

BACHELOR THESIS IN EUROPEAN PUBLIC ADMINISTRATION

Changing Welfare States?

**A comparative study between Germany and Japan regarding
Long Term Care Insurance policies between 1990 and 2018**

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Abstract

The German and Japanese governments have a problem. Their population is aging fast. This thesis analyses the policy changes in different welfare regimes and develops a conceptual framework for institutional change. It then analyses the German and Japanese long-term-care insurance systems. Finally, this thesis compares the two systems and their development in terms of familialisation..

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List of Abbreviations

LTC – Long-Term Care

LCTI – Long-Term-Care Insurance

LTCP – Long-Term-Care Policy

OECD - Organisation for Economic Co-operation and Development

PSG – Pflegestärkungsgesetz

1. Introduction

Many countries are facing huge demographic challenges at present. One such challenge is the massive growth of the population in certain countries. This thesis though, deals with the opposite problem, namely the decline of populations because of lower birth rates, lower fertility rates or an increasing life expectancy. All of these factors can result in the decline of a nation's population. While the ageing of a nation's population is indeed one important factor when it comes to policy change, policy change becomes even more pressing the faster the country's population is ageing. Therefore, the need arises to accommodate and deal with these changes in the population on a national level.

Because of limited time and resources, in this thesis I examine only the changes to long-term-care policies as one factor driving change in welfare states.

This thesis will analyse policy changes, long-term care and welfare-state change. It also investigates the introduction of long-term-care insurance policies between the years 1990 and 2018.

Two extremes have been chosen as units of observation – the country with the fastest-ageing population in the European Union, which is Germany, and the country with the fastest-ageing population worldwide, which is Japan. Both countries are welfare states, although with different typologies, as is explained in Chapter 2. Both countries also introduced long-term-care reforms in the years from 1990 to 2000.

Another important part of this thesis is the concept of 'defamilialisation', a term coined by Gosta Esping-Andersen in 1999. He defines defamilialisation as a measure to 'capture policies that lessen individuals' reliance on the family; that maximize individuals' command of economic resources independently of familial or conjugal reciprocities'. (Esping-Andersen, 1999:45)

While Japan has been close to pure familialism (Oichai, 2009) (thus the opposite of defamilialisation) in the past, and Germany's welfare regime was familialistic as well, this thesis analyses whether these states have changed when it comes to the concept of defamilialisation. This thesis also deals with institutional change and discusses whether and how the welfare states of Germany and Japan changed between 1990 and 2018, using the model Streeck and Thelen developed in 2005.

Overall, this thesis deals with welfare-state change and, more importantly, the question of whether there has been a change when it comes to defamilialisation. The overall research question is as follows:

How have the long-term care policies of Germany and Japan changed between 1990 and 2018, and how are both states affected by this change when it comes to the concept of defamilialisation?

Two sub-questions can be posed to help further this investigation:

1. How and in what direction has the role of the family changed when it comes to long-term care?
2. How do these changes affect the development of the welfare state in general?

The research question is descriptive. It analyses long-term-care reforms which have been implemented in two different welfare states. Its aim is to find out how these states have changed in regard to defamilialisation since the new long-term-care policies were introduced. For the time period 1990 to 2018, insufficient research on this topic exists.

Therefore it is the aim of this thesis to add to the existing body of knowledge and the current body of research' by analysing the long-term-care reforms within this time frame. Additionally, this topic may become even more relevant in the future, as population ageing is a problem not only of the two countries analysed in this thesis but also of other countries as well.

2. Theory and Concepts

This chapter outlines the theoretical framework for this thesis. It is essential because it builds the core of this research and guides the analysis. To do this, it focuses on the concept of welfare states and the various models for welfare states. It also evaluates whether Japan can be seen as a welfare state. The level of familialisation and/or defamilialisation and the question of institutional change are also considered.

2.1 Familialisation and Defamilialisation

Research on family policies grew during the last three decades of the 20th century. Examples are studies by Kamerman and Kahn from 1981 and Esping-Andersen from 1999.

The study of family policies remains an important topic and has remained on public agendas ever since. One reason for this is demographic change. Another is the challenge of ongoing globalisation. The subject of this research are those who cannot take care of themselves, including children, the handicapped or chronically ill and, in this thesis especially, frail elderly people. Related to this last group, this thesis also discusses the introduction of long-term-care policies. (Knijn and Kremer, 1997:329).

The welfare state is an important concept when it comes to familialism and defamilialisation and long-term care. Through national health care systems, LTC is directly linked to the structure of the welfare state. There are many methods for classifying welfare states, the majority of them focusing on social expenditure – for example, the model of Richard Titmuss (1974). The most prominent model, though, is the one developed by Esping-Andersen in 1990 and 1999.

He created three models, called ‘welfare regimes’, that are independent from any social spending because they were built on other principles (Conrad and Lützel, 2002), such as income pooling in families and ‘providing service and care for kin’ (Esping-Andersen and Myles, 2007:7).

The welfare state emerges based on the capitalist economy where labour is exchanged as a commodity in the market. An employee sells his labour power, therefore making himself a commodity, given the fact, that a worker cannot separate himself from his labour capability (Shinkawa, 2013:173).

Herlofson et al. (2011) state that ‘in all modern welfare states, the responsibility of caring for children and the elderly is divided between family and state, with various interactions between the two’, while Esping-Andersen (1999) defines these terms as familialisation and defamilialisation.

A familialistic system, . . . , is one in which public policy assumes – indeed insists – that households must carry the principal responsibility for their members' welfare. A defamilialising regime is one which seeks to unburden the household and diminish individuals' welfare dependence on kinship (cf. Orloff, 1993, in Esping-Andersen 1999).

Many social scientists have used the breadwinner model (Lewis, 1992) to determine the interdependencies within the familial structures. Leitner (2003:55) further identifies a gap between child care and the 'increasing labour market attachment of women'. She states that it becomes increasingly difficult to balance child care with two working parents and argues that the old 'male-breadwinner model' no longer applies. She further identifies a 'mismatch' in this regard as women become more economically independent, and she criticizes Esping-Andersen's welfare-state typology. Note that the male-breadwinner model is more commonly used in gender-related studies, which are not a focus of this thesis.

The research debate, when it comes to familialisation and defamilialisation, is a dynamic one. In the last 20 years, extensive research has been conducted in the field of family policies that use the models of defamilialisation and familialisation as a means to analyse whether there is a change towards more or less familialisation.

Solheim (2014) states that a high degree of familialisation implies a huge dependence on the family, which leads to many hours of unpaid care work. A high level of defamilialisation, on the other hand, means that the public 'takes on the responsibility of caring for the individual' (Solheim, 2014:122). This entails, for example, care services that are directly distributed to the individual, regardless of the family. It is important to add that Esping-Andersen clearly states that defamilialisation does not mean 'anti-family', and familialisation does not mean 'pro-family'.

De-familialization means not only taking away care responsibilities from the family. De-familialization also reduces the extent to which the satisfaction of individual care needs is independent on the individual's relation to the family. (cf. McLaughlin and Glendinning 1994:65)

And Shinkawa argues:

De-familialization does not deny the importance of family, nor does it mean the collapse of the family in general. It merely implies the decline of a specific family type, that is, the male breadwinner model. In the process of undermining the male breadwinner model, women have more opportunities to obtain financial resources to be independent of the family. De-familialization policy is a state initiative to remove barriers imposed on women in the traditional male breadwinner family. (Shinkawa, 2013:174)

Building on the foundations of Esping-Andersen’s (1999) work, Saraceno and Keck (2010) have developed a model that distinguishes among the four types of familialisation – namely, supported familialism, unsupported familialism, defamilialisation and optional familialism. Its aim is to show the distribution of responsibility for eldercare and childcare between the family and the state (see Table 1).

