POLITICAL INSTITUTIONS AND ELDERLY CARE POLICY

COMPARATIVE POLITICS OF LONG-TERM CARE IN ADVANCED DEMOCRACIES

TAKESHI HIEDA

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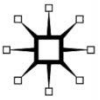

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Contents

Tables

Figures

Abbreviations

Sweden

C	Centre Party
FP	Liberal Party
KD	Christian Democrats
M	Conservative Party
MP	Green Party
SAP	Social Democratic Party
VPK	Left Party Communists

Japan

DSP	Democratic Socialist Party
JCP	Japan Communist Party
JMA	Japan Medical Association
JSP	Japan Socialist Party
LDP	Liberal Democratic Party
LTCI	Long-Term Care Insurance
MHW	Ministry of Health and Welfare
MMD	Multi-Member District
MOF	Ministry of Finance
PARC	Policy Affairs Research Council
SNTV	Single Non-Transferable Vote

United States

AARP	American Association of Retired Persons
ADA	Americans with Disabilities Act
AHA	American Hospital Association
AMA	American Medical Association
ANHA	American Nursing Home Association
HCBC	home and community-based care
HEW	Department of Health, Education and Welfare
HHS	Department of Health and Human Services
HIPAA	Health Insurance Portability and Accountability Act
ICF	intermediate care facility

ICF/MR	intermediate care facility for people with mental retardation
MAA	Medical Assistant for the Aged
MCCA	Medicare Catastrophic Care Act
MR/DD	mental retardation/development disabilities
OAA	Old Age Assistance
OAA	Older Americans Act
OBRA	Omnibus Budget Reconciliation Act
SMD	single member district
SNF	skilled nursing facility
SSBG	Social Services Block Grant
SSI	Supplemental Security Income

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1
Introduction

This book intends to reveal the political logic of the development of long-term care policy for frail older people in advanced industrialized countries. As the demographic structure and the composition of households have changed, long-term care services for the aged are becoming an imminent welfare state policy issue across advanced democracies. The increase of the 'older old-aged' (i.e., 75 years old and over) population creates the need for social care services as well as income security. Since fewer and fewer older people live with their offspring and more and more women participate in the labour market, the family cannot accommodate those needs within the household anymore. That is the reason why formal social care services are required to step in to help households take care of frail older people. However, public policies intended to fulfil the care demands for the aged are remarkably diverse across countries. While some countries directly provide social care services for older people, some other countries subsidize formal care services through social insurance budgets. Elderly care services are still provided as a means-tested program in many countries. The volume of publicly funded elderly care services is also considerably varied across advanced industrialized democracies. How can we explain this variety of policy responses to socio-demographic transformation? This is the research question this study tackles.

This study's specific interest in long-term care policy for older people is related to the broader research agenda on the emergence of 'new social risks'. New social risks are becoming an important research topic in comparative welfare states' literature (Armingeon and Bonoli, 2006; Bonoli, 2005, 2007; Häusermann, 2006, 2010; Taylor-Gooby, 2004b). While 'old social risks' mean all risks traditionally covered by industrial-era welfare programs – such as occupational injury, sickness, incapacity,

unemployment, and poverty in old age – 'new social risks' refer to those risks that people now face in their life course due to economic and social changes associated with post-industrialization (Taylor-Gooby, 2004a, p. 3). In the industrial periods, housewives provided child and elder care within a (nuclear or extended) family through their unpaid work. By taking advantage of the social structure of a male breadwinner and a female caregiver, the postwar industrial welfare states addressed old social risks with standardized cash benefits under a relatively stable family structure. However, the post-industrial welfare states are no longer able to leave the protection against social risks to cash benefits and family. The feminization of the labour force makes a household an invalid unit of social protection, and then the standard family model imposing the burden of child and elder care on females within a household is unsustainable. Working women cannot reconcile their careers with family burdens unless they can outsource care-giving to market and/or public programs, and, as a result, the demands for social care services have been growing in recent decades. In most advanced democracies, policymakers are now facing growing societal demands for care for frail older people because of these social transformations as well as population aging.

However, policy responses to those socio-demographic pressures are not homogenous at all. Scandinavian countries have developed generous public elderly care services, and they have provided high-quality services for their inhabitants based on their citizenship and care needs. In these countries, municipalities are obliged to provide care for frail older people, and their public social care services are funded by local tax revenues and state subsidies (Rostgaard and Fridberg, 1998). In the U.K. and parts of the former British Empire – Australia, Canada, Ireland, and New Zealand – and in the United States, long-term care programs are funded by general taxation and provided based on income- and/or asset-testing in general (OECD, 2005). Germany, Japan, Luxembourg, and the Netherlands established a social insurance system as a financial scheme covering long-term care costs for older people with disabilities. In Austria and France, the welfare state addresses elderly care issues with care allowance (Da Roit, Le Bihan, and Österle, 2007, p. 660). Aside from the differences in program schemes, the coverage and volume of elderly care services are also varied across advanced industrialized countries: while Scandinavian countries have achieved their extensive service coverage, other countries spend a smaller amount of resources on public social care services. Although Japan and some countries of Continental Europe are catching up with Scandinavian countries,

others maintain meagre coverage and expenditure levels (Colombo, Llena-Nozal, Mercier, and Tjadens, 2011).

What is the political logic transmitting socio-demographic changes into public social care programs? After the development of a huge pile of comparative welfare state studies, we cannot suppose that socioeconomic transformation is automatically translated into public policy. What made Scandinavian countries develop their generous public care services for the aged? Why have some countries developed social insurance programs to meet the growing demand for elderly care? Why do others hardly respond to the transformation of social risks on elderly care? This book tries to answer these questions.

1.1 Outline of the argument

This book tries to answer these questions by focusing on the state–society relations structured by *voter–politician linkages* and examining how the predominant mode of intra- and inter-party competition constitutes the voter–politician linkages. There are various types and forms of political competition across countries (cf. Kitschelt and Wilkinson, 2007b). Whereas political parties compete with each other through party platforms and generic public policy in some countries, party politicians in some other countries compete with each other through patronage-based, contingent benefits for clients. As Lynch (2006) has already exemplified in her pioneering work, while programmatic party competition promotes citizenship-based, universalistic welfare programs, particularistic party competition encourages occupation-based social insurance programs. This study also claims that whereas programmatic political competition is favourable for the development of public elderly care policy, particularistic political competition is unfavourable for it. This is because elderly care programs are provided, for those who need the services, as a means-tested or citizenship-based universal service, and their provision is hardly occupationally stratified.

Although Lynch (2006) does not specify the causal factors of types of party competition (programmatic versus particularistic), and Kitschelt and others (Kitschelt and Wilkinson, 2007a, 2007b; Müller, 2007) deny the effects of political institutions on the forms of citizen–politician linkage, this book claims that political institutions, especially electoral rules and party systems, affect the development of elderly care programs by determining to what extent the state retains its relative autonomy from societal interests. Universalistic social policy faces collective action problems because it assigns its benefits and burdens to the entire

citizenry equally, but societal interests seek to receive special treatment and convey its costs to the general public. Particularistic benefits are preferable for each societal actor. Hence, the universalistic social policy is less likely to develop unless the state is capable of coordinating the benefits and burdens of social protection programs in an equitable way. To what extent the state is embedded in societal interests is dependent on the dominant mode of intra- and inter-party competition in each country, and electoral rules and party systems influence the mode of political competition.

When electoral rules give party politicians within the same political party incentives to compete with each other, those rules promote particularistic political competition because, under those rules, politicians need to secure personal votes through particularistic benefits rather than wage their electoral campaign under the party platform. The intense intra-party competition dismantles the party leadership, paralyses the party platform, and motivates party politicians to favour particularistic benefits for their clients. In other words, when electoral rules allow politicians to have electoral independence from their party, these rules decentralize the party and sink the executive branch into the web of geographical, occupational, and/or industrial interests. On the contrary, when electoral rules organize an election so that its results are solely decided by the reputation of political parties, party politicians seek party votes rather than personal votes in their electoral campaign. Since political parties become the unit of political competition, those electoral rules centralize a political party and facilitate the party disciplining its rank-and-file members. Since, in a centralized party, the rank-and-file politicians have no incentive to retain their policy-making functions in the legislative branch and to cultivate their own constituency groups through public policy, the party is more likely to delegate its policy-making functions to the executive branch and promote its relative autonomy from societal interests, ceteris paribus.

On the dimension of inter-party competition, this study maintains, political parties prefer targeted social benefits if the party system is fragmented along lingual, ethnic, religious, and/or regional cleavages. When a ruling coalition is composed of various political parties representing their own social groups, each coalition partner tries to bring benefits to its own constituents. This practice prevents the state from assigning the benefits and expenses of social protection programs to various social groups equally, and then the distribution of public resources is biased towards particularistic benefits and occupational social insurance schemes benefiting these parties' constituency groups.

Even if political parties are centralized and compete with each other through party platform, universalistic social welfare programs are less likely to thrive under the fragmented coalition government: each coalition party has no incentive to appeal to broader constituencies through those universalistic programs. On the other hand, if a catch-all party dominates its ruling coalition, public policy is inclined to appeal to a broader constituency *unless the dominant party itself is decentralized*. Overall, whereas a party system fragmented along various social cleavages promotes particularistic party competition, one-party dominance by a centralized political party encourages the development of universalistic social policy.

This study maintains that the conditions under which universalistic social policy is likely to thrive lead to the development of generous, public long-term care programs for the aged. For the welfare state usually entitles its citizens to receive the benefits of public elderly care programs according to their citizenship and care needs, and the entitlement is rarely regionally, occupationally, and socially stratified. In other words, public elderly care policy is close to universalistic social policy. Hence, the relative autonomy of the state, which is stipulated by each country's electoral rules and party systems, accounts for the variation of those programs across countries.

1.2 Methodology

To explore the validity of the theoretical arguments above, this book combines both quantitative and qualitative methods. As is well-known, both methods have their own advantages and disadvantages: while quantitative regression analyses are superior to qualitative case studies in estimating *causal effects* between explanatory and explained variables and their uncertainty, qualitative case studies are better at untangling *causal mechanisms* of complex social events than the quantitative regression analyses (cf. Brady and Collier, 2004; George and Bennett, 2005; Gerring, 2004, 2007, 2008, 2010; King, Keohane, and Verba, 1994; Mahoney, 2007, 2008, 2010; Mahoney and Goertz, 2006; Mahoney, Kimball, and Koivu, 2009; Mahoney and Rueschemeyer, 2003; Seawright and Gerring, 2008). In other words, whereas statistical analysis assesses to what extent independent variables are correlated to a dependent variable, case studies can examine how those independent variables are connected to the dependent variable. The qualitative approach is advantageous in that it can observe the steps by which explanatory variables cause the effects of a dependent variable, and this approach

can distinguish spurious correlations from causal relations between those independent and dependent variables through process tracing.[1] However, the validity of qualitative case studies quite often relies too heavily on each researcher's 'craftsmanship' and is not necessarily open to criticism from other researchers. While qualitative researchers often construct 'convincing' narratives to explain a particular phenomenon by referring to a certain causal mechanism, it is hard for fellow scholars to judge whether omitted explanatory variables really have no influence on the outcomes or whether those factors are just ignored in the narratives. Hence, quantitative regression analyses can complement qualitative case studies by assessing the effects of explanatory variables on a dependent variable through explicitly controlling for the effects of other plausible factors and then by examining the external validity of the causal mechanism found in the case studies.

To overcome the limitations of quantitative as well as qualitative research, this book makes use of both approaches. On the one hand, it estimates the general structuring effects of political institutions by analysing pooled time-series and cross-section data from 1980 until 2001 among 15 OECD countries with multivariate regression models. Although the data availability of dependent variables and the conceptual validity of indicators representing explanatory factors are highly limited, this study's statistical analysis intends to capture how political institutions bias the distribution of public resources. On the other hand, this study also delves into the detailed political process of elderly care policy and then – through case studies in three countries – reveals *how* political institutions structure the policy-making process. Because of the limitations of time and language proficiency, the case studies focus on the effects of electoral rules, selecting these cases so that the heterogeneity of electoral rules is maximized. In this respect, the case study part of this book follows the 'diverse-case method', which selects a set of cases so as to secure the full range of values in explanatory and explained variables (Gerring, 2007, chapter 5; Seawright and Gerring, 2008). The diversity of selected cases along the explanatory and explained variables allows the case study to be likely to represent the population. Through this case-selection criterion, this book chooses three countries for its cases: Sweden, Japan, and the United States. While Sweden represents a country with the least personal-vote oriented electoral system and the most developed public elderly care programs, the United States represents the opposite. Japan stands for a peculiar electoral system with moderately developed public elderly care programs. Each of these case studies aims to reveal how its electoral system shapes policy makers'

incentive structures and the pattern of policy-making process peculiar to each country. In this sense, the studies intend to show causal mechanisms rather than causal effects.

