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

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1. Introduction

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Germany (1999)

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

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

Japan (2000)

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

8. Conclusion

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

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

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

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

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

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

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

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

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