn new ideas for programs. More research is needed comparing Canada and Japan as well as other countries that are facing the same problem of rapid population aging.

Limitations of the Study

Although the information provided in this study is important to help improve support systems for family caregivers, there are several limitations. First, public opinion polls used in this study were taken separately in each country. The questions asked in each country were not exactly the same, and the survey methods were also different. Comparing results from two polls with different types of questions was problematic because there was different bias included in each poll. While the Canadian poll appears to emphasize the significance of the government role in elder care, the Japanese poll appears to focus on the importance of the family role. Additionally, participants in Canadian opinion polls were not randomly selected; therefore, the results of the poll are not representative of the Canadian population. In order to fully understand public opinion in the two countries and to compare the differences in opinions between the two countries, two national surveys, in which the questions used in both countries are the same and the participants are randomly selected, are needed.

Second, since Canadian elder care policies and programs are established and implemented by the mix of the federal and provincial governments, this study could not include all policies related to elder care that exist in Canada. This study focused on policies and programs implemented by the federal government, which support families caring for frail elders. Additionally, the home care program in Manitoba was examined as an example of a Canadian provincial program. Examining and comparing all provincial differences in Canada would be valuable in order to wholly understand the situation of family caregivers in Canada.

Third, in analyzing the expected roles of families in elder care in each country, this study focused on reports from the federal government. As mentioned before, since provincial autonomy is fairly strong in Canada, examining reports from provincial governments would be beneficial. Also, public opinion was examined only from the results of opinion polls. The results of opinion polls captured only broad views of the public. Therefore, studying public views on family care in depth by interviews or surveys as well as by examination of a variety of reports written by non-governmental organizations would be important in order to obtain a more detailed view of public opinion.

Finally, this study focused on the description of existing policies related to elder care in the two countries. Extensive evaluation of those programs from the point of view of recipients was not included. The Japanese LTCI was started four years ago, and the Canadian Compassionate Care Benefit program started in 2004. Therefore, there was not much information available on the effectiveness of these programs. For a better understanding of the situation and problems facing family caregivers, evaluation of existing programs would be useful.

Future Research Suggestions

This study attempted to understand the role that Canadian and Japanese families play in the field of elder care as well as each government support system toward them. Although this study provided essential points to recognize in the current situation of families in elder care, further research will be needed. In order to capture the whole picture of elder care and identify issues in each system, understanding the situation from several points of view is critical. Research that includes voices and opinions from various

sources, such as family caregivers, formal service providers, and policy makers, will be valuable. Also, evaluation of existing programs is important to understand gaps in the current systems. In such research, including opinions of both family caregivers and care recipients in evaluations will be important. Specifically, examination and evaluation of family compensation programs, including actual use and / or misuse, need to be conducted in order to evaluate the effects of the programs in reducing family stress and improving care of frail members. Additionally, as the fertility rate declines and the proportion of people without children increases in many countries, public support systems toward the elderly need to be enhanced. Reexamination of the public support system for elders who do not have families who can provide care for them is also important.

Conclusion

This study examined the current situation of family caregivers in elder care in Canada and Japan. Policies and programs supporting frail elders and their family caregivers in each government were analyzed. In both countries, the emphasis of elder care has shifted from institutional care to community-based care. In the current trend in community-based care, governments' expectations on family caregivers have increased, and the responsibility of elder care is put on families. Although in both countries several programs that attempted to support family caregivers were established, these programs did not appear to provide sufficient support for them. It is hoped that this study provides information that can be a building block for policy makers and thus be a tool that helps to improve the situation of family caregivers.

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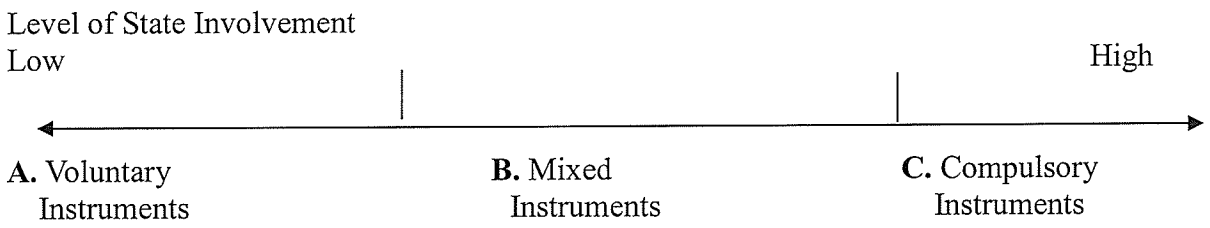
Appendix A

**A Spectrum of Policy Instruments*



A. Voluntary Instruments Instruments	**B. Mixed Instruments**	**C. Compulsory**
- Family and Community - Voluntary Organizations - Private Markets	- Information and Exhortation - Subsidies - Auction of Property Rights - Tax and User Charges	- Regulations - Public Enterprises - Direct Provision

*From *Studying Public Policy: Policy cycles and Policy Subsystems* (p. 82), by Howlett, M., & Ramesh, M. (1995). Toronto: Oxford University Press. Copyright 1995 by Oxford University Press Canada. Reprinted by permission of the publisher.