1.3 Contributions of the book

Comparative welfare state and social policy literature has accumulated an enormous quantity of theoretical and empirical works covering broad range of welfare programs, spatial variations, and temporal sequences. Although elderly care policy is relatively a less studied field in the literature, social care scholars have achieved remarkable progress in the last two decades (cf. Anttonen, Baldock, and Sipilä, 2003; EUROFAMCARE-consortium, 2006; Geissler and Pfau-Effinger, 2005; Jamieson, 1991; Kröger and Sipilä, 2005; Lechner and Neal, 1999). This book certainly contributes to this burgeoning literature because it gives a solid explanatory theory to these primarily descriptive social care studies.[2] However, this present study's theoretical scope is not limited to social care research. Through analysing elderly care politics and policy across advanced democracies, this book accounts for the variations of social protection systems more generally and reveals the political logic behind the diversity. It intends to make three theoretical contributions to the entire comparative welfare-state literature.

The first contribution is that this study offers a theoretical account for the qualitative variations of social protection systems in advanced industrialized countries. While the welfare regime theory presents a famous typology (i.e., social democratic, conservative, and liberal regimes) and validates its relevance with succeeding empirical studies (cf. Esping-Andersen, 1990, 1999), the reason why these three types of welfare regime were established and have persisted is under-theorized. Although Esping-Andersen himself tried to account for his typology with class alliance and the presence of guildic industrial relations in Continental Europe at first, the theoretical connection between these two variables and his typology became tenuous, especially after he accepted feminist critiques of his original argument (cf. Lewis, 1992, 1997; O'Connor, 1993; Orloff, 1993; Sainsbury, 1996, 1994). Simply stated, power resources theory – on which Esping-Andersen's original argument relied – is unable to account for why the strong presence of male-dominant trade union movements promotes 'defamilialization' of female citizens. Since the presence or absence of generous social care services is the core difference between the Social Democratic regime and other regimes, this study's theoretical explanation for

the variations in public elderly care policy can enhance the debate concerning the welfare regime typology. Furthermore, this book addresses other categorizations of social protection programs across countries. While some welfare states devote most of their social expenditures to pension benefits through occupation-based social insurance schemes, other welfare states spread their fiscal resources over citizenship-based social benefits, such as child care, family allowance, elderly care, and active labour market policy as well as old-age pension benefits (cf. Lynch, 2001, 2006). Some other welfare states protect their citizens against social risks through public work projects, industrial regulations, and tax benefits (cf. Estévez-Abe, 2008; Howard, 1997). This present study's theoretical model illuminates how political institutions bias the priority of the welfare state and the distribution of scarce public resources.

The second theoretical contribution speaks to the ongoing discussion on the relationship between electoral rules and welfare states. In general, the comparative welfare state literature has paid less attention to the effects of electoral systems on social policy and welfare states. Recently, Iversen (2005), Iversen and Soskice (2006), Persson and Tabellini (2005) and others postulate that single-member district (SMD) systems restrain the entire scale of the welfare state, whereas proportional representation (PR) systems enlarge the welfare state. However, these studies – unlike this book – treat electoral systems as a dichotomous variable between SMD and PR systems and deal only with total social spending. Electoral rules have different dimensions aside from the SMD–PR dichotomy and, as Carey and Shugart (1995) and Estévez-Abe (2008) point out, the differences in these dimensions lead to distinct distributional outcomes. This book joins this debate by showing that personal-vote oriented and party-vote oriented electoral rules have different implications for the development of public elderly care programs.

The third theoretical contribution is to shed light on the impacts of social cleavages other than class relations. Alber's (1995) pioneering work argues that power resources theory is, in itself, unable to account sufficiently for variations in social care services, and he proposes that research should take into consideration intergovernmental relations and church–state relations. In recent years, as the influences of power resources theory wane, a few comparative welfare state scholars started examining the impacts of non–labour-capitalist relations on the composition of welfare programs in Western European countries (Morgan, 2006; Van Kersbergen and Manow, 2009). This book contributes to this literature by theorizing how non–labour-capitalist social

relations affect the composition of social protection programs through party systems.

1.4 Plan of the book

Chapter 2 elaborates the theoretical claims this study empirically examines in the later chapters. This chapter presents 'historical rational-choice institutionalism' as this book's analytical framework, and it claims that the state–society relations structured by electoral rules and party systems affect the development of elderly care programs. Since universalistic social policy, including public elderly care programs, faces collective action problems, it is less likely to thrive unless the state, relatively autonomous from societal interests, is able to coordinate its benefits and costs in an equitable way. And, then, to what extent the state retains its relative autonomy is contingent upon the predominant mode of intra- and inter-party competition in each country.

Chapter 3 – based on the theoretical arguments in Chapter 2 – hypothesizes that while party-vote oriented electoral rules and one-party dominance are contributive towards public spending for elderly care services, personal-vote oriented electoral rules and/or fragmented ruling coalitions are unfavourable to this spending. Chapter 3, then, explains the data and methodology this study's multivariate regression models use and analyses the pooled time-series and cross-section data of 15 advanced democracies from 1980 to 2001. This chapter reveals that political institutions – specifically, electoral rules and party systems – structure the political process transmitting socio-demographic changes into public policy.

Chapters 4 to 6 are case studies of long-term care policy development and reforms in Sweden, Japan, and the United States. In each case, this book offers political and institutional contexts; it describes each country's social care services for the aged, and then it elaborates the elderly care policy-making process and elucidates how political institutions structure the politics of elderly care programs. Chapter 4 tries to understand the creative nature of Swedish social policy. Sweden had developed its generous social care services for the aged long before elderly care became an imminent policy issue in other countries. Why did this happen? Sweden also implemented the Ädel reform in 1992 and devolved the responsibilities of providing care for the elderly to municipalities. The reform also replaced a part of health care services with social care services. What is the political logic behind this reform? What made large-scale policy reform possible in Sweden? The chapter

shows that the relatively autonomous 'state' underpinned by the social democratic one-party dominance and the party-vote oriented electoral system universalized public institutional and community care services for the aged during the golden era of the welfare state. This chapter also demonstrates that the centralized ruling party facilitated the transforming of existing health and social care programs for the aged.

Chapter 5 addresses the question of why Japan established a new social insurance system to cover the costs of long-term care for frail older people under its strongly particularistic political competition. Chapter 2 argues that personal-vote oriented electoral rules create clientelistic political competition among politicians and then bias the distribution of public resources towards particularistic benefits for their constituencies. Does the enactment of public long-term care insurance law in Japan falsify the above theoretical argument? Chapter 5 demonstrates the value of the qualitative case-oriented approach. It shows that the general characterization of a 'clientelistic voter–politician linkage' illuminates just one side of the reality of Japan's politics under its peculiar electoral system – the single non-transferable vote (SNTV) with the multi-member district (MMD) system. Since the SNTV–MMD system forced politicians to compete with each other only in the ruling party – Liberal Democratic Party (LDP) – during its one-party dominance, the legislators of opposition parties waged their electoral campaigns under their party platform and party leadership while LDP politicians were engaging in clientelistic political competition. In other words, the SNTV–MMD system had asymmetrical effects between LDP politicians and opposition parties. The SNTV–MMD system allowed non-LDP parties to wage programmatic political competition. The non-LDP parties put the issue of long-term care for frail older people on the governmental agenda during the crisis and collapse of the LDP's one-party dominance, and the state actors – senior civil servants in Japan's context – took full advantage of this opportunity to establish the public long-term care insurance. However, the LDP's clientelistic politics left imprints on the public long-term care insurance enacted through LDP-*Sakigake*-JSP coalition governments: it preserved the vested interests of existing health and social care providers for the aged because those stakeholders were connected to LDP politicians. Although the quantitative indicator of electoral rules dismisses the nuance of this study's explanatory factors in statistical analysis, Chapter 5 reveals that subtle characteristics of electoral rules created dynamics in the elderly care politics of Japan.

Chapter 6 elaborates the evolution of long-term care policy in the United States. While Medicaid – a means-tested health care assistance for lower-income individuals and families – has covered the expenditures for nursing homes, the long-term care policy for the aged has not experienced comprehensive reform since the enactment of Medicare and Medicaid. The Medicare Catastrophic Care Act was enacted but repealed in the 1980s, Representative Claude Pepper's Home Care Act was killed in the Congress, and Clinton's Health Security Act collapsed in the early 1990s. Why is the United States unable to universalize its long-term care policy? This chapter shows that extremely individualistic political competition underpinned by the personal-vote oriented electoral system has prevented universalistic elderly care programs from being enacted in the United States. The single-member district (SMD) system with primary elections forces congresspersons to compete with their colleagues and then prioritize particularistic benefits rewarding only their own constituency over the public goods benefiting the entire party. This practice has motivated congresspersons to retain their policy-making functions inside the legislative branch and to make laws reflecting the demands from their own constituents. Each legislator has incentives to engage in bringing particularistic benefits to her constituents through her law-making power, and it is extremely difficult to coordinate the benefits and expenses of social protection programs in an equitable way in the U.S. polity because its political parties have weak party discipline under the personal-vote oriented system. As a result, a comprehensive policy proposal for establishing universalistic elderly care programs has rarely come out of the Congress because its electoral rules skew legislators' policy preferences towards particularistic benefits. As a result, Medicaid has evolved to fulfil the societal demands for long-term institutional and community care services without changing its core as means-tested health care assistance.

Chapter 7 highlights the key findings of empirical parts and connects them to the theoretical argument exemplified in Chapter 2. Based on the quantitative and qualitative evidence presented in empirical chapters, this chapter reveals the political logic under which universalistic social care services are more likely to be developed. Then, from the institutionalist perspective, the last chapter assesses the effects of electoral rules and party systems on social protection and compares alternative explanations with this study's approach.

2
Understanding the Politics of Universalistic Social Care Services: A Theoretical Framework

This chapter develops a political-institutional theoretical model for the analysis of universalistic social care policy. The question is why some welfare states devote more public resources to universalistic welfare programs – which benefit the entire constituency equally and charge the nation as a whole for their costs in an equitable way – than do other welfare states. Since public elderly care programs – which in Scandinavian countries include institutional and community care services funded by the general tax revenue, public long-term care insurance schemes in Germany and Japan, care allowance in France and Austria, and so forth – are rarely stratified along class, ethnic, occupational, or regional lines, these programs are a representative example of universalistic social policy. And, as Figure 2.1 indicates, the degree of population aging hardly explains the variations of public elderly care spending across advanced democracies. What encourages or discourages the welfare state to dedicate public resources towards these universalistic welfare programs?

This book tries to address the above question by combining the analytical elements of 'historical institutionalism' and 'rational-choice institutionalism' (cf. Hall and Taylor, 1996; Kato, 1996). On the one hand, this study presupposes that political actors interact with each other in an instrumentally rational way. In other words, these actors choose a strategy to maximize the possibility to fulfil their superior purpose. Based on the rationalistic assumption, this study develops a deductive model explaining the variations of social protection programs across welfare states and tests it with quantitative and qualitative data. Since it makes a theoretical argument circular to induce political actors' preferences and strategies in a specific institutional context from a case and applies the inductive explanatory model to the very same case, this

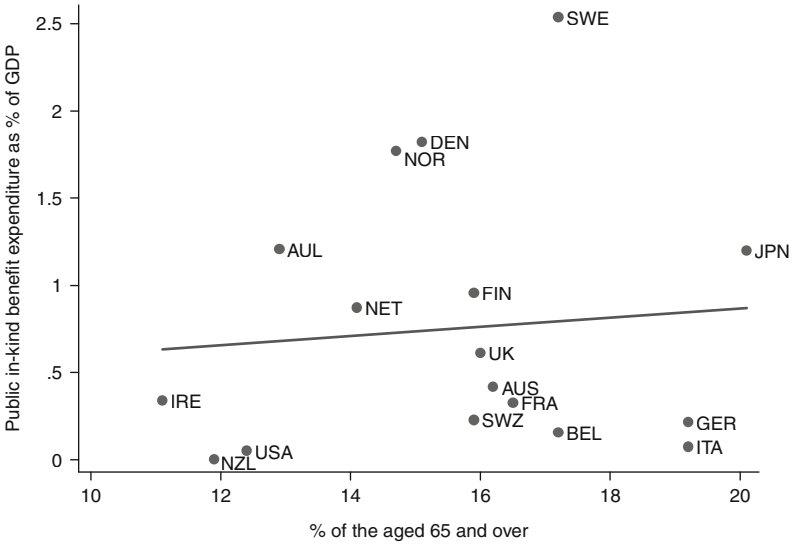

Figure 2.1 Scatter plot between aged population rates and public in-kind benefits for the aged as a per cent of GDP, 17 countries, in 2005

Note: Canada's data are missing.

Sources: Public in-kind benefit expenditure as percentage of GDP: OECD (2009b); percentage of the aged 65 and over: OECD (2009a).

rational-choice approach allows this study to avoid a tautological argument. On the other hand, this study incorporates each case's historical contingency into the analysis of causal mechanisms in its comparative historical analysis. For, in historical institutionalism's research tradition, it is insufficient just to estimate the probabilistic causal effects between explanatory and explained variables through case studies, and it is required to explain why each case follows its unique path in a deterministic way (cf. Steinmo, 2008).

Grounded on the approach above – 'historical rational-choice institutionalism' – this chapter theorizes how formal political institutions affect the arrangements of universalistic social care programs for the aged. This book's main claim is that the more benefits political actors try to bring to specific constituent groups, the less resources the welfare state allocates to universalistic welfare programs. The predominant mode of voter–politician linkage structures how political actors benefit their own supporters in each country, and political institutions – namely, electoral rules and party systems – influence the dominant form of state–society

relations. If electoral rules and party systems encourage politicians to serve particular constituents, the state's capacity to develop universalistic social policy would be constrained by special interests connected to particularistic political actors. By contrast, when electoral rules and party systems motivate political actors to benefit the broader constituency, the state would be autonomous from those special interests and capable of expanding universalistic welfare programs. The following sections elaborate the theoretical model and offer its observable implications for subsequent empirical examination.

