

Aging and Elderly Care Practice in Japan: Main Issues, Policy and Program Perspective; What Lessons can be Learned from Japanese Experiences?

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Abstract

This article presents an overview of the main issues, policies and programs related to aging and elderly care practice of Japan based on the available published evidence to date. The Japanese enjoy the world's longest and healthiest lives. This fortunate situation, however, is also causing concern. The rate of population aging in Japan is much greater than that in other developed countries. In Japan, the nuclear family, female employment, decreased fertility rate and changing patterns of family roles have combined to make it more difficult or less desirable to provide that care informally and there are greatly increased demands for community and institutional care. The aging process of Japan not only increased the ratio of the elderly in the population but also accompanied a fundamental change in family and community. Therefore, the various systems which are affected by these changes, such as pensions, medical care and long term care, need to be rebuilt. The aging issue requires a long term commitment with enough foresight; policies must be created as soon as possible with consideration for cultural and social conditions specific to each country and each city. I

think the care of the elderly therefore involves a holistic combination of health care, socio-economic care and the provision of suitable environment. In Japan the Long Term Care Insurance Plan and the New Gold Plan alongside other policies and programs are directed towards the care and welfare of elderly people. These policies and programs are actually imitable for countries like Nepal, where are no any substantial policies and programs for caring the elderly. So that we can learn various experiences of coping aging and elderly problem from Japan both in policy and program level. However, Nepal should develop its own policies and programs based on its own cultural traditions, economic capacity and social transitions in the society.

Key Words: Aging, elderly care, fertility, policy, programs, Japan, Nepal.

1. Introduction

The aim of this article is to describe some major issues related to elderly care and how Japan is moving toward solving these issues for the well-being of their super aged society. This article briefly discusses the aging situation both in Japanese and the global perspectives. Likewise, the article presents an overview of the major policies and programs regarding elderly care practice and issues related therein based upon the available published evidence to date. The article also tries to find what lessons can be learned from Japan concerning the elderly care issues in the Nepalese context. This article is organized as follows. The first section presents the concept of aging and global movement for care for the elderly. It discusses the trends of aging situation and traditional caring pattern in Japan. The second section analyses the fertility and changing patterns of marriage and also decline of familial support and development of home care services. The third section highlights the major policies

and programs regarding care and well-being for the elderly. And last section concludes how Japan can more feasibly implement policies for encouraging active aging perspectives and how Japanese experiences in relation to care for the elderly could be taken into the Nepalese context.

Aging is a broad concept that includes physical changes that occur in our bodies over adult life, psychological changes in our mental capacities and social changes in how we are viewed, what we can expect, or what is expected of us. Aging brings a distinctive set of problems which an individual must confront and master in order to achieve successful old age. People move from “middle age to young” old age and then, with increasing frailty, to “old” old age and death. Through this transition, five crises are almost universal: loss of social status; loss of significant people; internal and external body changes reflecting biological decline; confrontation with death; and modification of available roles and activities (Brieland et al., 1985: 369-71). However, aging may differ from one culture to another, not only in terms of their ethnic and racial differences but also urban and rural differences. Likewise, the health of the elderly differs from one country to another, affected by socioeconomic and environmental attributes.

The definition of aging as a social problem is not an objective crisis of demography, but a crisis in the significance of biological aging, family relationships and relations between individuals and the state. Three fundamental issues lie behind the definition of elderly care as a social problem such as demographics (the “aging of society”), decreased ability to count on historically assumed family care givers to provide care and financing of services (Long, 2000). The aging population certainly will create new demands on pensions, and when coupled with low fertility, it results in a heavier economic burden for future generations. Aging is also likely

to bring about demands on long-term care. Issues related to the retirement age, effective utilization of elder manpower and proper living arrangements for the elderly, etc. could all form important policy areas which need to be dealt with (Chen, 2005). The aging issue requires a long term commitment with enough foresight; policies must be created as soon as possible with consideration for cultural and social conditions specific to each country and each city. In all countries of the world, population aging is altering dependency ratios and dramatically increasing the number of elders who will need care.

The dramatic demographic shift which is taking place in the country directly and indirectly affects every sector of society, as well as the health and well-being of the elderly. Modernization has become one of the popular theories to explain the rapid demographic, social and economic change of Japan since the Second World War (Knight & Traphagan, 2003). Modernization theorists interpret the history of modern Japan as the gradual convergence toward democratic and liberal orders of the west (Garon, 1994). The assumptions of modernization theories are evident in the demographic transition theory which claims that societies will move from traditional states of high fertility and low mortality. Modernization theorist claim that, along with demographic transition, traditional societies will economically, socially, and culturally “converge” with western or modern societies through modernization which is characterized by industrialization, urbanization, secularization and individualism. (Caldwell, 1976; Crenshaw, Christenson, & Oakey, 2000; Knight & Traphagan, 2003). The general thesis of the theory is that modernization results in a relatively lower status of the elderly in any society. Modernization results in increased life expectancy and decrease in fertility because modern technology brings with it means to improve life and birth control (Cowgill & Holmes, 1972). The

consequences of modernization and urbanization will certainly contribute to the loss of a great deal of power and prestige of the elderly and also affect the care of elderly (Cowgill, 1986).

Cantor (1989) points out that the growing number of elderly is bringing about dramatic changes in family life, in the nature and extent of interventions necessary to support an aging population, and our notions about respective roles of family and community in providing for these needs. Although older people manage independently with only the ordinary assistance family members provide each other, growing numbers of the very old and persons suffering from frailty and incapacity require more extensive social care. The term “social care” is often used synonymously with “formal community services,” but the concept is broader, also encompassing informal family care. Social care is directed toward needs critical to independence: socialization and self-development help in tasks of daily living and assistance with personal care. The social care should be provided within family context, turning to formal community interventions only when families are unable to provide the required assistance. Knapp (1984), also has further expounded on the concept of ‘social care’; that there are advantages to adopting a broader focus of care arrangements than merely the formal ones, which should encompass informal support provided by family, neighbors and friends as well as that provided by the statutory service agencies. The argument here is that it is the combination of the formal and informal dimensions of care that constitutes the turning point for an understanding of the principles behind the social care system.