Table 1: Varieties of familialism

Unsupported familialism	Supported familialism	Defamilialisation	Optional familialism
<p>The state does not provide financial support for family care. Nor does it provide alternatives to family care.</p> <p>Normally implicit, can gain an explicit character due to laws.</p>	<p>The family receives financial support, either to care for their relatives or to pay others to care for them.</p>	<p>Family responsibility is reduced because the state compensates the individual in need of care, usually through public services like social insurance.</p>	<p>The family can choose between defamilialisation and supported familialism. It is their choice whether they want to receive financial aid for the care of their family member or make use of public services, which happens only in rare cases.</p>

Source: Keck & Saraceno (2010:10)

Esping-Andersen (1999) also distinguishes two types of defamilialisation. The first one is defamilialisation through the market, and the second is defamilialisation through public social policies. He further tries to determine the ‘familialistic character of a welfare regime by indicators that measure the intensity of familial welfare responsibilities’ (Leitner, 2003:357). These are, for example, the number of unemployed youth or the number of hours that women work without getting paid.

Taking these into account, one can say that the countries in the south of Europe and Germany stand out more than the Scandinavian countries, which are often described as partly defamilialised. This also includes Japan, because it can be said that Japan is a state that is close to pure familialism.

In contrast to Esping-Andersen, Sigrid Leitner (2003) distinguishes familialistic and defamilialising policies by developing a model of the four ideal types of familialism. She also considers that a welfare state can have both defamilialising and familialistic features (see Table 2).

Table 2: Combinations of strong/weak familialisation and strong/weak defamilialisation

<i>Familialization</i>	<i>De-familialization</i>	
Strong	Strong	Weak
Weak	Optional familialism De-familialism	Explicit familialism Implicit familialism

Source: Leitner (2003:358)

Leitner distinguishes among optional familialism, defamilialism, explicit familialism and implicit familialism. While explicit familialism strengthens the family through family-friendly policies when it comes to care, it doesn't provide alternatives, which means that there is no other way for the family to receive support for the care of their family member. The family remains the primary caretaker.

In contrast to explicit familialism, implicit familialism does not offer support through policies that are family-friendly or other social support that would drive towards defamilialisation. In contrast, optional familialism features family-friendly policies and defamilialisation, but the way is less straight-forward because families are able to choose whether they would like to care for their family member. In this regard, Leitner also argues that 'the family's right to care is not equal with the family's obligation to care' (Leitner, 2003:359).

The last type of familialism is defamilialism. Defamilialism is characterised by a low amount of familialisation. This is mainly through care services provided by the state and the market. In this model, the family is not burdened with the care of their family member. But this form differs from implicit familialism in that the 'right to care' (Leitner, 2005:359) for the family member is taken away.

This model also lets us see that there are welfare states that try to relieve families of the burden of caring for their relatives and welfare states that actively support familialism by supporting families to ensure that care of relatives in need is performed within the family. Regimes that feature optional familialism and defamilialism can provide opportunities for family members, when it comes to labour market participation. In contrast to defamilialism, people living in a welfare state that promotes optional familialism are free to choose whether they would like to receive formal care or would prefer to have family members care for relatives.

Leitner says that 'in contrast to defamilialising care policies, familialistic care policies directly regulate gender relations. On the one hand, they seem to automatically enforce traditional gender roles since they aim at maintaining and strengthening the family's caring function.

As family care is in most cases women's work, these policies will not only support the family as such in its caring function but will also strengthen the caring role of women and, thus, reproduce the gendered division of family care' (Leitner, 2005:366).

2.2. The Welfare State

While Esping-Andersen categorises the western welfare states into three regime categories, namely into social-democratic, the conservative-corporatist and the liberal regime, it remains hard to determine into which category Japan could be placed in.

The liberal welfare regime is the first one considered. Most liberal welfare regimes can be found in the Anglo-Saxon world, including Great Britain, Australia and the USA. They provide benefits for people with a low income and those who almost have nothing. It is one of the aims of these regimes to maintain equality between state and market. Thus, the state acts only when the market fails. While Esping-Andersen and Myles argue that the state acts only to 'uphold one's livelihood' (Esping-Andersen and Myles, 2007:8), the state's involvement is seen as an 'ultima ratio measure'.

The second regime can be described as the opposite to the liberal welfare regime. While the liberal welfare state grants benefits only to the poorest, the social-democratic welfare regime is 'characterized by its emphasis on universal inclusion and comprehensive definition of social entitlements' (Esping-Andersen and Myles, 2007:8). This means that everyone, regardless of his or her employment status, is entitled to social benefits – for example, eldercare and wage compensation that the state pays for. In all this, the state maintains a dominant role. The social-democratic welfare regime can mainly be found in the Scandinavian countries.

The third regime is the corporatist welfare regime, which Germany can be counted among. Esping-Andersen argues that in comparison to the social-democratic welfare states, most of the corporatist welfare state's 'foundations were built around social insurance', which means that the 'entitlement to benefits depends primarily on life-long employment' (Esping-Andersen and Myles, 2007:9). In contrast to the social-democratic state, the corporatist welfare state intervenes only at a late stage and maintains a limited role.

Where does Japan fit into this? The answer is it does not fit. While Esping-Andersen (1999) concludes that Japan is a hybrid, containing traits of the liberal and corporate welfare regimes, Bonoli and Shinkawa (2005) claim that all welfare regimes can be seen as hybrids. In this regard, Shinkawa (2013) introduces a fourth welfare regime typology that Japan could be placed into. He uses a matrix with a low rate of decommodification (found in the liberal welfare regime) and a low rate of defamilialisation (found in the conservative-corporatist regime) to add a fourth type (as other scientists have suggested) to Esping-Andersen's model of welfare states:

Table 3: Axis of decommodification and defamilialisation

		Decommodification	
		high	low
De familialisation	high	Social democracy	Liberalism
	low	Conservatism	Familialism

Source: Shinkawa (2013)

While the male-breadwinner model can be described as the root of the welfare state, it became outdated after ‘gender-neutral employment’ or employment where one does not need to have ‘manpower’ (and work that isn’t physically draining). Because of this, women have been flocking towards the labour market and traditional family values have been declining to some extent.

‘The familial welfare type is likely to be found where the capitalist economy and democratic politics are not mature enough to build a welfare state. Familialism is likely to be undermined after economic and political developments’ (Shinkawa, 2013:177).

One must note that the capitalist economy is not able to commodify all people. This means, that if a person is not able to fulfil the needs of the market, for whatever reasons, that person is cast out.