2.1 Rationality and historical contingency: analytical framework

Although this study is located in the research tradition of welfare state studies by historical institutionalists (e.g., Hacker, 2002; Immergut, 1992a; Morgan, 2006; Pierson, 1994; Rothstein, 1992; Skocpol, 1992; Steinmo, 1993), it explicitly presupposes that political actors interact with each other in a 'rational' way. In fact, the rationalist assumption does not necessarily contradict the approach of historical institutionalism (see Pierson, 1994, pp. 174–175). As Katznelson and Weingast (2005) argue, historical institutionalism and rational-choice institutionalism are approaching each other in recent studies, and both of them can learn about the preference formation of a political actor from each other.

Rational-choice institutionalism appears to assume an actor's preferences a priori and build its theoretical models deductively, but – in reality – it tries to identify an actor's preference structures through back and forth between deduction and induction. For instance, while U.S. legislative studies – the motherland of rational-choice approach – have assumed that congresspersons prioritize re-election since Mayhew (1974), the legislative scholars are fully aware of the fact that this assumption is not universally applicable across time and space. During the period of 'machine politics' in the nineteenth century, because serving as a legislator in Congress meant to contribute to the machine, each legislator did not necessarily prefer to keep holding the seat in his district (Lowi, Ginsberg, and Shepsle, 2008, p. 185). That is, the lexical preference order of re-election, promotion, and policy, which congresspersons are supposed to have, is endogenous to the institutional structure of the U.S. Congress in the twentieth century, and then the preference order is induced from the accumulation of legislative studies. Thelen and Steinmo (1992) once maintained, in their manifesto of historical

institutionalism, that the crucial difference between these two camps lies in the bifurcation between historical institutionalists' presumption of endogenous preference formation and rational-choice institutionalists' assumption of exogenous preference formation. However, there is no significant disagreement between these two schools, since rational-choice institutionalism is now approaching historical institutionalism.

On the other hand, some historical institutionalists have actively incorporated the characteristics of rational-choice institutionalism into their studies. While comparative historical analysis used to examine macro socio-political phenomena and easily assume collective identity and interests (e.g., class interests in Barrington Moore, Jr. (1966)), it can no longer conflate collective interests with individual ones after Olson's (1971) finding of collective action problems. Rather, succeeding historical institutionalists, such as Immergut (1992a, 1992b) and Pierson (1994), accepted rational-choice institutionalism's assumption of 'fundamental preferences' – namely, a political actor as a utility maximizer – and, with this micro foundation, revealed how different institutional configurations affect political actors' strategies and lead to distinct distributional consequences. Historical institutionalists have learned theoretical clarity from rational-choice institutionalists as well.

Since rational-choice institutionalism and historical institutionalism now agree that political actors are rational and their rational strategies are formed in the institutional contexts they are engaged in, it might be of no use to distinguish between these two schools. However, there are still slight differences between these two approaches. Rational-choice institutionalism, because most of its analytical tools are borrowed from microeconomics, has an advantage in explaining why and how *endogenous* – self-enforcing – institutions exist and benefit those actors who engage in a certain interaction (cf. Shepsle and Weingast, 1987). That is, rational-choice institutionalism regards political institutions as a Nash-equilibrium in which all participants have no incentive to change strategy. Political institutions are a social construct that actors create to reduce transaction costs, and these institutions benefit every participant in the transaction thereby preventing a 'prisoner's dilemma' situation.[1] On the contrary, historical institutionalism is better at accounting for why and how *exogenous* institutions bias the distribution of political power among actors and affect outcomes because historical institutionalism originated in political sociology and political science (cf. Immergut, 1998). Historical institutionalism emphasizes that political institutions are formed in historical contingency and then favour some actors but not others. Hence, they generate different outcomes in distributional

politics even when holding each actor's power resources constant. Since social policy studies concern the theme of 'authoritative distribution of resources' (Easton, 1969), it is no surprise that historical institutionalists have been dominant in the comparative welfare state literature.

This study combines the elements of both rational-choice institutionalism and historical institutionalism, and it calls the integrated analytical framework 'historical rational-choice institutionalism'. On the one hand, this book explicitly accepts rational-choice institutionalism's assumptions and builds a deductive explanatory model on them. It presumes that politicians have an instrumental rationality and the lexical preference order among re-election, promotion, and policy: politicians seek re-election, and, once it is achieved, they pursue career promotion in their political party or a government, and they strive for their own policy goal only after they secure their post. Based on these assumptions, this study generates a solid theoretical model and tests it with empirical data. By consciously using a deductive approach, this study avoids a potentially tautological argument – which derives an explanatory model from case studies and then applies the model to the same cases. On the other hand, this book focuses on the aspect that political institutions, such as electoral rules and party systems, are generated from historical contingency and create divergent policy outcomes through privileging some political actors and disregarding others. In addition, this study pays careful attention to political contexts and the contingency of each country in its comparative historical analysis, because – even though the assumption of instrumental rationality is accepted – political actors' actual strategies and behaviours are highly conditional upon those historical and institutional contexts. A minute difference in institutional settings can lead to divergent policy outcomes by interacting with historical contexts. By incorporating the contextual analysis in its framework, this study aims to understand not just *whether or not* but also *how* political institutions influence the development of welfare programs. In these respects, this book is still in line with the research tradition of historical institutionalism.

2.2 Political competition and universalistic welfare programs: theoretical model

This section claims that different forms of intra- and inter-party competition structure the voter–politician linkage in a different way and lead to divergent compositions of social protection programs across countries. In her pioneering work, Lynch (2006) has already argued that

while the programmatic party competition promoted citizenship-based welfare programs, the clientelistic party competition fostered occupation-based social policies. However, this study goes one step further and explains the institutional foundation behind those different forms of political competition.

Lining up behind the intellectual tradition of historical institutionalism (cf. Immergut, 1992a; Skocpol, 1985; Steinmo, 1993), this study maintains that the autonomous state is crucial for the development of universalistic social policy, and that the relative autonomy of the state is structured by electoral rules and party systems.

First, a state that is relatively independent of societal interests is necessary for the expansion of universalistic social welfare programs because those programs face collective action problems (cf. Olson, 1971). Since societal actors prefer to receive privileged treatment and diffuse its costs over the entire constituents, universalistic social policy is less likely to thrive when the policy demands on those societal actors are directly translated into public policy. In such a case, the distribution of public resources would be biased towards particularistic benefits rewarding specific constituents and/or those resources would dry up because nobody bears the fiscal burdens. The relatively autonomous state needs to mediate between policy demands and outcomes and internalize the costs and expenses of social protection programs in order to expand universalistic programs. This is because the state can offer benefits for, and assign burdens to, the entire citizenry in an equitable way.

Second, the dominant mode of intra- and inter-party competition influences the relative autonomy of the state. On the intra-party level, if electoral rules afford the rank-and-file legislators electoral independence of their party's reputation, these rules make a political party decentralized and less disciplined. Since party leaders have fewer instruments to control their rank-and-file members in a decentralized party, the legislators try to retain their policy-making functions in order to carve out public resources for their own constituencies. In other words, the dominance of a decentralized party immerses the state in the short-term interests of societal groups. In order for the state to coordinate the benefits and expenses of public policy in an equal and neutral way, a disciplined, centralized political party needs to delegate its policy-making functions to the executive branch. On the inter-party level, if a ruling coalition is fragmented along various social cleavages, each coalition partner tries to bring a larger share of public resources to the segmented social groups it represents. Since coalition partners compete with each other at the next election, they constrain

the state's capacity so that it implements social protection programs in the way each party can claim credit for them. Hence, the state is unable to coordinate the benefits and costs of public policy in a universalistic way unless a catch-all party encompasses diverse societal groups and internalizes their various demands. A single-party government or one-party dominance is a necessary condition for ruling parties to delegate the policy-making functions of the legislative branch to the executive branch in an adequate way so that the state can solve collective action problems.

As is clear in the above arguments, this study maintains that while the centralized political parties and the coherent ruling coalition allow the state to overcome collective action problems and then encourage the development of universalistic social protection programs, the decentralized political parties and/or the fragmented ruling coalition (reflecting diverse social cleavages) promote the particularistic political competition and impede the expansion of those universalistic programs. Public elderly care programs tend to be universalistic social policy because their entitlements are usually determined based on a user's citizenship and care needs. This study claims that the countries in which each ruling party is centralized and a ruling coalition is not fragmented are favourable to the development of public elderly care services.

Universalistic social policy and particularistic benefits

A government usually supplies various types of goods and services for its citizens. At one extreme, it provides them with *public goods* such as national defence, stable currency, and clean air. These public goods are characterized as the goods that benefit all inhabitants in a certain territory and cannot exclude any of those beneficiaries from the benefits. While the costs of public goods are borne by the entire citizenry, each citizen's contributions to the state cannot be used as a criterion to determine entitlement to public goods. At the other extreme, the government also provides *private goods* for its citizens. The characteristic of private goods is a relatively clear relationship between benefits and burdens: a citizen cannot enjoy the benefits unless she pays for those goods. In other words, a good or service provider can exclude those who do not bear the costs of those goods. Although private sectors can produce those private goods, a government often supplies its citizens with private goods such as public utilities, public transportation, and public housing due to various reasons such as positive externalities.

A variety of social protection programs that welfare states provide for citizens fall between the pure forms of public and private goods.

Table 2.1 presents a typology of social protection programs. The upper-left cell represents *universalistic social policy*. This social policy can be defined as a welfare program that entitles users to receive its benefits according to their citizenship and needs, and one which assign its costs to the general public. Universalistic social policy is close to public goods in that its benefits are not selective and its costs are borne by the general public. The health care systems in the United Kingdom and Scandinavian countries are typical examples because a citizen with medical needs can consult health care facilities regardless of income or contribution, and general tax revenues take care of the entire system. Social care services such as child daycare and elderly care can be universalistic social policy if their entitlement is solely determined based on a user's citizenship and needs. It is true that the benefits of childcare and elderly care programs are concentrated on households with infants and frail older people. Nevertheless, the important point here is that citizens probabilistically benefit from some aspects of these programs during their life's course, and that probability is not skewed towards a certain occupational, regional, or ethnic group. As is clear in the above examples, the feature of universalistic social policy is that it possibly benefits the general public and imposes its costs on the broader constituency.

The lower-right cell indicates *occupation-based social insurance*. Occupational social insurance schemes are closer to private goods than

Table 2.1 Typology of social protection programs

		Benefits	
		General public	**Specific constituents**
Burdens	General public	Universalistic social policy (child daycare, elderly care, NHS, non-contributory flat-rate pension, active labour market policy, etc.)	Particularistic benefits (pork-barrel, public work projects, industrial regulations, tax breaks, etc.)
	Specific constituents	–	Occupational social insurance (occupational pension insurance, health care insurance, unemployment insurance, etc.)

Source: The author created.

to public goods, and they can be characterized as the welfare programs that require beneficiaries to pay for insurance premiums and return the benefits to recipients according to their contributions. While social insurance schemes are usually subsidized through general tax revenues, the relationship between benefits and burdens looks to be closely connected in social insurance schemes. Although it is illusory under the pay-as-you-go system, participants subjectively feel piling their property rights through the system. Since occupational social insurance schemes segment the population according to occupations and social groups, the benefits and contributions under those schemes are regionally and occupationally stratified. As a result, occupational social insurance schemes benefit targeted constituents and also levy insurance premiums on them.

The upper-right cell represents *particularistic benefits*. The particularistic benefits can be defined as the public programs that benefit a targeted population but impose their costs on the general public. For example, a regulation protecting a certain industry benefits the employers and employees in the specific industry but is paid off through higher prices borne by consumers. Pork-barrel undertakings, such as a public works project, are typical cases of this type of social protection. A certain constituency profits from pork-barrel projects and foists the fiscal burdens onto all tax payers. Tax breaks can also be particularistic benefits because they exempt specific industries and consumers from taxation and fill in the revenue losses through general tax revenues. The characteristics of particularistic benefits are that their benefits are geographically or industrially concentrated but their burdens are spread across the nation.

Of course, the above typology represent ideal types, and most social protection programs fall between these categories. For instance, various means-tested programs such as public assistance are located between universalistic social policy and particularistic programs. On the one hand, these programs are targeted at those who have lower income below a certain threshold, and therefore they are not 'universalistic'. On the other hand, means-tested programs are usually established as part of a social safety net, and every citizen possibly receives their benefits when facing a predicament. It should also be noted that the coverage of means-tested programs can encompass almost the entire population, depending on the level of income threshold. For another example, income-related public pension schemes, such as the ones in the United States and Sweden, are between universalistic social policy and occupational social insurance. Whereas these programs cover the

entire population because they are not occupationally fragmented, their benefits and burdens are socially stratified according to the income of beneficiaries.