In Japan, as in all societies, most elderly who need assistance in daily living receive help informally, i.e. family members, friends, relatives and neighbors. Yet long life expectancies, nuclear family, job mobility, increased rate of female employment, decreased fertility rate, and changing patterns of

family roles have combined to make it more difficult or less desirable to provide that care informally and there are greatly increased demands for community and institutional care. Traditionally, in Japan care for the elderly was the responsibility of the eldest son with much of the actual physical labor falling to his wife. Extended family households of the past afforded some help but currently in Japan nuclear family households predominate, with many elderly living on their own. In numerous households both husband and wife work outside the home and housing is often small and too crowded for two generations to live together (Wu, 2004:4-7). Similarly, a shift of population from rural to urban areas resulted in the overcrowding of cities and depopulation of the country side, causing a breakdown in traditional community ties. Neighborly relationships and mutual assistance prerequisites for living in the traditional society have become weaker and weaker with advanced industrialization and urbanization. The elderly are often left alone at home during the day time in both urban and rural areas (Aratame, 2007). Therefore, care and support programs for the elderly are becoming a necessity and there is pressing concern to make our elders more active and healthier in their old age. It is also thus crucial for policy makers to raise the public awareness and formulate and evaluate measures and programs to cope with the demographic challenges of Japan.

2. The Global Movement for Care of the Elderly

The world population increasingly become aged it’s average life expectancy grows every year and reduces in mortality rate in both developed and developing countries. In the last 50 years period mortality rate in developing countries has declined. The life expectancy at birth has increased by 20 years since 1950 to 66 years and is expected to extend a further 10 years by 2050. In 2000 world population of aged 60 years and above was 600 million and is expected to be

doubled in 2025 and 2 billion by 2050. Population aging is a global phenomenon: the proportion of older persons in the World's population increased from 8.2 percent in 1950 to 10 percent in 2000. It is projected to increase to 15 percent in 2025 and 21 percent by 2050. By the middle of this century one in every five persons will be "old". All countries are either experiencing population aging or can be expected to do so over the next two decades (United Nations, 2002).

Over the past half-century, both the worldwide drop in fertility and concurrent rise in life expectancy have led to the gradual aging of the world's population. Since 1950, the share of persons ages 65 and older has risen from 5 percent to 7 percent worldwide. The Europe and Japan have led the way, with North America, Australia, and New Zealand close behind. However, older persons are now more than 5 percent of the inhabitants in many developing countries and by 2050 are expected to be 19 percent of Latin America's population and 18 percent of Asia's (World Population Data Sheet, 2007). The world is undergoing a centuries-long demographic transition that, when complete, will leave the global population larger and much older, on average, than it is today. The transition was triggered mainly by improvements in nutrition, sanitation, health practices, and medical care that have dramatically reduced infant mortality and extended the life expectancy of children and adults. With more children living to adulthood and having children themselves, the world is going through an unparalleled period of rapid and sustained growth in population. As population and incomes have grown, however, people have begun to reduce the number of children they have. The resulting decline in fertility rates is gradually reducing the rate of population growth, and the world population is gradually becoming older (Congress of the United States, 2005:1). While population ageing is common to all countries, the magnitude of the problem varies significantly from one country to the next.

In the international perspective the elderly are cared for by both formal and informal systems in varying ratios in different countries. Design thinking at a strategic level has to consider this duality of old age concerns and find appropriate solutions. Informal systems with no governmental intervention or little market involvement are still the primary mechanism of care in most developing countries. On the other hand formal systems practiced in developed countries offer more homogeneous and reliable support for the elderly. Legislation and policies create frameworks for the formal system but design intervention requires careful thought. Formal systems evolve on urbanization, nuclear families, change in the social fabric and breakdown of traditional social norms. But such practice also alienates the elderly, offers lesser control to an individual and does not accommodate exceptions easily (Dan, 2003). In Mediterranean countries the family has a legal duty to support relatives up to three times removed. In continental countries the family is the primary caring unit, but persons with more health problems have a legal entitlement to public services. In Scandinavian countries the public sector has primary responsibility for persons in need for care (Pommer et al., 2007).

Asian populations and their governments are faced with increasing numbers of older adults, and this raises various social and economic issues for both the family and state. Asian societies are experiencing dramatic changes in the larger environment brought about by economic development. Urbanization, industrialization, migration and most recently, globalization, are causing changes in family structures and the intergenerational support of older persons. In a seminal work produced by the World Bank (1994), evidence was provided to show that informal support systems are breaking down in some countries, e.g., China, whereas in some other

countries informal systems are adapting more positively to these changes, e.g., Thailand, Hong Kong, Singapore, Taiwan, Republic of Korea etc (Chan, 2006:270). However, caregiver issues are major concerns in Asian societies. Chronological aging brings certain life cycle changes, some of which are physically imposed, while others culturally defined or set by statutes. Among these life cycle changes are declining health status, retirement and declining roles and status in family and society. Thus, old age often brings with it dependency and disengagement and everywhere, including Asia, people and governments are concerned about the provision of care for the growing number and proportion of aged (Yap et al., 2006: 258). The challenge for public policy is to assess the viability of family support systems and to devise programs that will be supportive or complementary. Several governments have adopted such policies. In Singapore, children are now legally responsible for the support of their elderly parents. Many East and Southeast Asian countries are providing adult day care and other support services aimed at helping adult children care for their elderly parents. Malaysia and Singapore have revised their public housing policies to accommodate multi-generational living arrangements, and Malaysia also provides families with tax incentives for elderly care (World Bank, 1994). In many countries middle-aged people are responsible for their own children as well as aging parents. Special needs of women, who outnumber men in older age, need to be taken into account, as well as the situation of the disabled and the poor elderly. The demographics of aging need to be situated in society and the family (World Health Organization, 2004).