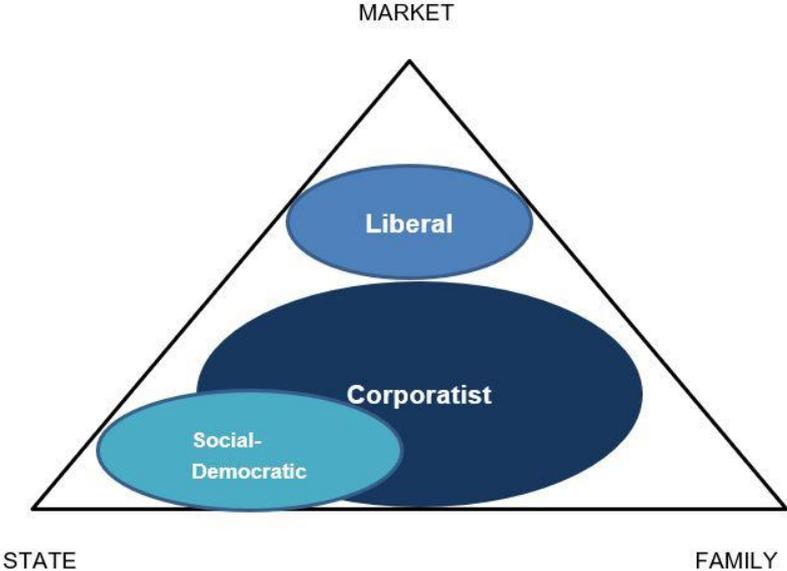
This mostly means that he (he when talking in regard to the male-breadwinner model) returns to the family. And it also means that the family might become entangled in financial difficulties when the male-breadwinner is no longer able to ‘win the bread’.

Then the need for public welfare arises, as a kind of safety net and to guarantee minimum living standards for people. While social democracy is providing public services – for example, for the care of the elderly or for child care – it is promoting defamilialisation. Because of support provided by the state, women are able to go to work and earn money, which can be described as ‘equal pay for equal work’, as well.

The liberal welfare state encourages women to work outside the home as well, but through cheap care services that the market provides. Because of this, the labour market has developed a two-part structure, at least for women – one part for women who are skilled but with no education or poor education, and the other part for those who are skilled and highly educated (Shinkawa, 176:2013).

As mentioned before, the familial and conservative regime share some similarities but have differences as well. The amount of decommodification in the familial regime is much higher than that in the conservative type. Both provide benefits to persons in public employment and share familial values. Those familial values depend on the political past and development of the referred country and are much stronger in the familial model than in the conservative one. One can refer to the welfare regimes as the 'welfare triad' as well. The welfare triad illustrates differences between three supporting elements of welfare (Figure 1). Depending on the arrangement of the three factors, one can distinguish the three welfare-state models.

Figure 1: The welfare triad



The welfare triad shows the distribution of the different welfare regime types according to Esping-Andersen (1999). It shows that the liberal welfare regime is closest to the mechanisms of the market while the family and the state play only a minor role, meaning that the state only acts if the market fails. When it comes to the corporatist regime, the roles change. The state and the family play an equally large role, while the market remains in the background. In the social-democratic regime, the state plays the largest role. In terms of care, this means universalism – everyone is entitled to social care services. If we try to put the familialistic regime type into the triad, it would sit in the last free corner – Family.

2.3 Institutional Change

Institutional change is another important theoretical part of this thesis. The theories provide the necessary tools for analysing the development of the welfare state – for example, the theories of institutional change by Streeck and Thelen (2005). By adapting the two cases of Japan and Germany to these theories, it can be determined if and how the welfare states have changed over time.

Esping-Andersen (1996) portrays a 'frozen welfare landscape' and hints that it might be 'impossible to bring about change in the welfare state status quo' (in Van Gerven, 2008:24). Taylor-Gooby also mentions that welfare states seem to be 'surprisingly resilient' (Taylor-Gooby, 2002:597) when it comes to even the smallest changes, for example when it comes to policy change in welfare states. This way of change is called 'path dependence' and tries to explain the ways of welfare-state changes. It predicts 'that welfare states follow specific development paths in how they adapt to new challenges, or in other words, history matters' (Van Gerven, 2008, Esping-Andersen 1996, Taylor-Gooby, 2002).

When it comes to discussing the change of welfare states, the works of Paul Pierson cannot be overlooked. He argues that there are many dangers when a welfare state changes, and all these dangers have to be looked at. Even the smallest changes in the welfare state can lead to huge 'electoral risks' (Pierson, 2001). He also argues that policy makers face a huge dilemma – on one hand through the pressure to get re-elected, which could make it impossible to change the system (Pierson, 2001:23); on the other hand, 'the welfare state evaluates what is needed and modernizes its services' (Pierson 2001). In addition to the concept of path dependence, another concept has been drawn into focus recently, that of path departure (Pierson, 2001), which refers to the situation in which changes have been implemented within a system and, as a result, a 'partial renewal of institutional arrangements' (Van Gerven, 2008:27) has taken place.

Another theory was developed by Streeck and Thelen, who argue that a changing process can also happen slowly over a very long (incremental) time period (2005). They distinguish between processes of change and results of change. The process of change can be either abrupt or incremental, while the results of change can mean either continuity or discontinuity. Abrupt change can lead to either 'survival and return' or 'breakdown and replacement'. In contrast, incremental change can lead to either 'reproduction by adaptation' or 'gradual transformation' if the result of change is discontinuity (Streck and Thelen, 2005:8–9). Additionally, Streck and Thelen distinguish among five mechanisms of change. (2005:19–30). These are exhaustion, displacement, drift, layering and conversion.

For the authors, displacement is revealed when new models emerge and spread. These models are 'challenging the existence of forms and organizational practices that have already been granted' (Streeck and Thelen, 2005:19).

They argue that the concept of drift works with the fact that 'institutional constancy is never automatic', while conversion is pointed out as a different form of layering and drift. Layering is described by the authors as a dynamic that is unleashed by putting a new 'variable' into the system. Over time, this variable may get stronger and even expel or replace the old system. The last of their mechanisms is exhaustion, in which case, the authors argue, 'the process in focus will necessarily lead to an institutional breakdown'.

3. Research Methodology

As already mentioned, it is the aim of this thesis to learn how the welfare states of Germany and Japan changed between 1990 and 2018. This case study also seeks to determine whether the welfare states were affected when it comes to the concept of defamilialisation. To analyse this further, one research question and two sub-questions were developed.

The main research focus is to analyse the change of the long-term-care policies in Germany and Japan between the years 1990 and 2018, by examining the degrees of familialisation and defamilialisation before and after the implementation of the new long-term-care policies.

The sub-questions dive deeper into the matter of familialisation and defamilialisation to further investigate what can be said about the general welfare state in the countries of interest.

3.1 Research Design

This case study is a comparative analysis of two countries. It features a dynamic comparison and can be described as longitudinal, because both countries are analysed over a time frame of 28 years. The units of analysis are, as seen above, the policies of Germany and Japan. The aim is to find out what the similarities and differences between both welfare states are when it comes to long-term care and the changes to familialisation and defamilialisation over time.

3.2 Case Selection

This research is interesting because both Germany and Japan are grouped into different welfare regime systems. First, Germany and Japan have completely different familial structures; Japan is much more traditional when it comes to familial care and support. Both countries are welfare states, Germany a conservative-corporatist one and Japan one in which the familialist regime is quite dominant. As already mentioned, Japan is close to pure familialism. Although there is no corresponding data for Germany, the rate of elderly people living with an adult child in Japan has been declining for several years (add ref). This means that the percentage of elderly people living alone has been growing.