Under what conditions does universalistic social policy flourish? Universalistic social policy faces collective action problems under the democratic political system as do other public goods. Since short-sighted societal actors are motivated to receive the benefits of social protection programs and charge other constituents with their costs, universalistic social policy is less likely to thrive unless the state is able to coordinate the benefits and costs of those programs in an equitable way. For the state sufficiently to play the role as a coordinator, the legislative branch needs to delegate its policy-making functions to the executive branch to a considerable degree. However, to what extent the legislative branch entrusts its policy-making functions to the executive branch varies across different political-institutional contexts.

First, when legislators represent geographical interests or specific industries and occupations and do not care about national policy, they might try to keep their policy-making functions in the legislative branch. Here, individual legislator prefer to bring benefits to their own constituents and consign their costs to the general public through particularistic benefits, and the legislator's law-making power is the sole instrument to accomplish this objective. Unless some sort of political mechanism disciplines those parochial politicians, a political party cannot have a coherent policy nor empower the executive branch to implement it. In this sense, the form of party organization is important to motivate rank-and-file legislators to subordinate their geographical interests to the party platform on the national level.

Second, when political parties represent specific industries and occupations, they also prefer to establish a social insurance scheme advantageous to the societal groups they stand for and have less incentive to develop universalistic welfare programs equally benefiting the entire constituency. Even if political parties control their rank-and-file members, universalistic social policy is less likely to thrive unless the ruling coalition solves collective action problems among coalition partners.

The logic of universalistic social policy development I: intra-party organization

Although it has not attracted enough attention in welfare state studies so far, the structure of intra-party organizations influences the arrangement of social protection. The 'intra-party organizations'

refer to the organizational structure under which the leaders of political parties control their rank-and-file, and the structure is considerably different across countries and political parties. At one extreme, the political party is highly disciplined, and it behaves as a unitary actor. For example, the Norwegian parliament party leaders control their legislative members, and the latter rarely defect from the party leadership in the roll-call voting (Rasch, 1999). At the other extreme, party leaders have little control over the rank-and-file legislators. For instance, the members of the U.S. Congress traditionally have weak party discipline, and their cross-voting is prevalent. The candidates of the House and the Senate run the campaign by themselves, and then party leaders have less control over candidate selection and campaign finance. As a result, political parties are so fragmented that they are 'no more than conglomerates of candidates' private organizations' (Katz, 1986, p. 102).

These characteristics of intra-party organizations derive from the degree of electoral and policy independence of each legislator. In general, the more of a personal hold members have over their office, the more difficult for the party leaders to coordinate and control them. The rank-and-file members do not need to follow the party leadership unless their re-election and career promotion hinge on the party leaders' discretion. To the extent that individual legislators attain electoral independence, a political party loses the discipline that makes the rank-and-file serve, not individual policy objectives, but the party's platform. And the legislators with electoral independence prioritize their personal reputation over their party's reputation and then decentralize the party functions of policy making, personnel, and campaign finances.

The distinction between 'party vote' and 'personal vote' is helpful for understanding this mechanism. The personal vote is defined as '[the] portion of a candidate's electoral support which originates in his or her personal qualities, qualifications, activities, and record' (Cain, Ferejohn, and Fiorina, 1987, p. 9). The personal vote becomes important when a politician is more likely to be elected as a result of being personally well-known and cherished by voters. By contrast, the party vote refers to the 'support for the candidates based on his or her partisan affiliation, fixed voter characteristics such as class, religion, and ethnicity, reactions to national condition such as the states of the economy, and performance evaluations centered on the head of the governing party' (ibid.). The less a candidate's personal reputation among her constituency influences her electoral fate, the more the party reputation matters to each candidate's electoral prospects.

The weight of the personal vote in determining each candidate's electoral fate has important implications for the mode of distributive politics (see Estévez-Abe 2008, pp. 56–59). When the candidate has incentives to cultivate her personalized support base, she is required to distinguish her policy position and objectives from those of her own party according to the demands of her constituency. In this respect, sticking to the party platform and providing generic public policy for their constituents is not the best strategy for politicians under the electoral environments emphasizing the personal vote, because the reputation acquired through generic programs goes to the party. Rather, under the heavy weight of the personal vote, each legislator is motivated to please her supporters with particularistic benefits, such as bringing 'pork barrel' funds and projects to her district or constituency groups, protecting a particular industry through regulations, and benefiting specific constituents through tax breaks.[2] If the personal vote influences the electoral result of each office, politicians try to secure their own support base at the expense of their own party's reputation if necessary. Overall, the heavier weight of the personal vote creates a decentralized political party with weak party discipline and motivates legislators to bring particularistic benefits to their constituents.

On the other hand, when the party vote mostly determines the electoral results, then committing to the party platform and advocating general public programs is a better strategy for the rank-and-file. Since the reputation of a party determines their electoral fates, each politician does not need to differentiate herself from her party's position. The rank-and-file legislators have no incentive to devote their precious resources to constituency services and bring particularistic benefits to their constituents because those services are costly and have no electoral rewards. Rather, those members delegate the management of policy making, personnel, and electoral campaign affairs to their party leaders so that the party leaders discipline those legislators who taint their party's reputation. As a result, contributing to the entire party secures each legislator's re-election and career promotion in the party. In sum, the heavier weight of party vote generates a centralized political party with strong party discipline and gives the rank-and-file legislators the incentives to support their party platform.

The composition of personal vote and party vote differs not only across countries but also across time periods and political parties. However, electoral rules have considerable influence over the relative importance of personal vote (or party vote) in an election. Some electoral systems give candidates the incentive to seek personal reputation rather than

party reputation in order to get (re)elected. For instance, the proportional representation (PR) system with open list induces a candidate to differentiate herself from other candidates to secure votes enough to get elected, and therefore it gives her the incentive to build her own support bases. The single majority district (SMD) system with primary or run-off elections similarly motivates a candidate to compete with her colleagues for the purpose of ensuring her candidacy. These electoral rules encourage politicians to strive for the personal vote. Since just sticking to the party platform does not give any leverage for candidates in the intra-party competition, these electoral systems encourage politicians to prioritize personal reputation over party reputation and defect from the party leaders if necessary. These practices weaken the party leadership (cf. Katz, 1986).

On the contrary, some electoral rules put more weight on the party vote than do others. For instance, the closed-list PR system induces politicians to pursue party reputation if their party leaders control access to the list and influence its order. In the SMD system, politicians are also conscious of the will of their party leaders if those leaders nominate a candidate in a district. These electoral systems encourage the rank-and-file legislators to follow the party leadership and make a political party look like a unitary actor. In other words, party-vote oriented electoral systems create a centralized political party and concentrate political power on its party leadership. Overall, whereas the personal-vote oriented systems create the clientelistic political competition, the party-vote oriented systems generate the programmatic competition in the political system.

Due to these reasons, electoral rules affect to what extent the state is embedded in the web of societal interests. If the ruling party is decentralized under the personal-vote oriented electoral system, the members of the decentralized party usually specialize in a specific policy field or a regional area to bring particularistic benefits to their constituencies. In order to trade those benefits with each other, the MPs create the venue of logrolling, such as the committee system in the U.S. Congress and the Policy Affairs Research Council (*Seimu Chōsa Kai*: PARC) in Japan's Liberal Democratic Party (LDP), under the personal-vote oriented systems (see Chapters 5 and 6). Since it is much easier to make a majority in those committees than in a plenary session, the personal-vote oriented system is more likely to grant veto power to vested interests. On the contrary, if the party-vote oriented electoral system allows a political party to concentrate its power on the party leadership, the party leaders are capable of disciplining dissidents from

the party policy. The executive branch is more likely to be autonomous when the cabinet is supported by a centralized political party, *ceteris paribus*.

As the above argument suggests, a centralized political party underpinned by the party-vote oriented system is a necessary condition for the development of universalistic social policy. If each candidate strives for the personal vote, a political party becomes decentralized and then the party leadership faces many difficulties in disciplining individual legislators to assure they subordinate their reputation in the electoral district to the party platform. As a result, the heavy reliance of the rank-and-file members on the personal vote biases the distribution of public resources towards particularistic benefits at the expense of the general public. Since universalistic social policy has a tendency to benefit broader constituents equally and imposes its costs on the general public, its development requires a centralized political party that can whip its parochial members into line.

The logic of universalistic social policy development II: inter-party competition

Following Alber (1995), this study also adopts Lipset and Rokkan's (1967) social cleavage approach. Lipset and Rokkan argue that in Western European countries, the party system reflects social cleavages that existed at that time when the system was 'frozen' after the extension of male suffrage in the 1920s. The authors classify those social cleavages into four dimensions: labour–capitalist dimension, centre–periphery dimension, state–church dimension, and land–industry dimension. As Alber (1995) points out, while power resources theory exclusively focuses on how public policy reflects the class relations (cf. Korpi, 1978, 1983), other dimensions of inter-party competition are also important for social services. This study claims that the centre–periphery relations are especially significant for the development of universalistic social welfare programs.

In the centre–periphery dimension, the party system can be fragmented along ethnic, linguistic, religious, and regional lines. If the electoral rules allow societal groups to be proportionally represented or, even under the SMD system, those minority groups are regionally concentrated (cf. Cox, 1997), political parties are aligned along these social cleavages. If the society is segmented along those cleavages, and political parties represent each group, those political parties need to target public policy at their ethnic, linguistic and religious groups. By contrast, political parties can appeal to broader constituencies if the

social cleavages are fewer. In other words, whereas the mode of inter-party competition approaches the particularistic one under the fragmented party system, it becomes the programmatic one when the social cleavages are negligible along ethnic, linguistic, and religious lines. Especially when one catch-all party dominates the administration, its policy programs are required to appeal to broader constituents unless the catch-all party itself is fragmented along societal interests.

The mode of inter-party competition has important implications for the development of universalistic social policy. When the ruling coalition is fragmented along various social cleavages, a better strategy for each party is to establish occupation-based social insurance schemes, pork-barrel projects, and subsidies and regulations for specific industries. This is because each party can bring these social protection programs to its constituents segmented along social groups, and can claim credit for those benefits. Social insurance schemes are desirable social policy for each social group because the operation of social insurance is usually left to relatively autonomous occupational and regional groups (cf. Lynch, 2006). The fragmented ruling coalition takes limited public resources away from universalistic social policy and biases their distribution towards particularistic benefits and occupational social insurance schemes. The fragmented ruling coalition forces the state to respond to policy demands social group by group, and prevents it from organizing social protection programs in a universalistic way. On the contrary, when the ruling coalition is one-party dominant, then citizenship-based, universalistic social policy is a preferable strategy for this coalition because this type of administration can internalize diverse policy preferences among societal groups and needs to appeal to broader constituents in an equitable way. Under the one-party dominant ruling coalition, the dominant party allows the state to be autonomous from these various constituency groups and distribute the benefits and costs of social welfare programs to these groups in a fair way, because it needs to satisfy all of these constituency groups. Since universalistic social policy brings its benefits and burdens to the entire electorate, it can serve this purpose.

The forms of intra- and inter-party competition complement each other, and the combination of both types of competition determines the predominant mode of political competition in each country. In an extreme case, even though all political parties are centralized under the party-vote oriented electoral system, the mode of political competition would be particularistic if each politician organizes her own party. By contrast, even though one party dominates the administration, the

predominant mode of political competition would also be particularistic if the members of the ruling party exclusively engage in constituency services and patronage-based politics under the personal-vote oriented electoral system. Thus, the most promising political condition for the development of universalistic social policy is one-party dominance by a centralized party with strong party discipline.

This section's theoretical argument provides us with testable hypotheses for the politics of elderly care policy. The provision of public elderly care services can be considered to be needs- and citizenship-based in most cases because their benefits are less likely to be geographically, occupationally, or ethnically concentrated. In addition, while the users of those care services are often required to bear out-of-pocket fees, the general tax revenues usually take care of the rest of their costs. Thus, public elderly care programs are universalistic social policy or close to it in most cases. As argued above, the expansion of universalistic social policy is required to overcome the collective action problems in the intra- and inter-party levels. Hence, the personal-vote oriented political system generates a decentralized party and is less likely to expand public elderly care programs, and the ruling coalition fragmented along various social cleavages is also unfavourable towards these programs. Public long-term care programs for the aged are likely to develop when a single-party government or one-party dominance supported by a centralized political party ensures that the state coordinates the benefits and expenses of social protection programs in an equitable and neutral way.

3
Political Institutional Conditions for the Development of Elderly Care Programs: Quantitative Evidence

3.1 Hypotheses

The previous chapter argued that the dominant form of voter–politician linkage structured by electoral rules and party systems affects the development of public elderly care programs in each country. While clientelistic political competition encourages political parties and individual politicians to pursue particularistic programs – such as public work projects, subsidies and tax exemptions for specific industries, occupational social insurance schemes – programmatic political competition motivates political parties to develop universalistic public policy, including public elderly care services. And electoral rules and party systems bifurcate the predominant mode of political competition into universalistic and particularistic facets: while party-vote oriented electoral rules and one-party dominance lead to the development of universalistic social policy, personal-vote oriented electoral rules and/or fragmented ruling coalitions skew the distribution of public resources towards particularistic benefits.

To examine the empirical validity of these claims, this chapter tests the following hypotheses through quantitative analysis:

> H1: Personal-vote-oriented electoral systems have negative effects on the development of public expenditures for elderly care services, compared to party-vote-oriented electoral systems, ceteris paribus.
>
> H2: The more fragmented a coalition government, the less public spending for elderly care services, ceteris paribus.