3. The Overview of Aging Situation in Japan

As of October 1, 2005, Japanese population was approximately 127.76 million, of which 26.82 million or 21.0% were aged 65 and over. The life expectancy rate of

male was 78.5 years and female 85.5 years in 2005. In other words, Japan is the most aged society in the world. By 2020, one in four Japanese is expected to be over 65. The ratio of age 65 and over, which was 10.3% in 1985, 14.6% in 1995, 17.4% in 2000, and 21.0% in 2005, and is projected 28.7% by the year 2025 and 33.2% by 2040 (Ministry of Health, Labor and Welfare, 2005). According to the Internal Affairs and Communications Ministry the population of octogenarian and older has topped 7 million for the first time, accounting for 5.6% of the total population. The number of men totaled 11.69 million; accounting for 18.8% and female came to 15.75 million, making up 24.1 % of the entire population (The Japan Times, September, 17, 2007). The rate of population aging in Japan is much greater than that in other developed countries. Therefore, the various systems which are affected by these changes, such as pensions, medical care and long term care, need to be rebuilt. The issue of long term care for the elderly is one of the most important issues faced by Japanese citizens, along with the issues of medical care and pensions (Japan's Long-Term Care Insurance Programs, 2000).

The aging process of Japan not only increased the ratio of the elderly in the population but also accompanied a fundamental change in family and community that provided support to the elderly. The household size has become smaller from approximately 5 persons in 1950 to 2.7 persons by 2000 and 2.58 persons in 2005. The proportion of households consisting of a single elderly person or an elderly couple has risen from 28% to 47%; the proportion of elderly person living together with their child or children has fallen from 69% to 46% (Aratame, 2007). Since the size of the labor force will decline after 2000 and the ranks of the retired will grow, government payments for pensions, health care and welfare will raise. The strain on the social fabric this will cause is being exacerbated by a breakdown in the pattern of

the extended family, which in the past could be relied on to provide much of the care of the aged. These changes all suggest a decline in number of caregivers and more fundamentally, a departure from the traditional pattern of elderly care through family members living together. Similarly, local communities that have supported daily life of elderly have also undergone a significant change. The rapid decline in the child dependency ratio and the rise in old age dependency have created significant new policy challenges. This pronounced upward shift in the age distribution of Japan is prone to generate a substantial increase in the demand for medical and long-term care services, both formal and informal.

4. Brief history of Elderly care in Japan

The traditional living arrangement of the Japanese elderly is the patri-lineal, patri-local stem family. Typically, co-residence family provided all kinds of support. Even if the elderly were completely dependent, their lives seemed secure because the co-resident family members were “protective” (Hashimoto, 1996). The traditional Japanese value system, which emphasizes filial piety and respect for older people, has placed primary responsibility for the support of older people on families. The norm of filial piety was propagated by the Imperial Japanese Government in combination with loyalty to the Emperor. Filial piety was repeatedly taught in moral education; for example, children were instructed to obey parents absolutely and never resist them. They were not even to stretch their feet in the direction of their parents while sleeping. Filial piety was an extremely important moral virtue corresponding to the infinite grace of parents, including the grace of bearing, nurturing and allowing marriage. The traditional Japanese system the “practice of primogeniture gave status to sons over daughter and first borns over others. The eldest son would inherit the family residence and assets

and in turn would be responsible for his parents in their old age (Rindfuss et al., 1992). The status of the eldest son and the presence of other siblings who might compete over parental resources can lead to distinct attitudes toward familial responsibility and transfer to elderly parents in Japan. A research report of Commonwealth of Australia (2001) states that in Japan the provision of public support dates back to the famous Relief Order in 1874, which provided assistance for older, sick persons aged 70 years and above who had no relatives to support them. In 1932 a new public relief law was implemented. This gave responsibility for relief of the poor to the National Government. In the late 1940s social welfare became a more important national goal, and by 1950 new public assistance laws had significantly improved the living conditions of older people. Since 1961 the National Government has enacted laws and issued policy statements designed to further promote the welfare of older people.

In Japan, the universal public pension and health insurance schemes were established in 1961 and a system of free medical care services for older people was introduced in 1973. Cost sharing arrangements, along with co-payments by older patients, were adopted in 1983 to cope with the increasing health care needs of older people. They were designed to spread the burden of medical expenditures for older people more equitably across the generations and the various insurance programs. The public pension system was restructured in 1985 to cater for the projected aging of the population, and retirement benefits were rationalized. Prior to 1988 long-term care was provided in welfare institutions, called Special Nursing Homes for the Aged, and in special types of geriatric hospitals and wards. In 1988 Health Care Facilities for the Aged, funded through the health insurance scheme, were established to meet the rapidly expanding needs for long-term care of older people. These institutions

are best described as halfway houses, between hospitals and the community, providing long-term care for older people with chronic illnesses who need intensive care and rehabilitation but not hospitalization. Subsidies have been widened with the establishment of community welfare centers and other facilities for older people. Tax deduction programs have been used to reduce the financial burden on families of supporting and caring for aged parents, especially those who were frail and impaired, in their own homes. Initiatives contained in the 'Gold Plan' of 1989 and the 'New Gold Plan' of 1995 effectively transferred responsibility for public health and welfare services for older people to local or municipal governments. The plans also established service development targets for a range of in-home services, facilities and staff development. The basic principles underlying the plans were autonomy, user-orientation, universality, supply of comprehensive services and regionalization. The introduction of the Long-Term Care Insurance to Japan in April 2000 based health and welfare services for older people on the principle of universal insurance. Complementary changes in the structure and delivery of aged care services are integral to the introduction of the long-term care arrangements (Commonwealth of Australia, 2001: 6-7). The following major factors should be considered to affecting care for the elderly in Japan;

1. Falling Fertility and Changing Patterns of Marriage

In many industrialized nations, fertility rates are now below the level of replacement, and life expectancy at birth is increasing. Japan is one of the salient examples among them. Population aging in Japan will become even more acute should the total fertility rate fall even further. In Japan the total fertility rate is currently below 1.26 births per woman, and life expectancy at birth is higher than in any other country. As a result, population age distributions are

changing markedly, with a relative increase in the numbers of elderly and a relative decrease in the numbers of young. Japan's demographic transition began more recently and has proceeded more rapidly (Mason et al., 2004). More importantly, Japan's fertility reduction has been the greatest in magnitude among all industrialized nations. In 2005, the Japanese population became the oldest in the world and its growth rate turned negative (Matsukura et al., 2007).