Some (who, cite) describe this phenomenon as the ruin of the traditional Japanese family, so it is interesting to see how this development plays out in terms of long-term care. It is also the case that women in both countries, due to globalisation, have become more emancipated over time. They are going to work and pursuing their own career instead of staying at home and caring for their relatives.

The ageing of the populations is another important factor when it comes to policy change. One of the factors that Germany and Japan share is a rapidly ageing population. While in 1990, 15% of the German population were 65 years and older, by 2020 about 22.5% of the population

will be aged 65 years and older. Japan is facing a similar development. In 1990, 12% of the population were older than 65 years. In the year 2020, almost 24% of the population will be older than 65. This also means that the number of elderly people who live alone will increase.

Table 4: People over the age of 65 years in Germany and Japan

	Germany	Japan
1990	15.5% of the population	12% of the population
2020	22.5% of the population (predicted)	24% of the population (predicted)

Source: Aging Demographic Data Sheet 2018

Another reason for choosing Japan and Germany as units of analysis is the declining birth rate. While both countries are ageing quite quickly, not enough babies are born (both Germany and Japan have a total fertility rate of 1.4 children per woman) to stop the shrinking of the population in both countries.

Table 5: Total fertility rates in Germany and Japan

	Germany	Japan
1990	1.45 births per woman	1.54 births per woman
2017	1.45 births per woman	1.41 births per woman

Source: OECD

While the total fertility rate is low in both countries, it has decreased further in Japan than in Germany. By looking at the last two figures in Table 5 and taking into account their rapidly ageing populations, it becomes clear that Germany and Japan will face serious population problems in the future.

3.3 Operationalization

If there is going to be an analysis, the factors have to be made measurable. In this case, the welfare state/policy as unit of analysis acts as the dependent variable. The question asked is in which direction have the welfare states changed?

3.4 Data Collection and Analysis

This study uses both quantitative and qualitative data for analysis. The data for the theoretical part was mostly derived from scholarly literature collected in university libraries in Germany and the Netherlands, while the data for the other parts was derived from sources such as Eurostat and the OECD.

3.5 Limitations of the Study

It is important to mention that this research design is limited to welfare states. Further, the results of the study apply only to Germany and Japan, since only those two countries have been looked at. A generalisation to other countries and other long-term-care systems is not possible. Furthermore, the data used in this thesis has not been collected by the author. The data for Germany in Chapter 4 has mostly been drawn from Eurostat and Destatis, which are reliable sources. Other data was derived from the literature.

The data for Japan in Chapter 5 has mostly been drawn from the Japanese Ministry of Health, Labour and Welfare, and from literature that has been written in English. The issue of working with limited data proved to be much more difficult when it became clear that most of the data was available only in the Japanese language. Therefore, the author used secondary sources in which Japanese data has been made available in English. Policy documents have been assessed either in German (for Germany) or in English (for Japan).

4. Germany

As this thesis examines and tries to understand whether the welfare states in Germany and Japan have changed, it is now only logical to apply the theories which have been explained in the theoretical part above.

This chapter assesses the status quo of long-term care in Germany. It also analyses whether the need for long-term care has grown or decreased, and it assesses whether the long-term care system has changed because of the ageing of the German population.

As one can already guess, Germany is a welfare state. But what makes it exactly that?

The German welfare system's two main goals are 1) predictability in economic development outcomes and 2) social security for the German population. The system consists of four pillars:

- 1) Cross subsidiation: Different funds support one another (e.g., health insurance and social solidarity insurance)
- 2) Economic governance: Minimizing costs for labour to maintain a highly skilled labour force (examples are sick leave, longer vacations, and early retirements)
- 3) The use of lower-skilled workers for labour that German citizens are unwilling to do
- 4) Providing help and assistance to those who are not being reached through the various social-assistance models (Taylor-Gooby, 1996)

According to Esping-Andersen's three worlds of welfare capitalism, Germany can be put into the corporatist sector. One can see that the four pillars mentioned above support social protection and social insurance while still trying to ensure the productivity of the work force – for example, with longer vacations and other benefits.

The market plays only a minor role in the German welfare system, as one can see in the welfare triad, and the state intervenes only if it is truly necessary (Esping-Andersen, 1999).

Another integral part in the change of the German welfare state is the family and the role it has played before and after the implementation of long-term-care policies. When it comes to familialism and defamilialisation, Germany can be counted as one of the more conservative welfare states, meaning that women in families are regarded as caregivers and nurturers rather than those who earn money for the family, which is still seen as the traditional role of the man. Lewis (1992) and Gottfried and O'Reilly (2002) also state that the male-breadwinner model is strong and is executed in nearly all aspects of daily life – for example, when it comes to family policies and educational policies.

Thus the degree of familialisation in Germany is still relatively high. It can be further categorised into a form of explicit familialism (Leitner, 2003), different from the social-democratic welfare regimes in northern Europe, which feature a high degree of defamilialisation.

4.1 Long-Term Care in Germany

In light of the ageing of the German population, a long-term-care policy was instituted in 1990. It is difficult to determine the actual need for long-term care in Germany because only the number of individuals who already receive long-term care is well known. The number of individuals who apply for long-term care but do not get benefits is believed to be much larger and can only be estimated. This is because the funds for long-term care are very restricted, and only individuals with impairments limiting daily living activities are granted benefits. In 1995, long-term-care insurance, as a part of the healthcare system, (its principles can be found in the Social Code Book, Part XI (*Sozialgesetzbuch*)) was introduced and has grown in importance because of the low birth rates and the aging of the German population. Until 1994, long-term caregiving was a task primarily handled within the family, and only those with insufficient funds could apply for help from the social-assistance scheme.

Almost everyone who is already covered by public health insurance is covered by the long-term-care insurance. The only ones exempt are those who have private health insurance, who must buy private long-term-care insurance if they wish to receive long-term care. The benefits of private long-term-care insurance are no different from the benefits of public long-term-care insurance.

Schulz (2010) states that the long-term-care insurance has five main objectives:

providing social security against the risk of needing care in a way similar to insurance against illness ... protecting income in old age, enabling persons in need to stay in their familiar home and family environment for as long as possible ... improving social security for carers who are not employed in order to promote willingness to provide care at home ... helping to mitigate the physical, mental and financial stresses resulting from the need for care ... [and] helping to expand and consolidate the care infrastructure and encouraging competition among service providers (Schulz, 2010).

Eligible are all insured persons that are in need of help with their daily activities of everyday life for at least half a year. The severity of those needs is divided into five care levels (*Pflegegrade*): Level 1, which includes those dependent on some care (for example, with feeding or personal hygiene), through Level 5, which refers to those dependent on extensive care – for example, people with a major health impairment who are not able to live alone and need more help than three times a day. Until 2016 there were only three levels *Pflegestufen*. In 2017 *Pflegegrade* (care degrees) were introduced and the old ranking system was abolished.

All people are eligible for benefits. Age, wealth or income do not play a role. The only criteria that has to be fulfilled is the period for to qualify for benefits, which is two years (since July 2008). Before being able to receive benefits from long-term-care insurance, a patient needs to be assessed by the Medical Advisory Service (*Sozialmedizinischer Dienst der Krankenkassen*) that is a part o the health care insurances.

The Medical Advisory Service has the right to deny the application of applicants found healthy enough to care for themselves. Such applicants receive no benefits but can apply for long-term care again if their health status changes.