Subsequent sections assess these two hypotheses by analysing pooled time-series and cross-section data of advanced democracies from 1980 to 2001, with multivariate regression models.

3.2 Data and variables

This study analyses the data of 15 advanced industrialized countries, from 1980 to 2001.[1] Its dependent variable is public elderly care spending as a per cent of GDP. Since this study is interested in the variation of universality, generosity, and accessibility of public elderly care policy, the aggregate expenditure levels are obviously a poor measure for what is to be explained. As the previous research suggests (Allan and Scruggs, 2004; Esping-Andersen, 1990), neither frail older people nor their relatives seek public spending per se. The aggregate expenditure does not tell how the spending is distributed among those who need care services and what kind of effects it has on social care arrangements in a household. Hence, it is desirable to construct an indicator measuring the program's availability, coverage, generosity, and so forth. However, the data of public long-term care programs for the aged is much less organized than other cash benefit programs, and thus it is almost impossible to create a comprehensive cross-national and time-series indicator reflecting their coverage and generosity (see, e.g., OECD, 2005). For instance, although Organisation for Economic Co-operation and Development (OECD) Health Data (OECD, 2008) publishes the number of institutional and home care recipients, the data on care service coverage have too many missing elements, especially in the 1980s and 1990s, to be viable for use as quantitative analysis. In addition, this study's interest is in what economic, social and political factors motivate the welfare state to dedicate its scarce resources for public elderly care services. This study is concerned with the entire welfare effort for elderly care rather than for individual well-being and, therefore, using an aggregate spending level as an approximate of welfare efforts is justifiable. These are the reasons why this study uses the expenditure data with some reservations.

Constructing time-series and cross-country data on the aggregate public spending for elderly care still faces quite a few practical problems. Although OECD (2005, p. 26) reports the data on public expenditures for elderly care as a per cent of GDP in 18 OECD countries, it covers just the data in 2000. To enhance the number of observations, this study substitutes 'public in-kind benefit expenditures for the aged as a per cent of GDP' for public spending on elderly care. The actual data comes from OECD (2004) *Social Expenditure Database (SOCX)*. However, 'public

in-kind benefit' does not include the public expenditures for care allowance, even though it plays a significant role in addressing elderly care demands in many countries such as Austria and Germany. This study generates another dependent variable combining public in-kind benefit expenditures for the aged with public spending for care allowance, the latter of which is classified under the category of 'cash benefits for the aged' in OECD (2004) SOCX. As Figure 3.1 indicates, care allowance constitutes a substantive part of public elderly care expenditures in Austria, Germany, Switzerland, and the U.K. This study's regression analyses report the results of both types of dependent variables.

OECD (2004) SOCX still has uncertainty in its quality. To assess the external validity of its cross-national expenditure ranking, the correlation between public in-kind benefit expenditures for the aged (% of GDP) from OECD (2004) SOCX and public expenditure on long-term care (% of GDP) from OECD (2005, p. 26) is calculated in terms of the data in 2000. OECD (2004) SOCX is considered to be valid to some extent because the correlation looks quite high (Pearson's $r = 0.917$). In addition, OECD (2004) SOCX presents several implausible gaps in the time-series changes of public elderly care spending. Although Japan's and Sweden's 'jumps' are caused by the implementation of, respectively, the Public Long-Term Care Insurance Act and Ädel Reform, the punctuated changes in Germany (1990) and Norway (1988–1989) appear to stem from changes in how of each country's data is defined. To address these data problems, this study adds dummy variables for Germany (1980–1989) and Norway (1988–1989) to some of its regression models in order to adjust the effects of those changes in definition.

The degree of 'personal vote' has been measured by the characteristics of electoral rules. Shugart (2001, pp. 36–40) creates an index of the extent to which an electoral system forces a candidate to rely on personal votes, as opposed to party votes, in order to get elected. The index is based on three components of electoral formulas: ballot, vote, and district.[2] First, the ballot component measures who controls access to the candidacy or the candidate list. Second, the vote component captures how voters cast their votes. While casting a party-list vote strengthens the party leadership, casting a nominal vote increases the weight of personal reputation over party reputation. Third, the district component measures the effects of district magnitude. While Shugart's index does not cover all advanced industrialized countries (Carey and Shugart, 1995; Shugart, 2001), Estévez-Abe (2008, p. 67) extends that index to most advanced industrialized democracies. Since this study looks to assess the effects of personal votes on mature welfare states, it uses Estévez-Abe's rank order. Table 3.1 shows the ranking of *Degree of Personal Vote* across advanced industrialized democracies.

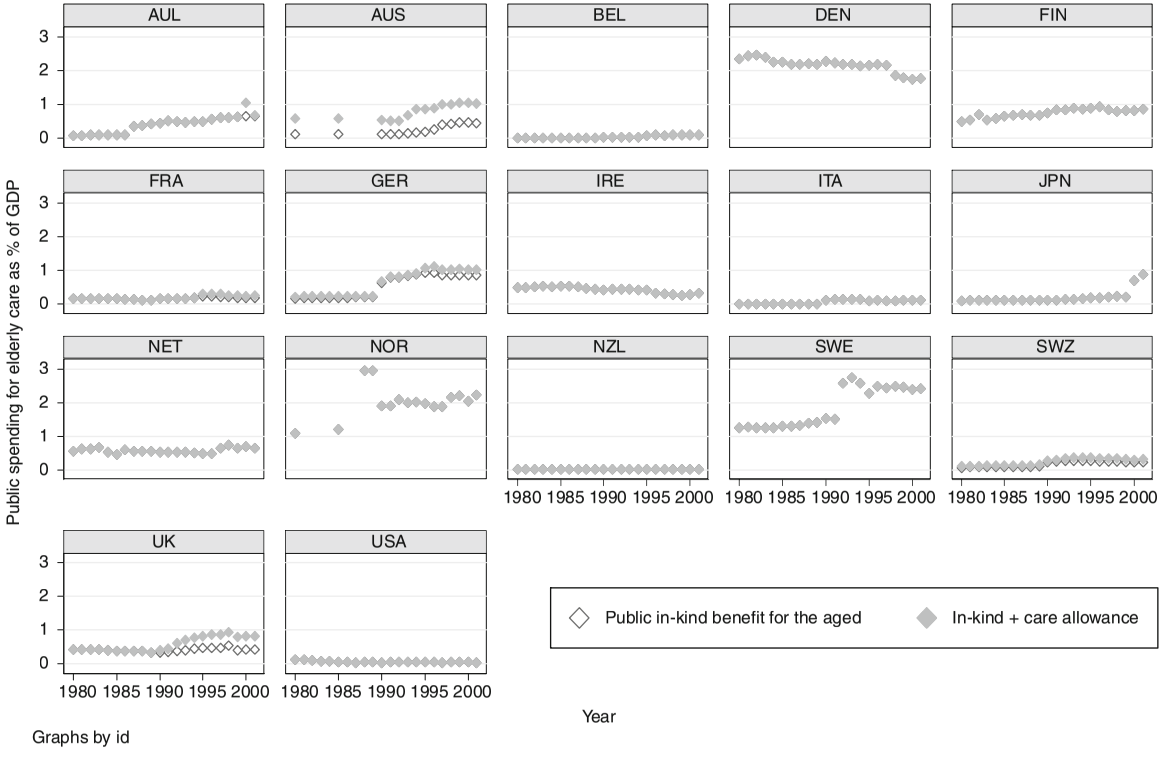

Figure 3.1 Time-series changes in public spending for elderly care as a per cent of GDP, by country, 1980–2001
Source: OECD (2004) SOCX.

Table 3.1 The strength of personal vote

Country	Rank order
Australia (1980–2000)	3
Austria (1980–2000)	2
Belgium (1980–2000)	2
Denmark (1980–2000)	2
Finland (1980–2000)	3
France (1980–2000)	2
Germany (1980–2000)	2
Italy (1980–1993)	4
Japan (1980–1995)	6
Netherlands (1980–2000)	2
Norway (1980–2000)	1
Sweden (1980–2000)	1
Switzerland (1980–2000)	2
United Kingdom (1980–2000)	1
United States (1980–2000)	6

Note: While '6' indicates the highest reliance on the personal vote, '1' indicates the lowest reliance.

Source: Based on Estévez-Abe (2008, p. 67).

The degree of fragmentation within a ruling coalition is measured by *Degree of Fractionalization of the Cabinet*. Since this study's theoretical argument is concerned with the extent to which ruling parties try to bestow benefits upon specific constituencies, it does not use the indicator of the entire party system. Instead, this study assesses the fractionalization of a governing coalition. The index pertaining to Degree of Fractionalization of the Cabinet is calculated using the following formula:

$$Fractionalization = 1 - \sum_{i=1}^{n} T_i^2,$$

where T_i = party i's decimal share of seats among ruling coalition parties in the lower house (cf. Cusack, 2003). This formula sums the square of each coalition party's ratio and then subtracts that total from one. When the government is a single-party Cabinet, the index takes zero as its value. In contrast, when the coalition government is extremely fragmented (e.g., each legislator has his or her own party), the index approaches one. In addition, a *Minority Government Dummy* is put into the regression models, because the index pertaining to 'Degree of Fractionalization of the Cabinet' underestimates the actual fragmentation of a governing coalition when the government is in a minority

status. If the Cabinet coalition has a minority position in either the lower or upper house, this variable takes one; otherwise, zero. All of these data derive from Cusack (2003) and the *European Journal of Political Research* (various issues).[3]

As Alber (1995) suggests, intergovernmental relations are crucial to the development of public elderly policy. While local governments usually bear the role of service providers, the forms of funding for universalistic social care services vary across countries. Although those services are traditionally funded by local governments themselves, those services would remain underdeveloped if they were to rely exclusively upon their own tax resources, because the demands for social care services are likely to outstrip the capacity of local governments to levy taxes. This is the reason why subsidies from the central government and fiscal redistribution across local governments are required for the development of public elderly care services. However, local governments are less likely to devote resources to social services if the constitution prescribes that local governments should be fiscally independent. Overall, the institutional configuration of intergovernmental relations affects the development of universalistic elderly care policy. To measure the extent to which regional governments are fiscally and administratively autonomous with regard to the central government, this study uses the federalist structure index of Huber et al. (2004). This index – *Degree of Federalism* – takes a value of two when a county's constitution adopts strong federalism, one when it is weak federalism, and zero when the county is a unitary state.

To assess the effects of power resources and political partisanship, *Union Density*, *Leftist Party Cabinet*, and *Christian Democratic Cabinet* were put into the regression models. *Union Density* indicates the percentage of net union membership as a proportion of wage and salary earners in employment. *Leftist Party Cabinet* and *Christian Democratic Cabinet* measure the percentage of parliamentary seats held by leftist parties and Christian Democratic parties as proportions of all government party seats. While *Union Density* and *Leftist Party Cabinet* are supposed to represent the strength of leftist movements and the degree of social-democratic party dominance, *Christian Democratic Cabinet* represents the strength of Christian Democratic parties. While van Kersbergen (1995) argues that rule by Christian Democratic parties is theoretically not conducive to developing social care services – given their ideological inclination to conserve the male-breadwinner/female-caregiver family model and value the principle of subsidiarity – Huber and Stephens (2000) show, through empirical evidence, that both Christian

Democratic and Social Democratic parties promote expenditures for public social services. Therefore, the effects of political partisanship have yet to be examined empirically. While the data of *Union Density* come from Visser (2009), the data concerning partisan variables are derived from Huber et al. (2004).

Furthermore, to assess the effects of women's political mobilization on the development of public long-term care programs for the aged, *Percentage of Women in Parliament* is put into the regression models (Armingeon, Leimgruber, Beyeler, and Menegale, 2006). It is highly plausible that women's mobilization influences public elderly care policy. The expansion of female labour force participation has certainly created demands for social care services by increasing the need to externalize unpaid care work that had been previously carried out within the household; additionally, the presence of women in the political sphere likely facilitates the translation of those societal demands into public policy (Huber and Stephens, 2000, 2006). Therefore, these factors should be taken into consideration when attempting to explain variations in elderly care policy.

To capture the impact of socio-demographic changes in recent decades, this study puts *Female Labour Force Participation Rate* (OECD, 2007b) and *Percentage of the Aged 80 and Over to the Population* (OECD, 2007a) into the models. While the extent of population aging is usually measured in terms of those aged 65 and over as a per cent of the entire population, the percentage of those aged 80 and over is preferable in this study's context, because people are more likely to require social care beyond 80 years of age. *Natural Logarithm of Purchasing Power Parity GDP per Capita* (OECD, 2007a), *Growth of Real GDP* (Armingeon et al., 2006), *Unemployment Rate* (IMF, n.d.), and *Consumer Price Index* (IMF, n.d.) were added to the regression models to control for the levels of economic development, business cycles, and inflation. Finally, all independent variables except macroeconomic indicators were lagged by one year, because a typical budgeting process occurs in the previous year of the current fiscal year and political factors influence the budgeting politics of the previous year. Table 3.2 shows the mean values of dependent and independent variables by each country.