A prime contributor to the low fertility rates in many countries has been a decline in the proportion of young adults who marry. This trend reveals that a greater proportion of the population is delaying and possibly foregoing marriage and this has implications for the family arrangements and needs of these cohorts as they age. Lower marriage rates are a response to a number of ongoing demographic, socio-economic and cultural factors. For example, increasing educational career opportunities for women open up alternatives to marriage and also increase the difficulty of finding suitable partners. And the decline of arranged marriages and the greater acceptance of premarital sex have helped reduce some of the pressure to marry (Retherford et al., 2001; Raymo, 1998; Hermalin, 2002:9). Women's changing views and behavior have profound implications for government policy in areas such as health, family planning, labor, and support systems for the elderly. For one thing, postponement of marriage or never marry has been an important factor bringing birth rates to unprecedented low levels in Japan. These low birth rates raise serious concerns about population aging and the size of the future workforce. (www.eastwestcenter.org/fileadmin/.../FuturePop04Marriage.pdf).

Ogawa (2007) states that the main reasons for later marriage and less marriage in Japan are the following:

- (a) Remarkable educational gains by women. The proportion of women enrolled in tertiary education increased from 5 percent in 1955 to 50 per cent in 2005.
- (b) Massive increases in the proportion of women working outside the home and earning a salary. Currently, about 99 percent of women work before marriage, almost all of them in paid employment, so that they have no financial need to marry.
- (c) A huge decline in the proportion of arranged marriages, from 63 per cent in 1955 to 2 per cent in 2002. People now must rely on themselves to find their own spouse, which is not so easy in Japan as the marriage “market” is not well developed.
- (d) A major decline in the proportion of young couples living with their parents when they marry; i.e., from 64 per cent in 1955 to 29 per cent in 2002. Young couples increasingly do not want to live with their parents; with the decline in co-residence, young couples face greater financial difficulty in getting married and setting up a household.
- (e) A major increase in premarital sex, implying that young people do not need to get married to have a sexual relationship. Between 1990 and 2004, the proportion of single women aged 20 and over who reported that they were using contraception rose from 39 to 57 per cent.

As a consequence of those changes, Japanese women of marriageable age have become more individualistic in outlook. They increasingly do not want to live with a mother-in-law and they aspire to a more egalitarian relationship with their husband whom they expect should help in child-rearing and housework. The Government of Japan has employed two approaches to raising fertility: (a) direct subsidies for marriage, childbearing and child-rearing; and (b) institutional measures to facilitate marriage, childbearing and child-rearing (Ogawa, 2007).

As regards direct subsidies, the Japanese government introduced child allowances in 1972. The economy was still booming and fertility was still at replacement level then, so there was no pro natalist intent. The purpose was instead to help low-income families who were being left behind by rapid economic growth and the accompanying rapid social changes that went with it. After 1990, pro natalist concerns led to a substantial increase in the allowances. In recent years, both central and local governments of Japan have been implementing a series of policies with a view to raising fertility levels (Retherford, Ogawa, and Matsukura, 2001; Retherford and Ogawa 2006). In addition, the majority of large and medium-scale firms have recently initiated a variety of programs for relieving child-rearing burdens on their employees and their families. Although the government of Japan has implemented a series of programs and policy measures in hopes of boosting fertility since the early 1990s, their impact on fertility has been insignificant so far. To cope with the formidable difficulties arising from its rapid population aging, Japan should explore the feasibility of alternative policy options (Ogawa, 2007).

2. Decline of Familial Support for the Elderly

Declining of familial care and support for the elderly is another major issue of the Japanese super-aged society. The number of people in each household had been approximately 5 until 1955 in Japan. However, the census in 2005 shows that it is now 2.58. As for the households with the elderly, the number is 2.73 in 2005. According to the Comprehensive Survey of Living Condition of the people on health and welfare (2005), 18.53 million households (39.4% of the total households) contain those aged 65 and over, of whom 4.07 million (22.0%) live alone, 5.42 million (29.2%) live only with a spouse and 3.95 million (21.3%) live in three generation families.

Living arrangements are a major determinant of the level of support of the elderly. In particular, the availability of care from a spouse or a child may be essential to the well being of the very old and the frail elderly. In the long run however, the importance of the family as a source of support for the elderly will decrease. This is inevitable because the share of the frail elderly population will increase and the capability of families to care for older parents will decrease (Horlacher, 2002). Likewise, Maeda and Nakatani (1992:196-99) argues that the traditional family care of the elderly in Japan has been declining due to the industrialization and urbanization accompanied by the rapid economic growth. Therefore, the role of public social services should be expanded and much more responsibility will be placed on local and national governments in order to supplement and strengthen the family care. They further emphasizes that mainly four factors should be considered as causes of the decline of family care in the context of the Japanese social situation, such as: change in socioeconomic structure as a result of rapid economic development and urbanization, demographic changes, decrease in capability of family to care for their aging parents and development of formal support and care services. Long (2000) also highlight that the family care giving is seen as a burden in Japan by both givers and receivers of care and the government has accepted responsibility for creating a new system to fund alternatives to family care.