The assistance benefits provided by the long-term-care insurance are set by law (Social Code Book XI). Recipients can choose among the different services, which are provided in cash and in kind. While benefits for patients outside of care facilities have been available since April 1995, benefits for patients inside care facilities became available in July 1996.

Examples of benefits include short-stay institutional care of up to four weeks in a care facility (§42), cash for informal care (§37) and medical equipment and technical aides (§40), to name a few.

Patients with greater need for long-term-care benefits (for example, those at Level 5), are more likely to receive more benefits than patients whose need is considerably lower.

In Germany, long-term-care insurance is based upon self-administration. Schulz (2010) states, that 'each health insurance fund has an affiliated care insurance fund. That means they carry out the legally mandated tasks under government supervision but are organisationally and financially independent'. The main tasks of the long-term-care insurance funds are to organize and provide care, to assess the quality of the provided long-term care, and to negotiate with care providers, given that every care facility has its own price structures.

As stated earlier, Germany is one of the conservative welfare states.

This means that the male-breadwinner model is one of the pillars of this welfare state. This ensures that in a heterosexual relationship a man can provide for the family and give protection and security while the woman cares for the household, children, the frail, or the elderly. The other pillar is the 'principle of subsidiarity', which means that it is the family's duty to provide for social protection (Kulawik, 1989:246).

Sandermann (2014) agrees that 'the male breadwinner and his social-security protection give women the opportunity not to participate in the market in order to care for family members. On the other hand, unpaid care by women secures the functioning of the "service lean" conservative welfare regime'.

Another factor that undermines the idea that Germany is a regime that shows features of explicit familialism is that the state provides cash allowances (as seen in the explanation of the German long-term-care system), which a welfare regime with implicit familialism would not do.

The changes in the long-term-care system have had a slowly transformational effect on familialism in Germany. While Germany's system showed almost purely implicit familialistic features, it has been slowly transforming to an explicit familialistic one. While after World War II it was mandatory and not questioned that the family was the primary caregiver, roles have been changing over recent decades.

This happened mainly through a shift of paradigms in the 1970s. While the German government promoted the idea of the 'traditional' family (male breadwinner and stay-at-home-mother) in the years after the Second World War as an 'economically and culturally indispensable basic organisation', the 1970s brought the feminist movement and the general idea that women should be independent from their husbands. Later, different family policies, mostly regarding child care, were implemented to strengthen the family while maintaining a partly modernised male-breadwinner model and encouraging women to join the work force, either out of choice or out of necessity (see Appendix Figure 1).

This means that while in the past women stayed at home to care for older relatives in the past, they now go to work. While it is now possible to apply for a cash allowance for the care of relatives, many people choose to stay in employment and assign care agencies (with the majority of the care workers being from Eastern Europe) to care for their relatives.

When it comes to child care, however, Germany has made the move towards optional familialism, moving away from the male-breadwinner model, by introducing the *Elterngeld*, a parent-related payment while a male or female employee is at home with a newborn child instead of the normal wage. While the *Elterngeld* is only a small factor, it can be generally said that Germany moved from implicit familialism to explicit familialism when it comes to eldercare. This is due to the ageing of the German population, the increasing employment of women in the labour market and cultural changes.

All in all, it can be said that the implementation of long-term care policies was not the catalyst for the transformation from implicit familialism to explicit familialism in Germany. Rather, long-term-care policies played a role in manifesting those changes. The changes themselves started much earlier with the end of the Second World War and in the 1970s.

Further, the implementation of long-term care and other family-friendly policies did not affect the welfare state in general. In terms of the theory of Streeck & Thelen (2005), one could describe the change as incremental.

5. Japan

This chapter assesses the Japanese place in the welfare world and its long-term-care system. Japan has one of the fastest-aging populations in the world. This chapter analyses the status quo of long-term care in Japan and reviews the changes that occurred during the years 1990 to 2018.

As discussed in Chapter 2, Esping-Andersen (1990) considers Japan to be a hybrid rather than putting it into one of his developed welfare-state patterns, because it features characteristics of both the liberal and the conservative welfare state. The liberal regime is recognised for its strong ties to the market and a low degree of decommodification, and the conservative-corporatist regime is recognised for its welfare system and the provision of welfare by the family.

It can be said that the Japanese welfare state has been in a transitional state since the end of World War II.

When it comes to familialism, Oichai (2009) argues that Japan is one of the few countries that show patterns of pure familialism. Suzuki (2013:70) states that, in Japan, the family has been the 'centre of practically all activities' in the late 20th century. The family provides everything, including care, education and the 'production of value'. This is because of a long tradition of Confucian beliefs and a strict hierarchical structure.

Until the Second World War, the son and his wife were legally subordinate to the head of household in the husband's family line (mostly but not necessarily the father), who could make decisions over arranged marriage and inheritance (Lill, 2018:107).

While many states in the Western countries have abolished laws regarding the care of family members, Japanese law (Article 877 in the Japanese Civil Code) still requires sometimes even third-degree relatives to legally care for each other.

Long (2014), however, finds that these beliefs have been weakening over the decades, in part because of the country's economic growth during the 1960s. This growth led the Japanese state to ease the caring burdens of the family through welfare benefits such as healthcare co-payments. These benefits were mostly for employees and even included health insurance and other benefits for the spouses of employees. But to discourage women from participating in the labour market, these benefits were only accessible if the family annual income remained below a certain amount (Shinkawa, 2013).

Because of the oil crisis in the 1970s, Japan shifted towards a more liberal welfare-state model through welfare retrenchment, as the common belief of the government was that the welfare state shouldn't offer too many incentives. In this way they actively promoted familialism. This

welfare retrenchment was carried out through regulations and co-payments for eldercare and childcare.

5.1 Long-Term Care in Japan

The Japanese long-term-care insurance system was introduced in 1989 and can be called very generous when compared internationally. The system is universal. People older than 40 years become automatically insured, but they have to pay premiums. People over 65 years of age are eligible, regardless of disability, income or availability of family care. 'The official purpose of LTCI is to help frail older people 'to maintain dignity and an independent daily life routine according to each person's own level of abilities' (Ministry of Justice 2002 in Creighton Campbell et al., 2014:10).

Another purpose of the Japanese long-term-care insurance model is to relieve caregiver stress. The Japanese government identified these four aims in introducing its long-term-care insurance system:

To facilitate a system in which the society as a whole support those who are facing the need of long-term care, society's major cause of concern in terms of becoming old.

To establish a system in which the relationship between benefits and burdens are made clear, by way of introducing a social insurance approach, which can easily gain public understanding.

To reconstruct the present vertically-divided system between health, medical and welfare services, and to establish a system by which service users can receive comprehensive services from a variety of institutions of their choice.

To separate long-term care from coverage of health care insurance, and to establish a system which aims to decrease cases of 'social hospitalization' as the first step toward restructuring the social security system as a whole. (www.s-lite.jp/web/en/product/universal_care2.html, 2002)

When it comes to long-term-care insurance, the Japanese state distinguishes between two groups of insured people: people older than 65 years and people from 40 to 64 years of age. The beneficiaries of the first (65 years and older) from the second group (40–64 years) are almost the same. The state offers long-term care to insured people who are bedridden, for example, due to dementia, and to those who have become frail and are in need of more extensive support. The premiums for this long-term-care insurance are collected by municipalities.