3.3 Analytical method

Since the data analysed here has observations across the 1980–2001 periods and across 15 countries, this study uses pooled ordinary least square (OLS) models for its analysis. While a cross-section analysis of 15

Table 3.2 Mean value of dependent and independent variables, by country

	AUL	AUS	BEL	DEN	FIN	FRA	GER	ITA	JPN	NET	NOR	SWE	SWZ	UK	USA
Public In-Kind Benefits for the aged (% of GDP)	0.37	0.25	0.03	2.16	0.74	0.16	0.54	0.06	0.19	0.57	2.03	1.85	0.17	0.41	0.06
Public In-Kind Benefits for the aged + care allowance (% of GDP)	0.39	0.79	0.03	2.16	0.74	0.18	0.62	0.06	0.19	0.57	2.03	1.85	0.23	0.58	0.06
Logarithm of GDP per capita (PPP)	9.78	9.82	9.78	9.81	9.72	9.75	9.83	9.75	9.75	9.78	9.85	9.80	10.02	9.68	10.01
Consumer price index	5.40	2.90	2.50	4.30	4.50	4.40	2.60	7.30	1.60	2.70	5.20	5.60	2.70	4.80	4.20
Growth rate of real GDP	3.30	2.30	2.10	1.90	2.50	2.30	2.10	2.00	2.60	2.50	3.20	2.00	1.80	2.30	3.00
Unemployment rate (t–1)	8.00	3.40	9.00	9.10	8.50	9.80	7.00	9.40	2.90	6.20	3.80	4.40	1.80	8.90	6.40
% of the aged 80 and over (t–1)	2.20	3.30	3.30	3.50	2.70	3.50	3.80	3.20	2.40	2.80	3.60	4.10	3.50	3.50	2.80
% of female labour force participation (t–1)	59.50	55.70	52.40	75.40	71.60	58.20	57.30	43.00	59.60	50.40	70.20	77.00	65.50	63.60	66.50
% of union density (t–1)	29.50	31.40	35.80	58.90	56.40	7.50	21.80	24.90	14.90	16.40	46.10	60.70	20.70	28.00	12.50
% of women in parliaments (t–1)	8.70	16.70	10.00	30.20	32.50	7.30	17.90	10.50	2.70	24.00	33.40	34.80	15.30	8.00	8.00
Minority government dummy (t–1)	0.30	0.82	0.59	0.50	0.81	0.70	0.20	0.67	0.32	0.45	0.26	0.00	0.38	0.18	0.82
% of leftist party cabinet (t–1)	59.10	67.90	35.20	47.50	45.50	59.50	24.40	27.70	4.40	24.10	63.80	69.30	29.10	18.20	0.00
% of Christian democratic cabinet (t–1)	0.00	29.40	47.70	2.00	1.10	0.00	63.90	50.30	0.00	40.60	10.60	2.10	24.30	0.00	0.00
Degree of fractionalization of the cabinet (t–1)	0.14	0.35	0.74	0.38	0.67	0.29	0.32	0.50	0.12	0.53	0.15	0.17	0.74	0.00	0.00
Degree of federalism	1.00	1.00	0.80	0.00	0.00	0.00	2.00	0.00	0.00	0.00	0.00	0.00	2.00	0.00	2.00
Degree of personal vote	3.00	2.00	2.00	2.00	3.00	2.00	2.00	4.00	6.00	2.00	1.00	1.00	2.00	1.00	6.00

Source: See the *Data and variables* section.

countries does not allow us to control the effects of socio-demographic factors in assessing the effects of political variables due to a lower degree of freedom, a simple time-series analysis of single country is unable to examine the effects of political variables on public spending because they are less varied across time. By contrast, pooled-OLS models with time-series and cross-section (TSCS) data enable econometric models to estimate the effects of political institutional as well as socio-demographic variables on public spending by analysing their variations across time and space (cf. Plümper, Troeger, and Manow, 2005). Although econometric analysis of TSCS data is never a panacea (e.g., Kittel, 1999; Kittel and Winner, 2005), it is still a powerful tool for estimating the impacts of political variables while controlling for the influences of socio-economic factors on public spending. Pooled-OLS models are a typical method for conducting the analysis of TSCS data in comparative political economy.[4]

Pooled-OLS models still require us to address the contemporaneous heteroscedasticity and serial autocorrelation of residuals. Following the conventional methods in comparative political economy, this study uses panel-corrected standard errors to model contemporaneous heteroscedasticity (Beck and Katz, 1995). Furthermore, since the time-series changes in this study's dependent variables are relatively small (see Figure 3.1), less variance is left to the estimation of the effects of other independent variables if a lagged dependent variable is put into the regression models. Following Huber and Stephens (2000, 2001), this study uses the Prais-Winston autocorrelation correction method, to correct the serial correlation of residuals in regression models.

In addition, this study also uses interaction terms to assess the effects of timely invariant political institutional variables. This study's theoretical argument does not claim that political institutions themselves have preferences for some types of social protection programs; rather, it simply maintains that political institutions bias the distribution of limited public resources when those institutions transmit societal demands to public policy and, as a result, encourage or discourage the development of public elderly care programs. As Thelen and Steinmo (1992, p. 3) argue, 'institutions constrain and refract politics but they are never the sole "cause" of outcomes'. Essentially, political institutions intervene between socio-economic conditions and policy outcomes by structuring battles among political actors. Within the context of this study, while changes in political variables supposedly covary with those in the dependent variable across time, we cannot observe this covariation if these political variables are timely invariant. Hence, the coefficients of rarely changing political institutional variables simply

reflect the static cross-national variation of the dependent variable in the pooled-OLS models. This is why interaction terms between timely invariant political institutional variables – namely, 'Degree of Personal Vote' and 'Degree of Federalism' – and a socio-demographic factor – namely, 'Percentage of the Aged 80 and Over' – are put into the regression models. If these political institutions are responsible for structuring the political process that translates socio-demographic changes into public policy, the effects of socio-demographic factors should be contingent upon the values of the political institutional variables.

These interaction terms allow us to assess the effects of political institutions on the time-series changes of socio-demographic factors even when these political institutional variables themselves are not timely changing (see Kam and Franzese, 2007). Although all political variables are supposed to have intervening effects between socio-demographic factors and the dependent variable, this study only uses the interaction terms between rarely-changing variables and the main driver of public elderly care spending – 'Percentage of the Aged 80 and Over' – because we can observe these intervening effects through the covariation between timely changing political variables and the dependent variable across time and because putting possibly all interaction terms into regression models spoils their parsimony due to multicolinearity.

3.4 Results

Models A1–A6 in Table 3.3 estimate the effects of explanatory variables on public spending for elderly care, as a per cent of GDP, with pooled-OLS models. Model A1 assesses the effects of independent variables on 'Public In-Kind Benefit for the Aged' without interaction terms. Its results clearly show the expansionary effects of socio-demographic factors: both 'Percentage of the Aged 80 and Over' and 'Percentage of Female Labour Force Participation Rate' indicate statistically significant and positive effects on the dependent variable. Among political mobilization variables, 'Union Density' and 'Percentage of Women in Parliaments' show positive effects on the dependent variable with statistical significance. These results suggest that the strength of trade union movements and the degree of women's political mobilization are positively correlated with the size of public spending on in-kind benefits for the aged. By contrast, political partisanship variables – 'Percentage of Leftist Party Cabinet' and 'Percentage of Christian Democratic Cabinet' – indicate no statistically significant effects.

Concerning political institutional variables, in Model A1, 'Degree of Fractionalization of the Cabinet', 'Degree of Personal Vote', and 'Degree

Table 3.3 Regression of public elderly care spending as a per cent of GDP on explanatory variables with pooled-OLS models, 1980–2001

Model	**A1**	**A2**	**A3**	**A4**	**A5**	**A6**
Dependent variable	**In-kind**	**In-kind**	**In-kind + Care allowance**	**In-kind + Care allowance**	**In-kind + Care allowance**	**In-kind + Care allowance**
Logarithm of GDP per capita (PPP)	−0.284	−0.310	−0.177	−0.039	0.175	0.155
	(0.198)	(0.208)	(0.207)	(0.163)	(0.172)	(0.174)
Consumer price index	−0.005	−0.005	−0.006	−0.006	−0.007+	−0.006
	(0.004)	(0.004)	(0.004)	(0.004)	(0.004)	(0.004)
Growth of real GDP	−0.003	−0.004	−0.004	−0.006	−0.008	−0.007
	(0.006)	(0.006)	(0.006)	(0.005)	(0.005)	(0.005)
Unemployment rate (t–1)	−0.005	−0.003	−0.008	0.001	0.003	−0.007
	(0.008)	(0.008)	(0.009)	(0.008)	(0.008)	(0.010)
% of the aged 80 and over (t–1)	0.161*	0.309*	0.329*	0.333*	0.306*	0.314*
	(0.081)	(0.134)	(0.136)	(0.133)	(0.127)	(0.134)
% of female labour force participation (t–1)	0.021**	0.021**	0.018**	0.016**	0.002	0.002
	(0.005)	(0.005)	(0.005)	(0.004)	(0.005)	(0.004)
Union density (%) (t–1)	0.010**	0.009**	0.009**	0.011**	0.002	−0.001
	(0.002)	(0.002)	(0.002)	(0.002)	(0.002)	(0.003)
% of women in parliaments (t–1)	0.014**	0.014**	0.013**	0.011**	0.002	0.000
	(0.004)	(0.004)	(0.004)	(0.004)	(0.004)	(0.004)
Minority government dummy (t–1)	0.169**	0.153**	0.128**	0.103**	0.064+	0.041
	(0.048)	(0.045)	(0.046)	(0.039)	(0.037)	(0.037)
% of leftist party cabinet (t–1)	−0.001	0.000	−0.001	−0.001	−0.001+	−0.001
	(0.001)	(0.001)	(0.001)	(0.001)	(0.001)	(0.001)
% of Christian democratic cabinet (t–1)	0.001	0.001	0.001	0.001	0.001	0.001
	(0.001)	(0.002)	(0.002)	(0.001)	(0.001)	(0.001)
Degree of fractionalization of the cabinet (t–1)	−0.271*	−0.202+	−0.244*	−0.205*	−0.239*	−0.224*
	(0.106)	(0.105)	(0.110)	(0.100)	(0.098)	(0.104)

Degree of personal vote	–0.056*	0.065	0.061	0.093	0.086	0.114
	(0.025)	(0.094)	(0.095)	(0.090)	(0.086)	(0.088)
Degree of personal vote × % of the aged 80 and over (t–1)	–	–0.043	–0.051	–0.063*	–0.070*	–0.072*
	–	(0.032)	(0.033)	(0.030)	(0.029)	(0.029)
Degree of federalism	–0.099**	0.186	0.196	0.194	0.17	0.195
	(0.033)	(0.166)	(0.162)	(0.147)	(0.130)	(0.134)
Degree of federalism × % of the aged 80 and over (t–1)	–	–0.084	–0.083	–0.077+	–0.051	–0.051
	–	(0.051)	(0.051)	(0.044)	(0.039)	(0.040)
German dummy (1980–1989)	–	–	–	–0.406**	–0.419**	–0.409**
	–	–	–	(0.107)	(0.105)	(0.112)
Norway dummy (1988–1989)	–	–	–	1.153**	1.102**	1.081**
	–	–	–	(0.129)	(0.116)	(0.113)
Scandinavian dummy	–	–	–	–	0.900**	0.938**
	–	–	–	–	(0.157)	(0.177)
Social spending (% of GDP) (t–1)	–	–	–	–	–	0.028**
	–	–	–	–	–	(0.010)
Public cash benefit expenditures for the aged (% of GDP) (t–1)	–	–	–	–	–	–0.052**
	–	–	–	–	–	(0.016)
Constant	1.280	1.023	0.027	–1.279	–2.079	–2.023
	(1.698)	(1.892)	(1.888)	(1.444)	(1.436)	(1.494)
Observations	264	264	264	264	264	260
Number of countries	15	15	15	15	15	15
R-Squared	0.617	0.615	0.621	0.705	0.727	0.721

Notes: (a). Panel-corrected standard errors in parentheses; (b). + significant at 10%; * significant at 5%; ** significant at 1% in a two-tailed test.

of Federalism' each indicate negative effects on the size of public spending on in-kind benefits for the aged, with statistical significance. These results illuminate three findings. First, a fragmented ruling coalition would restrain public spending for old-aged in-kind benefits. Second, a personal-vote oriented electoral system would discourage the welfare state to dedicate public expenditures for in-kind benefits for the aged. Third, a higher degree of independence among regional governments would also dampen public expenditures for those benefits. However, since 'Degree of Personal Vote' and 'Degree of Federalism' are almost invariant across time, it is misleading to infer the structuring effects of these political institutional variables on public spending solely from Model A1. The effects of the interaction terms between these two variables and the demographic variable will be discussed in the next model.[5]

Model A2 inserts into Model A1 the interaction terms between timely invariant political institutional variables and 'Percentage of the Aged 80 and Over'. Following the procedures recommended by Kam and Franzese (2007), this study calculates the marginal effects of 'Percentage of the Aged 80 and Over' on the dependent variable, depending on the various values of these political institutional variables.[6]

Figure 3.2 shows the extent to which the predicted marginal effects of the demographic variable depend on 'Degree of Personal Vote' and