It was customary for Japanese families to take care of their elderly relatives, and the state intervened only in exceptional cases when families were unable to provide such support. However, today the ability of families to care for elderly members is declining. As people are living longer and fewer babies are being born, the factors behind the rapid aging of the population, the ability of families to take care of their

elderly members has weakened. Another significant factor is the change in the role of women who have been chiefly responsible for household duties such as housework, child care, and care of the elderly. It has become economically difficult for women to live simply as a “housewife” even if they desire such a lifestyle, and a double-income family has become the social norm by necessity. Consequently, less time and energy can be directed to the care of elderly people, and, proportionately, the burden of nursing care is becoming heavier. There has been an increase in the number of elderly people who are themselves caring for other elderly people, such as children over 60 years old taking care of their parents (Hotta, 2003). According to the Ministry of Health, Labor, and Welfare (2001) the proportion of such cases now exceeds 50 percent. Of course, care-providers are predominantly female in such cases. According to the Comprehensive Survey of the Living Conditions of People on Health and Welfare (2004), 74% of the main care takers to the elderly who live with them were women. According to the same survey, 55.6% of the care takers were 60 years old or over, 19.7% were between 70 and 79, and 8.5% were between 80 and 89. Moreover, the percentage of the single households of the elderly was increasing. To address the elderly issues, Japanese government has introduced and implemented the following major policies and programs:

(a) **Public Long-Term Care Insurance Plan**

Japan introduced the Public Long-Term Care Insurance Plan in 1997. This plan is designed to provide care for the elderly via a new type of social insurance. The plan provides the legal basis for the shift from a government-based welfare system to a more plural one which would include both private and nonprofit service providers. From 2000 Japan implemented a new social insurance scheme, the Long Term Care Insurance for the frail and elderly. In fact, it is an epoch-

making event for the history of the Japanese public health policy, in which Japan has moved toward socialization of care in modifying its tradition of family care for the elderly (see also <http://www.kaigo.gr.jp/JLCIhp.htm>). In April 2004, the revised long-term care insurance system was implemented and “long-term care prevention-oriented” system was established. Municipalities should provide “community support services” to the elderly people who are likely to be in need of support or long-term care in near future. “Community support services” include support for training muscles, improving nutrition, and dental care. It is expected that 5% of the elderly population use the community support services. The long-term care insurance system is the mechanism for giving those in need of long-term care due to a disease caused by old age or for other reasons necessary services in a comprehensive and uniform way so that they can lead an independent life as much as possible. It is a user oriented system where they can use the service by their own choice.

Four goals of the long term care insurance program are: (a) to enable a chronically impaired old adult to chose long-term care services; (b) to deliver a comprehensive long term care service package; (c) to provide a variety of arrangements for receiving long-term care services; and (d) to reduce unnecessary hospitalization.

I. Basic Principles of Long-Term Care Insurance (LTCI) System

The basic principles of long-term insurance system are as follows:

(a) Elderly people should be entitled to utilize home care services and facility services in accordance with their own needs and desires without feeling a sense of reluctance, regardless of their income level and family situation.

(b) The second principle is to integrate the two existing systems for the elderly, the welfare system and the Health Service System for the Elderly.

(c) The third principle is to encourage diverse private sector. Under the conventional welfare system, there has been a mechanism in which municipal governments choose service providers and contract with them to deliver service.

The long-term care insurance system, however, will abolish the system of contracting by the municipalities in order to have the same conditions for public and private sector service providers for competition.

(d) The fourth principle is to introduce the concept of “care management” in order to provide a variety of services in conjunction.

This mandatory long-term insurance program requires everyone age 40 years and older to contribute premium payments to the national insurance pool. For workers aged 40-64 the program will provide services in the event of disability. In addition, general tax revenues will fund 50% of the program with this burden shared by the national and local governments (25% national, 12.5% prefectures and 12.5% municipalities). The beneficiaries, mostly frail elderly, will pay a 10% co-payment at the point of service for nursing care. With the introduction of long-term care insurance most of the services covered by the Gold Plans were transferred to the insurance program, and the means-tested care services are being left for low income elderly receiving social welfare (*seikatsu hugo*) and for the disabled, who are not covered under the insurance has meant that all elderly requiring care now have the right to receive care, regardless of income or family situation (Peng, 2002).

Under Japan’s long-term care insurance system, the central government, prefectures and municipalities are mandated to work together to implement long-term care for the elderly.

While the outline of the Gold Plan is set at the national level, localities retain significant flexibility in adapting it to local norms. Interestingly, this policy introduced a new concept to Japanese society, that long-term care is no longer expected from the family or allocated by the state on the basis of need, but rather a social contract based on a system of mandatory contributions, uniform entitlements and consumer choice (Izuhara, 2003). On the one hand, it redefines care of the elderly from a filial to a social function but on the other by including financial benefits for informal family cares as well as formal ones, it reinforces traditional Japanese values.

Japan's long-term term insurance plan, municipalities as the insurers of the long-term care insurance have the responsibility of promoting the health and welfare of the elderly at home. However, municipalities contract with a wide variety of organizations including private-sector companies for home care. This reflects not least the fact that care users access services based on individual long-term care service usage plan and can make use of public and private medical care and welfare services comprehensively. They can choose the type of service and facilities they desire from services provided by various organizations such as private companies, agricultural cooperatives, livelihood cooperatives, volunteer organizations and so forth (Bureau et. al., 2006:8). Enomoto (2006) stated the following services are provided under the long-term care insurance system:

(A) In-home services 1) Home-visit services (Home-visit long-term care, Home-visit bathing, Home-visit nursing care, Home-visit rehabilitation, In-home medical care management counseling 2) Commuting services (Commuting for care, commuting rehabilitation 3) Short-term stay (Short-term stay at a care facility, Medical care service through a short-term stay 4) Other services (Care service provided in for-profit private homes for the elderly, Welfare devices leasing, Allowance for purchase of welfare devices (B) Support for

in-home long-term care (C) Services at facilities (Long-term care welfare facilities for the elderly, Long-term care health facilities for the elderly, Long-term care medical facilities for the elderly (D) Community-based services (Small-sized multi-functional in-home care, Home-visit long-term care during nighttime, Day service for the elderly with dementia, Community houses for the elderly with dementia, Community-based care service provided in for-profit private homes for the elderly, Community-based long-term care for the elderly in long-term care welfare facilities for the elderly (E) Other: Allowance for home renovation (handrails, removal of level differences, etc.).