The method of collecting these premiums differs by group. While there are fixed premiums per income bracket for those older than 65 years, insured persons from 40 to 64 years of age are covered by either the National Health Insurance or the Employees' Health Insurance, provided and partially paid for by the employer. The cost of the premiums through the National Health Insurance is calculated by adding the income with a 'fixed amount per capita', which is paid for by the state. The premium within the Employees' Health Insurance adds up the salary with an extra long-term care premium rate. Parts of this rate are covered by the employer. It is also of note that poor persons with a low income or pension pay lower premiums.

When an insured person applies for long-term-care insurance benefits, a so-called long-term-care approval board assesses the applicant's physical and mental state and, after evaluating the results with a doctor, determines the amount of benefits the insured person will receive. Benefits are distinguished between home-care services and services provided in care facilities. Home-care benefits include, for example, home visits with bathing, nursing care, medical care, counselling or 'care service provided by for-profit private homes for the elderly' (Japanese Government, 2002). Long-term-care insurance also provides cash allowances, either for home renovations (for example, for making the home accessible for wheelchairs) or for the 'purchase of welfare devices'.

Familial care in Japan is evolving. The foundations for long-term care in Japan were built in the 1980s, when population decline and the ageing of the population started being discussed in the Japanese media more frequently. The number of frail and elderly people also became much higher within the years. Other reasons were the decline of informal care by wife, mother, daughter or daughter-in law, because the rate of adult children living with their relatives has decreased.

In Japan, the idea of Confucian filial piety (the basis for the traditional Japanese family model) still remains strong. This means that the eldest son and his wife live together with his parents and care for them, while the other children move out and build their own families. But with time, the role of the daughter-in-law as a caregiver has decreased, and in the country with the longest-living population, taking care of frail and elderly people has become much more difficult.

Demographic change and a change in attitudes can be named as other reasons. Many Japanese women joined the workforce and simply were no longer available to care for their relatives. Because of the longevity of the Japanese people, hospital costs rose, and because of the changes in how family members are cared for, other sources of care had to be developed and introduced.

For the above reasons, the Japanese government established the national long-term-care insurance system (*Kaigo hoken*) in the year 2000. When the Japanese government introduced the *Kaigo hoken*, its goals were mainly 'to give 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' (Raikhola and Kuroki, 2009:58). Goals for the system also included creating competition and minimising costs by putting people into a long-term-care insurance system so that they would not have to be cared for in hospitals.

This balance shifted slightly when it came to the introduction of the long-term-care policy, which relieved women of their caring burden and made it possible for them to join the workforce.

In 1963, Japan passed the Welfare Law for the Elderly, which provided home helpers and nursing homes for a small fee. In 1973, the ruling Liberal Democratic Party started to offer free medical care for anyone above 70 years of age. It has to be mentioned that this medical care was not exactly free and was introduced only after much political pressure from the opposition. Instead, the policy meant that the state would cover the additional costs that would arise for anyone within the public health insurance system.

While this thesis focuses only on the years 1990 to 2015, the basis for the long-term-care insurance Japan has today was created in 1989.

In 1989, the Japanese government introduced their 'Gold Plan', a 'Ten-Year Strategy of Promoting Health Care and Welfare for the Aged'. The follow-up, the 'New Gold Plan' was introduced in 1995. The goals of both plans were to transfer the responsibility for public health to the municipalities. 'The basic principles underlying the plans were autonomy, user-orientation, universality, supply of comprehensive services and regionalization' (Raikhola and Kuroki, 2009:53).

'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 non-profit service providers' (Raikhola and Kuroki, 2009:58).

The Gold Plan was created in response to the rapidly ageing population. Its aim was to put welfare service into the hands of the municipalities and to provide care (Lee et al., 2000). The Japanese government also stated that it wanted to create the image of an ageing community 'with vitality'.

These were the first steps towards a long-term-care insurance system in Japan. The actual system, the Gold Plan 21, was introduced on April 1st, 2000.

While this has not been an official change of policies, Raikhola and Kuroki mention that there are recreational homes for the elderly in Japan. Many people retire after they have turned 60, and these recreational homes provide everything from hot springs to different kinds of sports. Additionally, there are about 130,000 senior citizens clubs, which promote a healthy lifestyle and mental and physical fitness.

It can be said that the changes in familial care in Japan are evolving. The foundations for long-term care in Japan were built in the 1980s when population decline and the ageing of the population started being discussed by the Japanese media more frequently. Another thing was that the amount of frail and elderly people became much higher within the years. Other reasons were the decline of informal care (wife, mother, daughter and daughter-in law) because the rate of an adult child living with their relatives has decreased as well.

In Japan, the idea of the Confucian filial piety (the basis for the traditional Japanese family model) still remains strong. This means that the eldest son and his wife live together with his parents (and also care for them) while the other children move out and build their own family. But with time, the role of the daughter-in-law (as a caregiver has decreased more and more) and in the country with the longest-living population, taking care of frail and elderly people became much more difficult.

Demographic change and a change in attitude can be named as another reason. Many Japanese women joined the work force and simply 'were not there anymore' to care for their relatives (Appendix Figure 7). As in Germany, this will become a more pressing issue in the future.

6. Comparison

Germany's and Japan's long-term-care insurance policies were both introduced in a time of change. Both countries faced general elections in 1990 and the media continually broadcast news about demographic change and the ageing of the population.

While both countries started to implement their long-term-care policies in the 1990s, their approaches differed. While Germany opted for a combination of formal services and a cash allowance that an elderly person could spend for care services,

Japan opted for a model where service would be delivered 'in-kind' and not in cash. One half of the money for these services would be provided from premiums and the other half from taxes. Politicians argued that Japan should go the same route as Germany when it came to covering the costs of long-term-care insurance, but this approach was broadly rejected, as many people argued it would destroy the traditional family in Japan. Criticism came from the feminist faction as well, as they believed that women caring for their relatives (mostly daughters-in-law) would not be relieved of their burden if there was a cash allowance for long-term care.

Given the background of the Japanese family system, it was not surprising that the Japanese public would reject a cash allowance for family care, but it has to be understood that the Japanese perception of family differs completely from the German perception.

In some cases, by receiving cash, the pattern of family caregiving would become fixed, and in particular there is the danger that women will be tied down to family caregiving. A cash benefit is allowed in German LTCL, but the family situation is different in Japan and Germany (Creighton Campbell, 2002).

This is due to many adult children (over 65) still living at home and the tense relationship between mother and daughter-in-law. As discussed above, the family of the eldest son lives with his parents and cares and provides for them.

A woman's having to physically care for and provide for people she is not related to by blood and having to be respectful to her mother-in-law can lead to tense situations in which she feels exploited ('caregiving hell'). This topic was widely covered by the media, both in newspapers and also in Japanese television dramas. Given the sensitization of the public by the media, it may not have been surprising that the Japanese did not opt for a cash allowance for care.

This problem of daughter- or in-law exploitation did not exist in Germany. A cash allowance for long-term-care insurance in Germany was less controversial, as the country did not have the family structure issues that Japan had.

Both Japan and Germany opted for a social insurance model for long-term care. But while Japanese long-term-care insurance provides care only for people over 65 years of age, German long-term-care insurance provides services for disabled people of all ages.