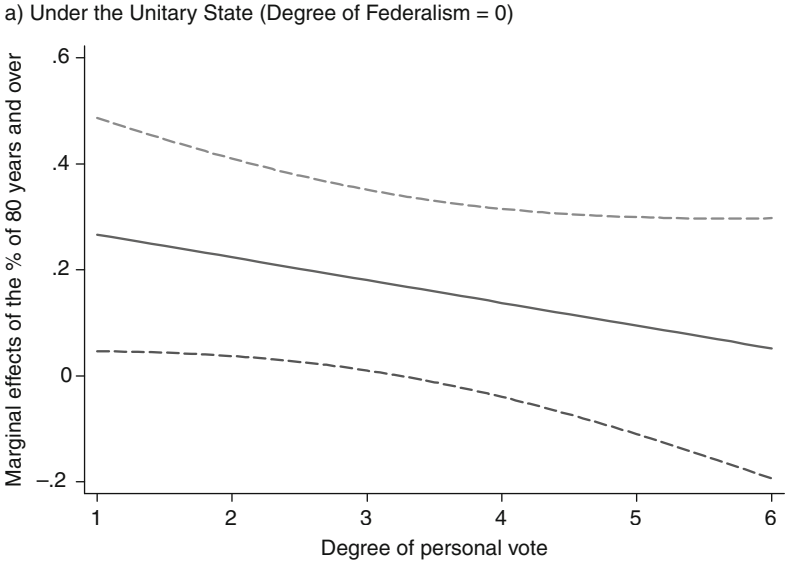

Figure 3.2 Continued

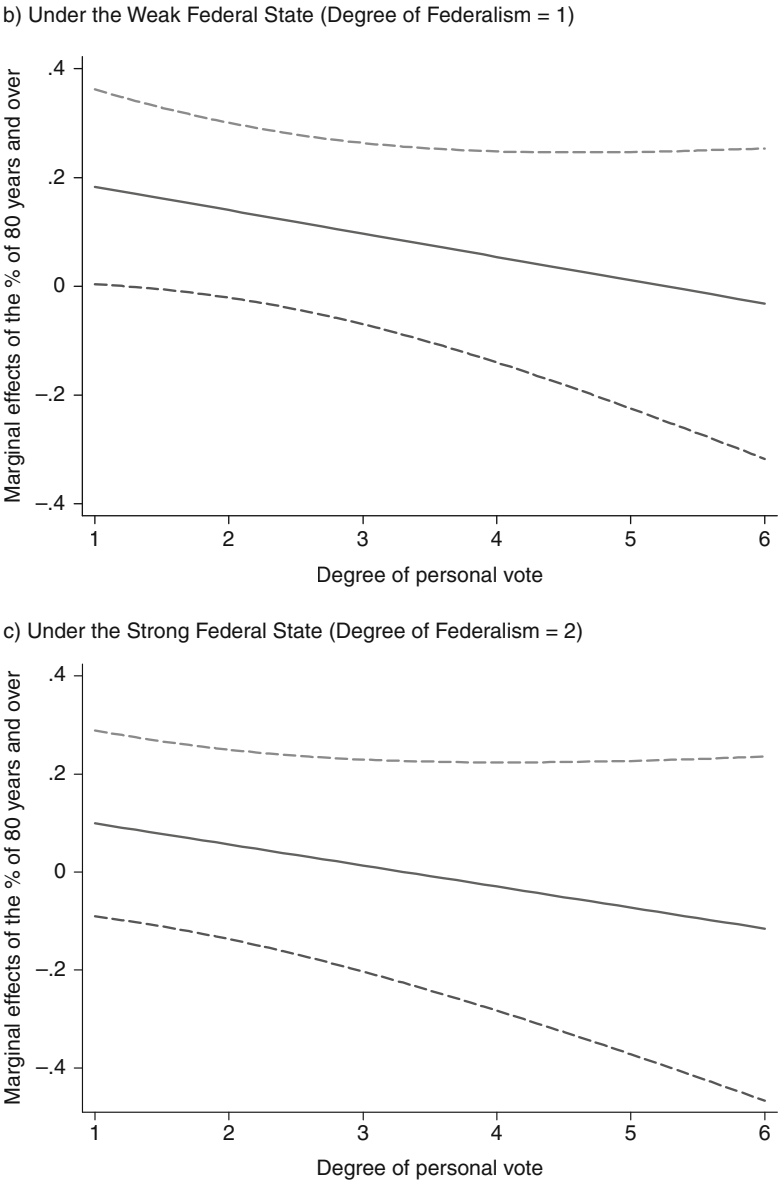

Figure 3.2 Predicted effects of population aging, interacted with the degree of personal vote and the degree of federalism, with 95 per cent confidence interval, in Model A2

Source: Calculated by the author.

'Degree of Federalism' in Model A2. Figure 3.2.a demonstrates that the marginal effects of 'Percentage of the Aged 80 and Over' are varied according to the degree of personal vote. Under the unitary state system (i.e., 'Degree of Federalism' = 0), the marginal effects of 'Percentage of the Aged 80 and Over' have positive values with the conventional significance level when the degree of personal vote takes lower values (1–3), but the demographic variable becomes statistically insignificant when the degree of personal vote takes higher values (4–6), ceteris paribus. For instance, Figure 3.2.a indicates that – under the unitary state – while a 1 per cent increase in 'Percentage of the Aged 80 and Over' would raise the dependent variable by 0.266 (= 0.309 – 0.043 × 1 – 0.084 × 0) per cent of GDP if 'Degree of Personal Vote' takes 1 as its value, the same change in 'Percentage of the Aged 80 and Over' would increase the dependent variable by only 0.137 (= 0.309 – 0.043 × 4) per cent of GDP if 'Degree of Personal Vote' is 4, *holding other things constant*. Furthermore, as the lower bound of 95 per cent confidence interval goes below zero when the degree of personal vote is more than 4, the latter effect cannot be distinguished from 0.

Figure 3.2.b and 3.2.c illustrate that the effects of the demographic variable also rely on the degree of federalism. Figure 3.2.b shows that under the weak federal state (i.e., 'Degree of Federalism' = 1), while a 1 per cent increase in percentage of those aged 80 and over would increase the dependent variable by 0.182 per cent (= 0.309 – 0.043 × 1 – 0.084 × 1) of GDP with statistical significance if the degree of personal vote takes 1 as its value, the marginal effects of the demographic variable become indistinguishable from 0 when the degree of personal vote takes 2 and above as its value. Furthermore, Figure 3.2.c indicates that, as the lower bound of 95 per cent confidence interval goes below 0 across all values of 'Degree of Personal Vote', 'Percentage of the Aged 80 and Over' becomes statistically insignificant regardless of the degree of personal vote under the strong federal state (i.e., 'Degree of Federalism' = 2), ceteris paribus.

Models A3–A6 check the robustness of these findings in Models A1 and A2. Model A3 replaces public spending on in-kind benefits for the aged with combined expenditures for public in-kind benefits for the aged and care allowance as a dependent variable. As Table 3.3 indicates, Model A3 shows practically the same results with Model A2. Model A4 adds period dummy variables of Germany (1980–1989) and Norway (1988–1989) to Model 3 in order to adjust the effects of seemingly implausible changes of public spending for elderly care in these two countries (see Figure 3.1). Although the direction of coefficients of explanatory variables and their significance levels are rarely changed

between Models A3 and A4, the effects of interaction terms between timely invariant political institutional variables and the demographic variable appear to be reinforced in Model A4. While the interaction term between 'Degree of Personal Vote' and 'Percentage of the Aged 80 and Over' becomes significant with less than 5 per cent level, the one between 'Degree of Federalism' and the demographic variable becomes significant with less than 10 per cent level in Model A4.

Model A5 controls for the effects of 'welfare regime types' to assess the effects of explanatory variables (cf. Esping-Andersen, 1990, 1999). While Scandinavian countries developed their universalistic and generous social care policies during the 'golden age of welfare states', other advanced democracies are trying to address the increasing care demands for the frail elderly under 'permanent austerity' (Pierson, 2001). Since this study analyses the data from 1980 to 2001, the programs and spending structures developed prior to 1980 should be controlled. Thus, Model A5 adds 'Scandinavian dummy' (a dummy variable: Denmark, Finland, Norway, and Sweden take 1; others take 0) to Model A4. After incorporating the effects of the Social Democratic regime into the model, Model A5 shows surprising results: the variables characteristic to that regime (higher female labour force participation rates, higher union density, and higher percentage of female legislators in the parliaments), which are consistently significant across Models A1–A4, lose their statistical significance in Model A5. While these factors have reinforced each other and generated the generous social service state in the Social Democratic regime (see Iversen and Wren, 1998), they seem to have no linear positive effects on public elderly care spending beyond the context of the Social Democratic regime after 1980. On the contrary, this study's key explanatory variables ('Degree of Fractionalization of the Cabinet' and the interaction term between 'Degree of Personal Vote' and 'Percentage of the Aged 80 and Over') maintain their expected effects with statistical significance.

Model A6 also assesses the effects of explanatory variables on the dependent variable while controlling the 'crowding-out' effects of welfare state maturation (cf. Bonoli, 2007; Bonoli and Reber, 2010). As discussed above, while Scandinavian countries developed their elderly care programs under fiscally favourable conditions, other countries have been facing growing demands for elderly care services under the fiscal pressures from other welfare programs, especially old-age pensions, in recent decades. To control the effects of fiscal austerity stemming from the welfare state maturation, Model A6 puts *Total Social Spending* and *Public Cash Benefit Expenditures for the Aged*, as a per cent

of GDP respectively, into the regression model.[7] The results of Model A6 suggest that the maturation of welfare programs suppresses the growth of public elderly care spending. The size of the welfare state ('Total Social Spending') itself is positively correlated with the size of public spending for elderly care, but, once it gets controlled, the size of old-age pension expenditures ('Public Cash Benefit Expenditures for the Aged') constrains the development of public elderly care spending. However, this study's main findings are hardly changed.

Overall, the results of this study's regression analyses confirm the validity of the hypotheses developed in Chapter 2. This chapter offered two hypotheses: First, personal-vote oriented electoral systems are less favourable to the development of public elderly care services than party-vote oriented electoral systems; Second, a fragmented coalition government spends less for public elderly care services than does a cohesive ruling coalition. Models A1–A6 verify these two claims: the degree of personal vote itself and its interaction term with the degree of population aging indicate their constraining effects on public spending for elderly care across the regression models; the degree of fractionalization of a ruling coalition also shows its negative effects on public spending for elderly care consistently. These results suggest that political institutions – electoral rules and party systems – structure the political process transmitting the impacts of population aging into public care programs for the aged. Furthermore, the degree of federalism also indicates its consistently negative effects on public spending for elderly care. The presence of autonomous regional governments restrains the public expenditures for elderly care. On the contrary, the effects of political and social mobilization by trade union movements and women are not confirmed in this study's regression models. While higher union density, higher female labour force participation rates, and higher percentage of female legislators in the parliaments are correlated with higher public spending for elderly care, the positive effects of these variables disappear once the impacts of the Social Democratic regime are controlled. These political and social mobilization factors characterize the Social Democratic regime, but they appear to have no linear impact on public elderly care expenditures outside Scandinavian countries. In addition, political partisan variables – the presence of a leftist party government and the presence of a Christian Democratic government – indicate no positive effects on public spending for elderly care.

To show that personal-vote oriented electoral rules and fragmented ruling coalitions do not have same restraining effects on particularistic welfare programs, this study applies the same regression model above

(Model A2) to the following two other dependent variables: 'Public Cash Benefit Expenditures for the Aged' and 'Total Social Spending', as a per cent of GDP.[8] While the former is supposed to measure the size of public old-age pension spending, the latter measures the size of welfare state in general. As Lynch (2006) reveals, particularistic political competition biases the distribution of public resources towards occupational social insurance schemes and then broadens the scale of old-age pension benefits. Hence, this study expects that variables of electoral rules and party systems have opposite effects between the models with public elderly care spending and old-age pension spending.

In fact, as Table 3.4 suggests, these political variables show contrasting effects on the size of old-age pension and total social spending, compared to those on public elderly care expenditure. Model B1 illustrates that higher fractionalization of a ruling coalition actually encourages the expansion of public old-age pension spending, while a higher degree of personal vote reinforces the expansionary effects of population aging on pension spending. Model B2 also indicates that 'Degree of Fractionalization of the Cabinet' is positively correlated with the size of welfare state, and that the interaction term between 'Degree of Personal Vote' and 'Percentage of the Aged 80 and Over' has positive effects with statistical significance. The fragmentation of a ruling coalition stimulates welfare spending as a whole, and a higher degree of personal vote bolsters the expansive impact of population aging on the welfare state. It can be inferred that because in many countries occupational social insurance programs are dominant in old-age pension and other welfare programs, the impact of party systems and electoral rules on the size of old-age pension and the welfare state in general is opposite to the impact on public elderly care services. These results agree with this study's theoretical claim.