II. Framework and Responsibilities of Public and Private Sectors in Providing Long-term Care Services in Japan

As of July 27, 2007, there are 47 prefectures and 1,804 municipalities in Japan. There are central government and local governments in Japan. Local governments consist of municipalities and prefectures. Municipalities are basic local governments responsible for supplying basic public services to residents. Prefectures are wide-area local governments responsible for supplying public services which require special knowledge in supplying them and the coordination between municipalities. Municipalities are mainly responsible for providing long-term care for the elderly people. They are insurers of the long-term care insurance system and the elderly people consult with the municipalities about long-term care services. Prefectures are responsible for supervising long-term care service providers and bear a part of costs necessary for providing services. Central government establishes the legal framework of the system and bears about 1/4 of the costs. There are mainly two types of specialists/professionals who provide health and welfare services to the elderly people currently in Japan (a) Medical

Doctor and b) Nurses are as specialists of health services. Home helper, certified care worker, and certified social workers are also involved in providing welfare services to the elderly (Enomoto, 2006).

Likewise, long-term care services are mainly provided by service suppliers in private sector. They provide services to the elderly people and claims costs to municipalities. Facility services are provided only by social welfare corporations, which are specially established for providing welfare services. Other services can be provided by any forms of private entities. Recently, the number of for-profit corporations and NPOs (non-profit organizations) which provide long-term care services is increasing. However, it is getting difficult to maintain the level of the quality of care.

(b) The Gold Plan

Recognizing that family care giving for older persons was becoming increasingly difficult; the Japanese government developed and implemented the Gold Plan in 1989 which defined specific goals to be achieved over a ten-year period ending in 1999.

The purpose was to increase and restructure community based health care and social services while restricting the use of long term institutional care facilities. It stressed the need to keep disabled elderly in the community and out of institutional care. In recognition of a rapidly aging population and inadequate or overburdened home care, efforts were made to coordinate health and welfare services as well as community and short term institutional care by municipal governments. The unique feature of the plan was the development of systematic community facilities and services to provide care for the elderly and their family care givers (Lee, et al., 2000). The major part of the Gold Plan was

directed at improving home-based services for the elderly by improving three types of services: (1) home helpers, (2) short-term stay facilities, and (3) elder day care centers. In short these goals included numerical targets for facilities and workers in the field of long term care for the elderly.

In implementing the gold plan, each of the municipal governments conducted fact-finding survey on the elderly people living within its jurisdiction, and formulated a specific action plan for the development of a service infrastructure based on the results of the survey. Prefectural governments also drew their action plans of the municipalities within their prefectures. Making these plans at these prefectural and municipal levels increased public interest for the issue of long-term care for the elderly. However, while in the process of creating action plans at local levels, it became apparent that the target levels specified in the Gold Plan were not sufficient to meet the needs of the elderly people. So in 1994, Japanese government revised the Gold Plan and formulated the New Gold Plan by raising the numerical targets and the "Direction for Health Care and Welfare Measures for the Elderly" (Japan's Long-Term Care Insurance Programs, 2000). Families are expected to pay little or nothing for these Gold Plan services. They are to be paid for by national and local governments. If the New Gold Plan is completed, the quality of life of frail elderly and their families will be improved significantly compared to the present level.

(c) Old-Age Pension and Medical Care Plans

To address the issue of care for the elderly, Japan managed to establish its universal pension and medical care schemes in 1961. Since then, Japan's social security system has grown remarkably. Currently, Japanese public pension has "pay as you go" system, in which the premiums paid by the working-age population (normally ages 20-59) are used to pay for the

pension benefits of the elderly. A part of the pension benefits comes from the public tax. The public pension system has two tiers. The "national pension" is for all the citizens, and it provides the basic benefits. The additional benefits are provided depending on the income level through either "employees' pension" or "mutual aid pension. People usually become eligible to receive the pension benefit at age 65, but they can start receiving it before reaching 65. Yet, this system is gradually fading out. As the population ages, the amount of pension premium and benefit are revised every 5 years.

Between 1961 and 2005, the share of social security benefits increased from 4.9 to 23.9 percent of the national income (National Institute of Population and Social Security Research, 2007). Moreover, the proportion of the social security expenditure allotted to the pension schemes increased from 22.7 percent in 1964 to 52.7 percent in 2005, while the corresponding value for the medical schemes declined from 54.4 to 32.0 percent over the period in question. Owing to population aging, as well as the maturity of the old-age pension schemes, the relative share of pension benefits paid out in national income has been on an upward trend in recent years. Japan undertook major reforms of its public pension schemes in 2004. One of the primary objectives of the 2004 pension reform was to fix the level of future contributions in order to make the program more transparent for younger workers, but this reduced the benefits considerably. The government introduced a mechanism to automatically balance benefit levels according to future changes in the population age structure. The goal was to avoid repeated reforms and to restore the younger generations' trust in government pension schemes. This may be regarded as a paradigm shift in Japan's social security provisions (Sakamoto, 2005).

The second major component of social security benefits is medical aspect. Subject to Japan's economic growth performance, the coverage in medical insurance plans has been revised on a periodic basis. Despite these changes that have taken place in the past few decades, the absolute amount of financial resources allotted to medical care services has been continuously rising. One of the factors that have been causing the rapid growth of medical costs and set Japan apart from other industrialized nations is an extremely long period of hospitalization in Japan (Ogawa et al., 2007). In 2005 it was 35.7 days, which is the longest among the 19 OECD countries, followed by 13.4 days in France (OECD, 2007). In response to the upward spiral in medical care costs, the government of Japan implemented the Long-term Care Insurance Scheme (LCIS) in 2000 with a view to reducing the average duration of hospitalization for inpatient care by facilitating in-home care. The LCIS is expected to alleviate the care-giving burden to be placed upon family members, many of whom are middle-aged women (Ogawa and Retherford, 1997). Because the expenditure for the LCIS had grown at an alarming rate since its inception, the scope of its services was critically reviewed and downgraded in 2006 with a view to curbing future costs.