In terms of familialisation and defamilialisation, the family remains important in both Germany and Japan when it comes to providing care. While Japan surprisingly shows defamilialistic tendencies in its long-term care system, the opposite is true in Germany. While it is the aim of the German government to support in-family caregivers, it is the aim of the Japanese government to release the family from its caregiving burden. It is important to note, however, that this is the case only when it comes to eldercare. In terms of childcare, Germany is slowly abandoning the male-breadwinner model, while Japan is much more familialistic in this regard.

7. Conclusion and Discussion

This thesis addressed the following research questions:

How have the long-term care policies of Germany and Japan changed between 1990 and 2018, and how are both states affected by this change when it comes to the concept of defamilialisation?

Two sub-questions were formed:

1. How and in what direction has the role of the family changed when it comes to long-term care?
2. How do these changes affect the development of the welfare state in general?

Firstly, it is important to mention that eldercare, or long-term care, is still rather neglected when it comes to research into family policies. There is actually much more research about families with smaller children and the implementation and enactment of childcare policies, and the lack of research regarding eldercare is a clear gap.

As discussed in previous chapters, the male-breadwinner model is still strong in both Germany and Japan. The reasons for this can be found not in the type of welfare state but in post-World-War-II history. While the German population tried to move beyond the 'sacred mother' figure that the NSDAP had broadcast, many Japanese women had to care for sons and husbands who were injured during the war, including those injured by atomic bombs.

Thus, both countries started with an implicit familialistic system. While Germany developed an explicit familialism through several reforms over the years, slowly abandoning the traditional male-breadwinner model, Japan was not as quick to change and has only more recently begun to develop forms of an explicit familialism. The role of long-term care being the relief of the woman as caretaker of the old in general.

Germany on the other hand, is well on the road to an optional familialism, one example being the implementation of a reimbursement for staying at home with the family.

One might argue that the implementation of long-term care was the start of defamilialisation in Germany, but the process actually started decades earlier. As Streeck and Thelen (2005) argue that changes in the state take time, one could describe the changes in welfare state policies as incremental in Germany and having little effect on the welfare state in general. This corresponds with the theory that welfare states are relatively unchanging, though Japan is shifting towards a more liberal welfare-state model.

Japan went from having almost no long-term care at all to one of the world's most advanced long-term care systems, while in Germany social security has been a priority and has been rooted in German politics since Bismarckian times. In contrast, the Japanese welfare state is shifting to make welfare more universal and applicable to everyone.

Another important part is the change of the family. While in the past women stayed at home to care for their relatives, they now go to work and assign others to provide care in their place. In Germany, there are agencies that facilitate the careers of women (mostly nurses) from Eastern Europe, especially Poland and the Ukraine, or less-skilled immigrant workers.

The situation differs in Japan. While women stayed at home in the past as well, most still choose to stay at home to this day. While the use of formal care has increased, this increase cannot be compared to Germany. The reasons for this are two: firstly, the idea of Confucian filial piety is still deeply rooted in Japanese culture, and secondly, Japan has not historically seen much immigration, and the thought of non-Japanese workers caring for their relatives is simply foreign to most Japanese people. Another problem in Japan is the shifting of living arrangements. Many people, especially the younger ones, choose to live alone, which makes it difficult to provide support within the familial structure.

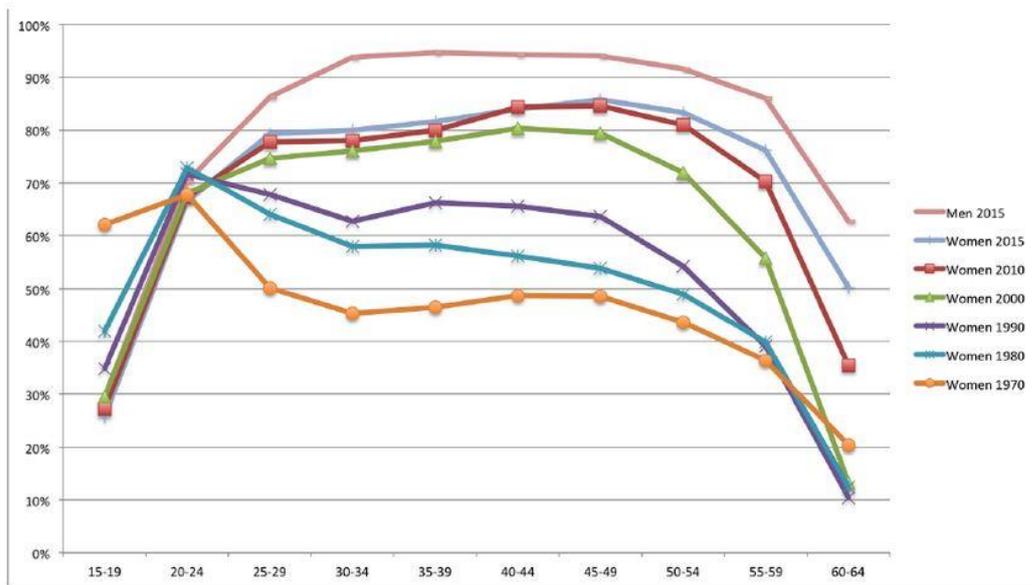
What would be policy options to overcome these challenges? One option in both countries would be to raise the retirement age as the population becomes older and stays fit longer. Another option for Japan would be to attract migrants, as it has a lower rate of migration than Germany (see Appendix Table 10).

This is the question that needs to be explored: What policy changes would be needed to help Germany and Japan make the transition to optional familialism?

8.Appendix:

Table 7:

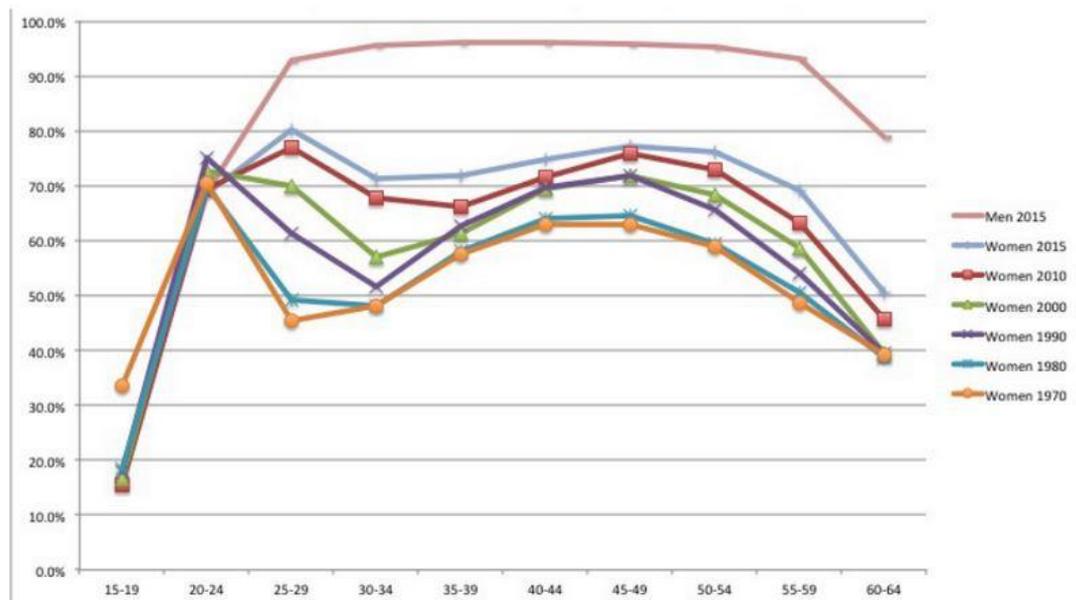
Figure 3: German labour force participation by sex and age