Appendix B

**Public Input on the Future of Health Care by POLLARA (2002)*

1. Government should increase health care spending in order to create a national home care program. N= 3,237

Strongly Agree	41%
Agree	36%
Neutral	14%
Disagree	7%
Strongly Disagree	2%

2. Do you really believe that a national homecare program should only cover medically necessary services or do you believe that it should also cover social support services-like meal preparation and housecleaning-where providing these services will probably reduce
hospital use? N= 3,621

Only Medically Necessary Services Covered	Strongly Agree	5%
	Agree	10%
	Neutral	6%
Social Support Services Should Also Be Covered	Agree	39%
	Strongly Agree	40%

3. Which of following is closest to your point of view on who should bear the responsibility for homecare? Caring for injured, disabled, or older people in homes is the responsibility of their family and friends, not the government. OR Government should provide as much formal homecare as needed so that we don't rely on family and friends to provide care to insured, disabled, or older people in the home. N=2,993

Family and Friends	Strongly Agree	2%
	Agree	9%
	Neutral	16%
Government	Agree	41%
	Strongly Agree	32%

4. Government should increase health care spending in order to support unpaid caregivers through tax breaks, respite care, day hospitals and other means. N=2,968.

Strongly Agree	38%
Agree	37%
Neutral	9%
Disagree	8%
Strongly Disagree	9%

*POLLARA (2002). *Public input on the future of health care*. Retrieved March 25, 2004, from http://www.queensu.ca/cora/polls/

Appendix C

**Survey on Elder Care in Japan by the Cabinet Office (2003b)*

1. Do you often worry about providing care for your family members when they become bedridden or have dementia?

Very Often	26.5%
Often	46.9%
Seldom	17.3%
Never	7.5%

2. What is your main concern to have a family member who is bedridden or has dementia and who needs constant care?**

Physical stress from providing daily care and lack of sleep.	62.5%
Psychological stress.	57.9%
Lack of Freedom	52.5%
Financial stress.	50.3%

3. What is your main concern if you become bedridden or demented and need care?**

To be a burden on the family.	68.1%
Financial burden.	53.6%
Loss of income.	27.9%
Loss of enjoyment of life.	27.6%

4. If parents become bedridden or demented, and need care, do you think the children should provide care for their parents?

Providing care for their frail parents is the children's obligation.	48.6%
Children do not always have to be caregivers for their frail parents.	36.1%
Neutral	14.0%

5. What should the government focus on in order to improve the elder care situation in the country?***

Improve home care services by increasing the number of home care attendants and nurses.	60.5%
Improve facilities such as nursing homes and long-term care homes	49.7%
Improve short stay, day services, and adult day care services.	49.6%
Expand support for family caregivers.	46.3%
Improve services in medical facilities such as hospitals.	45.4%

*Cabinet Office (2003b). *Koureisha kaigo ni kansuru seronchyosa*. [Public opinion poll on elder care]. Retrieved March 25, 2004, from http://www8.cao.go.jp/survey/h15/h15-kourei/images/zu06.gif

**Respondents were asked to list their answers. These are the top four answers.

*** Respondents were asked to list their answers. These are the top five answers.

Appendix D

**Evaluation Criteria for Operating Characteristics of Social Policies.*

Operating Characteristics	**Evaluation Criteria**
A. Goals and objectives	1. Concern with means, not end 2. Clarity, measurability 3. Inclusion of performance standards/target group specifications 4. Fit of terms of objectives with social problem analysis: with problem definition, independent variables of causation, ideology regarding definitions of adequacy and equity 5. Analyst's evaluative perspective 6. Social control implications: fit with other evaluative criteria
B. Forms of benefit or service	1. Target efficiency 2. Cost-effectiveness 3. Stigmatization 4. Complexity of administration 5. Adaptability across users 6. Political risk (political visibility) 7. Consumer sovereignty/reliance on free-market mechanisms 8. Substitutability 9. Coerciveness/intrusiveness 10. Fit with social problem analysis 11. Tradeoffs between criteria

Evaluation Criteria for Operating Characteristics of Social Policies, continued.

Operating Characteristic	***Evaluation Criteria***
C. Entitlement rules	1. Social problem analysis: fit to target specifications/ideological constrain 2. Stigma and alienation 3. Off-target benefits 4. Overwhelming costs 5. Over/underutilization 6. Opportunity for political interference 7. Work disincentives 8. Procreational incentives 9. Marital breakup 10. General dependency 11. Special applications: personal social services and public social utilities

*Adapted from *Social policy and social programs* (2nd ed.) (pp. 79-81) by Chambers, D.E. (1993). Toronto: Maxwell Macmillan Canada. Copyright 1993 by the Name of Copyright Holder.

Appendix E

Tax Credits for Caregivers in Japan

Categories and the amount of the credit, in yen, based on the status of the care recipient.*

		Non-special need**	Special need***
Spouses		480,000	830,000
Non-spousal relatives	Non-parents	480,000	830,000
	Parents****	580,000	930,000 *****

*1 yen = CD$ 0.0123588 (May 29, 2004) (The Universal Currency Converter, 2004)
**Basic credit: 480,000 yen
***Caregivers of the elderly with special need: Basic credit + 350,000 yen
****Caregivers of a parent (including a parent of the spouse): Basic credit + 100,000 yen
*****When the care recipient is bed-ridden, another 400,000 yen will be added to the tax credit.

Source: National Tax Administration Agency (2004).