In April 2008, the government of Japan implemented a new medical insurance scheme specifically for senior citizens aged 75 and older as another step toward curbing the nation's mushrooming medical costs. Under this new medical scheme, premiums are automatically deducted from pension payouts. However, because premiums have actually become higher under the new scheme for a certain segment of the targeted elderly age group, a possible revision of the new scheme has already become one of the most urgent political issues at the national level.

(d) The Welfare Law for the Elderly

Homes for the elderly, home care aid services, respite care which is called “short stay program” and other similar services have been covered by the funds from the taxes of the central and local governments under the Welfare Law of the Elderly which was enacted in 1963. This law has two characteristics: (a) it is a fundamental law that stipulates several basic principles with which all the other laws, as well as governmental and voluntary actions related to the life of the elderly, should conform and (b) it regulates public social services for the elderly, including institutional services, community services, health related services, educational services and recreational services.

The Law for the Welfare of the Elderly (LWE) regulates three types of institutional care for the elderly as follows:

a) Nursing home for the aged (for seriously impaired older persons). Anyone can apply for admission to this home, regardless of their income. When the income of an applicant and family is under a certain level, a fee is waived. b) Home for the aged (for slightly or moderately impaired older persons with income under a certain amount set by the national government). c) Home for the aged with moderate fees (for those older persons who are independent in daily life and with a limited income). It is to be noted that Japan was one of the leading countries in the world to enact a special law for the welfare of the elderly.

(e) Development of Community Services

According to Maeda and Nakatani (1992:204-5) there were no public community services for the elderly before 1962. Since then, a variety of community services has been started. The national government focuses on three major community services for the frail elderly: (a) home help service, (b) short

term stay service and (c) day service. In addition, the national government subsidizes several other community services for supporting family care to the elderly. The special loan is also available for those family care givers who plan to build or remodel their houses so as to have a room for their aging parents. The income tax-deduction program is applied to those taxpayers, regardless of the amount of income, who are supporting a person aged 70 or older. When an older person is seriously impaired, the deductible amount is increased.

(f) Enactment of the Law for the Health and Medical Services for the Elderly

This law which was enacted in 1982 is based on chapters on health and medical services from the Law for the Welfare of the Elderly. New provisions that every local government is required to give health check up services regularly to all citizens age 40 and older are provided for a moderate fee and free of charge were added. The law again introduced a new facility for the impaired elderly which is called Health Care Facilities for the Aged. Such facilities provide long-term care for older persons who are suffering from chronic diseases but do not need hospitalization.

(g) The Health Service System for the Elderly

This introduced facility services in special nursing homes and home care aid services among other services which are provided under the Welfare Law for the Elderly. In Japan, all of the citizens are covered by an insurance plan for medical services. Elderly people in particular can receive medical services with a lower co payment than the working generation under a special system for the elderly which is called the “Health Service System for the Elderly”. This system covers all of the medical services necessary for the elderly, including admission to hospitals.

The Ministry of Health and Welfare along with the Ministry of Finance drafted the Health Care for The Aged Law of 1982 which effectively terminated the free medical care for the aged by imposing a small deductible charge for outpatient and hospital care. This law also discouraged the use of acute care hospitals for long term care. It should be noted that in Japan hospitals and clinics are often owned and operated directly by the resident physicians where they also dispense the medicines which they prescribe. The introduction of this law also effectively curtailed any unjustified use of these hospitals for extended care and private profit. With the percentage of the very old rapidly growing, family size shrinking and the cost of health care and pensions increasing the Japanese government was forced to devise a new and inventive program geared to meet social needs and containing costs (Lee et al., 2000:139). Although the Japanese health care system is well organized and has ample hospitals, many hospitals offered only basic facilities and fairly low staffing levels. As a result, low income people faced the prospect of a poor standard of care.

(h) Promoting Social Participation

In Japan, it is the custom to respect people to retire at the age of 60 and to search for alternative employment between the ages of sixty and sixty five. Most people aged 65 or over are supported by the social security system, although recently the number of such people who wish to work as long as possible has increased. As a consequence, the ratio of elderly people in the work force is quite high compared to other developed countries.

There are many activities offered by voluntary organizations and senior citizen's clubs in Japan. As many as 40 percent of the population sixty years of age and over attend a total of

roughly 130,000 senior citizen's clubs. Their purpose is to promote health, provide a social service and enrich the mind to cope with the processes of change. As an indication of their perceived importance, the national government provides subsidies for upgrading club activities, in order to promote the social participation. All over Japan, there are also many "recreation homes" in places such as hot-spring areas, where elderly people can stay for a short period.

(i) Adult Guardianship Program

The elderly are most concerned about the health of themselves and their families. Their next biggest concern is daily care and guardianship in old age. For those who have physical disabilities and/or cognitive dysfunctions, the local welfare and human rights protection program provides assistance in management of their financial and administrative matters as well as utilization of welfare services. The adult guardianship program takes a further step. When people suffer from dementia, they can have someone they trust manage their finance and apply for long-term care services under this program.

This program started in April 2000, the same as the long-term care insurance. The program consists of optional system and statutory system. Under the optional system, people can assign their guardian (e.g., family member, relative, lawyer, and judicial scrivener) when their cognitive status is intact. They will sign the notarized deed. The statutory system provides support for those who suffer from dementia. Their spouse, relative, or mayor can submit an application at a family court, and the court chooses the appropriate guardian (there are 3 levels of guardians depending on people's cognitive level) to support them. This program is essential in order for us to live with dignity even if we suffer from

dementia. However, this program is not widely used yet probably because of the slow progress to train the guardians.