Data source: OECD Employment and Labour Market Statistics Database (2016)

Table 8:

Figure 4: Japanese labour force participation by sex and age



Data source: OECD Employment and Labour Market Statistics Database (2016)

Table 9: Differences in the LTC systems in Japan and Germany, 2008

EXHIBIT 3

Differences Between Long-Term Care (LTC) Systems, Germany And Japan, 2008

	Germany	Japan
Policy objective	Support family caregivers	Decrease burden of family caregivers
Policy design	Contain spending to within the premium level set by law	Increase expenditures as services become more available
Organized and managed	Sickness funds (but LTC is managed separately)	LTC insurance section of the municipal government or their coalitions
Financing	Premiums 1.95% of income up to a ceiling	Half by premiums, half by taxes 1/3 of premium revenue from those age 65+, with 6 premium levels based on income 2/3 from those ages 40–64 at 1% of income, up to a ceiling
Regional differences	No difference in premium levels	For those age 65+, premiums linked to local spending level For those ages 40–64, pooled at national level and redistributed; municipalities having low income levels and more residents age 75+ receive more
Population covered	All ages	Unconditional for those age 65+ Limited to age-related diseases for those ages 40–64
Percentage of those age 65+ who are eligible	10.5%	17%
Percentage of those age 65+ who are receiving benefits	10.5% (all of those eligible receive benefits)	13.5% (20% of those eligible have not chosen to receive benefits)
Eligibility levels	Three (plus a limited additional hardship level in HCBS)	Two for the “preventive care” program, five for regular LTC insurance
Benefit ceilings per month (\$ PPP)	No copayment or deductible Cash: \$250–\$794 plus caregiver pension premiums HCBS: \$490–\$1,730 (hardship: \$2,260) Institutional care: \$1,200–\$1,730 Room-and-board costs not covered; low income covered under public assistance	10% copayment (included below) Services only HCBS preventive care: \$430–\$950 HCBS regular program: \$1,440–\$3,400 Institutional care: \$1,680–\$3,670 One-third of room-and-board costs covered, up to all costs paid by LTC insurance if income level is low
Fee schedule for services	Negotiated regionally between sickness funds and providers	Negotiated nationally, conversion factor for regional cost differences

SOURCES Government publications on long-term care insurance (see Notes in text). **NOTES** Benefit amounts are for 2008 for Germany and 2009 for Japan. Converted to dollars using the purchasing parity (PPP) rate of 0.85 euro to the dollar and 116.32 yen to the dollar in 2008 (OECD health data, 2009). Maximum benefit amount for Japan is for municipalities having the highest level. HCBS is home and community-based services.

Source: Creighton Campbell & Ikegami (2010:89)

Table 10: Public LTC spending for the Elderly, 2005

EXHIBIT 2

Public Long-Term Care Spending For The Elderly In The United States, Germany, And Japan, 2005

	United States	Germany	Japan
Home and community-based services	\$512	\$480	\$617
Care at home	477	441	236
Home help services	474	140	236
Services, no medical	277	140	197
Services with medical	197	0	39
Cash allowance	0	290	0
For caregiving	0	237	0
Caregiver benefits	0	52	0
Respite care	3	11	0
Care outside home	0	17	368
Day care	0	5	293
No medical	0	5	203
With medical	0	0	90
Respite care	0	12	75
In nonmedical facility	0	12	59
In medical facility	0	0	16
Material aid	35	22	14
Assistive devices	35	0	3
Home renovation	0	0	11
No breakdown	0	22	0
Institutional care	1,094	654	1,061
Nursing homes	1,094	654	730
LTC in general hospitals	0	0	222
Care in residential facilities	0	0	109
Dementia group homes	0	0	78
Private-pay homes	0	0	31
Administration	0	51	74
Care management	0	16	74
Accounting	0	35	0
Total LTC	1,605	1,185	1,751

SOURCES See Technical Appendix, online at <http://content.healthaffairs.org/cgi/content/full/29/1/hlthaff.2009.0548/DC1> **NOTES** A zero in a specific category, such as day care, can mean that spending is captured in a broader category, such as home and community-based services, rather than no public spending at all. See Technical Appendix. Dollars are U.S. dollars in purchasing power parity per person age sixty-five and older.

Source: Creighton Campbell & Ikegami (2010:90)

Table 11:

Table 1: Demographic indicators, Germany and Japan, percent (unless otherwise stated).

	1980-84 avg	1985-89 avg	1990-94 avg	1995-99 avg	2000-04 avg	2005-09 avg	2010-13 avg
<u>Age dependency ratio (0-20 and 65+ as share of working-age population)</u>							
Germany	37.71	34.77	36.30	37.97	38.96	39.62	39.41
Japan	39.56	38.99	37.95	37.40	38.32	39.95	41.65
OECD av.	44.14	42.71	41.66	41.07	40.48	40.06	40.05
<u>Youth dependency ratio (0-20 year old as share of working-age population)</u>							
Germany	43.78	36.61	34.07	34.26	33.64	32.19	30.16
Japan	49.67	46.02	40.12	34.74	32.15	30.78	30.46
OECD av.	59.77	55.12	51.05	48.25	45.59	43.22	41.60
<u>Old dependency ratio (65+ year old as share of working-age population)</u>							
Germany	20.06	19.15	23.22	26.26	29.35	33.14	34.51
Japan	15.79	17.90	21.04	25.01	29.97	35.76	40.94
OECD av.	19.27	19.42	20.37	21.46	22.42	23.63	25.20
<u>80+ year old population share</u>							
Germany	2.85	3.44	3.89	3.79	3.98	4.71	5.30
Japan	1.56	2.03	2.68	3.37	4.23	5.59	6.86
OECD av.	2.03	2.33	2.68	2.90	3.17	3.65	4.07
<u>Life expectancy at birth (in years)</u>							
Germany	73.54	74.92	75.86	77.28	78.60	79.96	80.80
Japan	76.78	78.28	79.28	80.30	81.68	82.54	83.05
OECD av.	n.a.						

<u>Life expectancy at birth (in years)</u>							
Germany	73.54	74.92	75.86	77.28	78.60	79.96	80.80
Japan	76.78	78.28	79.28	80.30	81.68	82.54	83.05
OECD av.	n.a.						
<u>Period total fertility rate (Source: Human Fertility Database 2015)</u>							
Germany	1.48	1.42	1.32	1.34	1.37	1.38	1.41
Japan	1.76	1.68	1.51	1.40	1.32	1.31	1.39
OECD av.	n.a.						
<u>Inflow of foreign population as percentage total population (latest data cover 2010-14)</u>							
Germany	n.a.	n.a.	n.a.	n.a.	0.78	0.70	1.22
Japan	n.a.	n.a.	n.a.	n.a.	0.28	0.26	0.24
OECD av.	n.a.						
<u>Population share of foreign nationals</u>							
Germany	7.15	7.30	8.16	8.91	8.74	8.19	8.71
Japan	0.70	0.74	1.01	1.16	1.45	1.67	1.63
OECD av.	n.a.						

Source (unless stated otherwise): OECD (2017c), own calculations.

Source: Lill (2018) & OECD (2017c)

Literature

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