Old age ideally represents a time of relaxation of social obligations, assisting with the family farm or business without carrying the main responsibility, socializing, and receiving respectful care from family and esteem from the community. In the late 1980s, high (although declining) rates of suicide among older people and the continued existence of temples where one could pray for quick death indicated that this ideal was not always fulfilled. Japan has a national holiday called Respect for the Aged Day, but for most people it is merely another day for picnics or an occasion when the commuter trains run on holiday schedules. True respect for the elderly may be questioned when buses and trains carry signs above especially reserved seats to remind people to give up their seats for elderly riders. Although the elderly might not have been accorded generalized respect based on age, many older Japanese continued to live full lives that included gainful employment and close relationships with adult children.

5. Concluding Remarks and Discussion

With advances in medical technology and improvements in public health and nutrition, the average life span of the Japanese people has markedly increased. As the elderly population expands, the number of bedridden and senile persons who require care is growing rapidly. According to projections made in 2004, by the middle of the 21st century one in every three Japanese will be age 65 or over, so the number of elderly people who need care can only continue to increase. Aggravating society's care problem is the fact that the average family's ability to provide such care is decreasing, partly because of the ongoing transition from extended to nuclear family patterns. In response to these

circumstances, the government is reorganizing the welfare system for the elderly together with medical services for those elderly requiring care. As part of this reorganization, in 2000 a long-term care insurance system was inaugurated as a new social insurance system. In fact, it is an epoch-making event for the history of the Japanese public health policy, in which Japan has moved toward socialization of care in modifying its tradition of family care for the elderly.

In Japan, the traditional family support system is under reassurance from demographic, social, and economic change. The fertility has been low for decades, the elderly have few adult children to provide support, and many of these children have moved away from their family homes. Marriage rates have dropped sharply and women are entering the work force in increasing numbers. Middle-aged women, the traditional caregivers, are likely to have less time than they did in the past to care for elderly family members. Increasing exposure to the West may also be introducing new ideas about marriage, family and individualism ideas that clash with the traditional sense of responsibility for the elderly (Ogawa and Retherford, 1997). Although the government of Japan has been implemented a series of programs and policy measures in hopes of boosting fertility since the early 1990s, their impact on fertility has been insignificant so far. To cope with the formidable difficulties arising from its rapid population aging, Japan should explore the feasibility of alternative policy options (Ogawa, 2007). The Japanese welfare state's policy responses to gender and demographic pressures, though clearly significant, have yet to show signs of success, that of reversing or even slowing the decline of fertility. It seems that the policy reforms have been largely focused on relieving women of undue care burdens by putting most of the effort on expanding social care. According to the World Health Organization, Japan is the world's healthiest nation; the typical Japanese person lives free from disability until age

75. This fact is often overlooked in dire predictions of Japan's future. Older people are a vital resource to society, as volunteers, care givers, grandparents (providers of child care), and consumers. On the open market, these services would have a significant economic value. In addition, studies on intergenerational exchange have repeatedly shown that the flow of goods and services from older parents to adult children is much greater than vice versa. Considering future advancements in health and medical technology, longer lives will not necessarily aggravate old age dependency. It is more likely that increasingly healthy older persons will raise the social and economic output of the society (Usui, 2003). She further argues that, Japanese people will tend toward "active aging" not just because they enjoy good health, but because they do not view leisure-based retirement as an entitlement. That is, they do not expect to completely take it easy at the end of a long career, partly because Japan's public pension programs are relatively new and partly because continuing as a productive member of society is seen as virtuous. Thus, leaders in Japan can more feasibly implement policies for encouraging active aging compared to other countries where generations of people have looked to retirement as "prepaid leisure."

Japan's initial overall success with Long-Term Care Insurance (LTCI) is encouraging to other countries that are considering the introduction of similar programs. Within a short period, LTCI has been widely accepted in Japanese society. The computer-aided needs assessment has made it possible to assess a large number of seniors efficiently and objectively. The Japanese experience also suggests several important lessons, such as the importance of building into the system the right incentives for various constituencies (seniors, family, service providers, and insurers) to promote seniors' functional independence, rather than excessive dependency on institutions and the government. For example,

it is important for LTCI to promote preventive services, include an assessment item indicating expected or potential improvement in function and health, and reward providers who contribute to seniors' improvement (Tsutsui and Muramatsu, 2005).

As we know, Nepal is a developing country where agriculture remains the major industry. The family structure is tending towards nuclear families in urban areas. In the Nepalese context the fact is that elderly care mainly takes place within the family (i.e. informal care), and therefore the result of restrictions by social policies or lack of effective and substantial policies and programs, which build barriers to access of formal care. Traditional forms of care for older people in Nepal are fast disappearing like in other countries due to modernization and the nuclear family system. I think we should learn from the experiences of Japan both in policy and program and also practice level. Nepal should develop its own policies and programs based on its own cultural traditions, economic capacity and social transitions in the society. The most important thing for Nepal to do without delayed, I think, is to establish a nationwide pension system and health care insurance scheme for all citizens. At the same time, it is necessary to develop social services to meet the expanding social demands of elderly people as well.

In recent years, a number of NGOs and elderly homes for the elderly have been established in Kathmandu valley and other areas of Nepal. Despite some efforts to help elderly persons and use their knowledge and experience for the development of society, there is still much to do in these areas in the Nepalese context. Although there have been increases in the population of elderly persons, there have not been proportionate increases in the resources and budget for their welfare. Inadequate resources; sub-standard and inadequate old-age home facilities; lack of relevant institutions, human

resources, and community arrangements to look after the need and health of elderly persons; and a lack of long-term plans, regulations, and coordination mechanisms among the related agencies are the present challenges. In particular, poverty and the rise in nuclear families taking the place of joint families present special challenges to this sector. More importantly, Nepal is going to be federal states, which also needs broader understandings regarding the social welfare policy and programs of care for the elderly. So that, we can take enormous experiences from Japan in terms elderly related policies and programs into the Nepalese context.

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