3.5 Discussion

This chapter's quantitative analysis has shown the effects of political institutions on social care arrangements for the elderly. The regression analysis suggested that the extent to which electoral rules encourage the personal vote structures the effects of population aging on the size of public elderly care expenditures, and that the fractionalization of a ruling coalition also affects spending on those programs. On the contrary, while social and political mobilization by trade unions and women appears to be correlated with higher public spending on elderly care programs, its positive effects do not go beyond the context of the

Table 3.4 Regression of other public spending programs on explanatory variables with pooled-OLS models, 1980–2001

Model	**B1**	**B2**
Dependent variable	**Public cash benefit exp. for the aged (% of GDP)**	**Total social spending (% of GDP)**
Logarithm of GDP per capita (PPP)	–1.379**	–5.015**
	(0.497)	(1.162)
Consumer price index	0.005	–0.044
	(0.012)	(0.032)
Growth of real GDP	–0.048**	–0.292**
	(0.014)	(0.045)
Unemployment rate (t–1)	0.071**	0.497**
	(0.026)	(0.063)
% of the aged 80 and over (t–1)	1.379**	2.325**
	(0.296)	(0.566)
% of female labour force participation (t–1)	–0.015	0.037
	(0.015)	(0.037)
Union density (t–1)	–0.028**	0.008
	(0.008)	(0.013)
% of women in parliaments (t–1)	0.008	0.131**
	(0.011)	(0.028)
Minority government dummy (t–1)	–0.180*	0.233
	(0.081)	(0.321)
% of leftist party cabinet (t–1)	0.008**	0.017**
	(0.002)	(0.004)
% of Christian democratic cabinet (t–1)	0.009**	0.028**
	(0.003)	(0.009)
Degree of fractionalization of the cabinet (t–1)	1.247**	2.657**
	(0.268)	(0.621)
Degree of personal vote	–0.240	–1.908**
	(0.236)	(0.470)
Degree of personal vote × % of the aged 80 and over (t–1)	0.104	0.489**
	(0.086)	(0.167)
Degree of federalism	–1.495**	–3.652**
	(0.519)	(0.958)
Degree of federalism × % of the aged 80 and over (t–1)	0.522**	0.937**
	(0.160)	(0.301)
Constant	16.699**	57.081**
	(4.652)	(10.965)
Observations	284	284
Number of countries	16	16
R-squared	0.749	0.870

Notes: (a). Panel-corrected standard errors in parentheses; (b). + significant at 10%; * significant at 5%; ** significant at 1% in a two-tailed test.

Social Democratic regime. In addition, political partisanship hardly indicated any impact on public elderly care programs.

Although this study intends to explain the variations of public elderly care policy, its theory is applicable to other welfare programs as well. The theory suggests that personal-vote oriented electoral systems and/or a fragmented ruling coalition encourage the state to dedicate public resources for particularistic benefits including occupational social insurances, while party-vote oriented electoral systems and a cohesive ruling coalition promote the development of universalistic welfare programs. In fact, this chapter's preliminary analysis revealed that personal-vote oriented electoral rules and fragmented ruling coalitions enlarge the size of public old-age pension expenditure and total social spending. These empirical results espouse this study's theoretical arguments exemplified in Chapter 2.

However, the utility of this chapter's quantitative evidence is somehow constrained by various factors. First, the limitation of data availability makes it impossible to assess the effects of political institutions correctly. Since the countries having the most generous public elderly care services developed their programs in the 1960s and 1970s and other advanced democracies have been catching up with them in recent decades, a proper data analysis requires the data covering longer time periods. But the analysis covers the data only after 1980 due to the data's availability. The data of independent variables are also restricted. The rank order of electoral rules along the personal-vote versus party-vote dimension has just 15 countries, and it does not cover the new electoral rules of several countries after their electoral reforms. These deficiencies of data make the regression analysis susceptible to sample selection bias due to the small number of units and shorter time periods.

Second, more importantly, this study's quantitative analysis discards many aspects of rich data and information in real politics. For instance, the size of public spending for old-age in-kind benefits does not tell us the characteristics of welfare efforts by the state because those expenditures might be distributed among frail older citizens through actual services or might be wasted as a pork-barrel project for the proprietors of nursing homes. While this study is interested in these features of welfare spending, the purely quantitative indicator does not measure them. As another example, the indicators of electoral rules ignore the information concerning actual operation of those rules. Although Japan and the United States share the characteristics of highly personal-vote oriented electoral systems, the single non-transferable vote system in Japan and the single-member district system with primary voting in

the United States motivate politicians in these two countries differently. The different incentives might generate distinct political processes.

In the following chapters, this study conducts case studies of Sweden, Japan and the United States. It offers a more nuanced explanation for the development of public elderly care programs and assesses the effects of electoral rules and party systems on the dependent variable. These case studies intend to fill in the above-mentioned deficiencies of this chapter's quantitative analysis and to complement it.

4
Sweden: The Manipulative State

Sweden has one of the most developed elderly care systems in the world. Publicly financed home help and institutional care services, regardless of class, ethnicity, and gender, guarantee that older people live independent lives as much as possible. In the Swedish elderly care system, based on the principle of local self-government, local municipalities (*kommun*) are in charge of delivering social care services to those who need care. Local municipalities collect revenues from their inhabitants through local income tax, and provide those care services for their residents as a universal service. Older citizens are enjoying the high-quality care services with nominal or low out-of-pocket fees. Although Swedish central and local governments experienced economic hardship during the 1990s, these generous elderly care services have not been dismantled, at least, in terms of the percentage of GDP devoted to those services.

In addition, Sweden also succeeded in modernizing health and social care services for the aged in recent decades. Sweden has conspicuously restrained the growth of geriatric medical care costs since the 1990s by transferring a huge amount of public resources from its geriatric health care sector to social care services. The average length of stay of in-patient care has been reduced, the number of hospital beds has been decreased, and the number of care episodes has declined (Swedish Association of Local Authorities and Regions, 2007, p. 42). The 'bed blockers' have been expelled from hospital beds, and long-term geriatric medical care wards were integrated into residential care facilities.

How has Sweden achieved its generous elderly care services? How did it adapt its social and medical care services to the ageing population? The Swedish case appears to fit the argument developed in Chapter 2 well. While the centralized ruling party – the Social

Democratic Party – underpinned by the party-vote oriented electoral system produced the state autonomous from societal interests seeking particularistic benefits and allowed the state to develop universalistic social services, the same characteristics facilitated it to reform existing care policies. However, this argument leaves one important puzzle in Sweden's case: why did fiscally autonomous and administratively independent local governments develop such universal and generous elderly care services? As I depict in the next section, local governments have the ability to levy local income tax on their inhabitants enough to finance their own activities, and they bear the role of providing social care services for their residents. The principle of 'local self-government' has been highly valued in Sweden's political history. If local governments are fiscally and functionally independent, they would race to the bottom in theory. That is, they are supposed to avoid imposing higher tax rates on their inhabitants in order to attract investors and citizens (cf. Weingast, 1995). How has the state controlled 'supposed-to-be-autonomous' local governments and had them follow its lead?

This chapter argues that the strong state espoused by the catch-all ruling party – the Social Democratic Party – has manipulated local governments through various political devices, such as legislation, earmarked grants, and guidelines, in order to achieve universalistic elderly care services. The relatively autonomous state was also capable of reforming existing social and health care programs run by county councils and local municipalities so that they adapt to social and demographic changes. However, as Sweden faces economic downturns and its political system changes from 'dominant coalition' to 'shifting coalition' governments (Steinmo and Tolbert, 1998), the state's policy has been swinging between the principle of local self-government and the principle of equality in elderly care.

This chapter describes the development and changes of the elderly care system in Sweden. Section 4.1 illustrates how strong party governments supported by electoral rules structure Sweden's policy-making and policy-implementation processes. It looks at the key elements of constitutional, electoral, intra-party, and inter-governmental institutions. Section 4.2 describes the characteristics of social and medical care programs for older people. Then, Section 4.3 gives an overview of the development of the elderly care system during the twentieth century in Sweden. Section 4.4 examines the policy process of Ädel reform in 1992. Section 4.5 describes the privatization and decentralization of elderly care programs, and explores the policy process of 'maximum

fee reform' in 2002. Section 4.6 summarizes the argument of the entire chapter.

4.1 The characteristics of political institutions in Sweden

Sweden's political system is characterized by highly concentrated political power in the executive branch, *de jure et de facto*. As its constitution adopts a parliamentary system, Sweden has no institutional separation of powers between the legislative branch and the executive branch as is the case under presidential systems. The relation between these branches is symbiotic: while the legislative branch forms a strong party government and delegates its policy-making and policy-implementing functions to the executive branch, the cabinet relies on the confidence of the parliament (*Riksdag*).[1] Furthermore, Sweden's constitution is quite 'flexible', and its polity does not have an independent constitutional court. Amendment of the constitution requires just a majority vote in two successive sessions of the Riksdag.[2] Although Sweden has the 'Council on Legislation', which is the court the government asks to review important legislative proposals, the executive branch is not obliged to follow its rulings (Larsson and Bäck, 2008, p. 203). In addition, as the government agencies can act like a court in matters of appealing administrative decisions, the boundary between the executive branch and the judiciary branch is vague. As Immergut (1992a, chapter 5) points out, the executive branch dominates the entire political system in Sweden.

The electoral system also facilitates the concentration of political power in Sweden. Until 1998 it used a proportional representation (PR) system with a closed list for the election of Riksdag members. While this system allowed party leaders to be gate-keepers regarding candidates in the list, those candidates could entrust the electoral campaign to their political parties. The previous electoral system in Sweden – the PR with a closed list – helped the party leadership control campaign funding, personnel affairs, policy decisions, and so forth. As a result, the various political capitals concentrate on the party leaders' hands. Since rank-and-file politicians can rely on party programs and platforms in their elections and therefore do not need to cultivate their own constituencies, under the Swedish system interest groups encounter insurmountable difficulties in building up a veto point either inside or outside of ruling parties. Although its multi-party system and encompassing interest coordination might make Sweden a typical case of 'consensus

democracy', it does not mean that stakeholders have any 'teeth' in the Swedish political system.[3]

The above features – amalgamated three branches and strong party leadership – have created party-centred politics in Sweden. The political parties dominate interest-representation and the policy-making process. The centralized political parties are main actors in the Swedish political system.

Electoral rules and intra-party organization

The Swedish political system has adopted proportional representation (PR) as its electoral policy since the extension of suffrage in the early twentieth century. In 1907–1909, when the Liberals and the Social Democrats forced the Conservatives to extend the suffrage to all men, the Conservatives decided to adopt the proportional representation systems in both chamber elections. They proposed that while the Second Chamber should be elected in multi-member districts with PR rules, the First Chamber should be elected also with PR rules but indirectly by county councils and the councils of county-free cities. The logic behind the adoption of PR systems was to prevent the Conservatives from being squeezed between the Liberal Party and the Social Democratic Party, which was rapidly gaining power at that time. The Conservatives feared they would be extinguished in the Second Chamber under a 'first-past-the-post' system, and the PR system was one way to preserve conservative influences there. On the other hand, the dominance of the Conservatives was secured in the First Chamber because the income-graduated voting rights were retained in county and city council elections. In addition, the indirect election rule – one-eighth of member of seats are elected by county and city councils in each year – was intended to perpetuate the Conservative political clout in the First Chamber (Larsson and Bäck, 2008, pp. 140–143; Särlvik, 2002, pp. 235–238). However, this indirect electoral system of the First Chamber later backfired for the Conservatives (see below).

In the Swedish electoral rules, the candidates of the Second Chamber are selected in 29 multi-member districts with a proportional representation formula. While the electoral rules have been slightly changed under its universal suffrage democracy as Table 4.1 indicates, the essence of electoral rules has not changed so much in Sweden. That is, constituencies vote for the party list they favour rather than for a particular candidate in elections. There was a formal possibility for a voter to make adjustments on the ballot paper – delete or add new names – but, in reality, this has never had practical significance in Swedish politics

Table 4.1 Swedish electoral systems of the second chamber (*Andra Kammaren*)

Year	Name of electoral system	District magnitude	Number of districts	Assembly size	Adjustment seats	Electoral formula	Legal threshold	Effective threshold (4)
1921–1968	PR with a closed list	8.21	28	230 (1)	–	d'Hondt (2)	–	8.5%
1970–1994	PR with a closed list	Upper-tier: 349 Lower-tier: 11.1	Upper-tier: 1 Lower-tier: 28	350 (3)	39	Modified Sainte-Laguë	4% (12%)	4%
1998–present	PR with an open list	Upper-tier: 349 Lower-tier: 11.1	Upper-tier: 1 Lower-tier: 29	349	39	Modified Sainte-Laguë	4% (12%)	4%

Notes: (a). In 1956 and 1964, additional seats were added and then the total was raised to 233; (b). 1952–1968: Modified Sainte-Laguë; (c). Through the 1973–1976 'Lottery Riksdag', in which the socialist and the non-socialist blocks held the exact same number of seats (175), the assembly size was reduced to 349; (d). 'Effective Threshold' is the minimum percentage point a candidate is required to collect to get elected. Teff = 50 per cent / (M+1) + 50 per cent / 2M. Here, M = district magnitude.*Sources*: Lijphart (1994); Larsson and Bäck (2008, chapter 7); Särlvik (2002).

(Pierre and Widfeldt, 1992, p. 784). Furthermore, facing threats from a populist party the established political parties introduced a preference vote in 1998, but it has not changed the party-based political system. The new system allows voters to select only one candidate, and the candidate needs to collect at least 5 per cent of the total votes for the relevant list in order to change its pre-determined rank order. In fact, only 22 per cent of the constituencies used a preferential vote in the general election of 2006, and in only a few cases did those preferential votes have an impact on the final selection of candidates (Larsson and Bäck, 2008, pp. 149–151).

These party-vote oriented electoral rules have had several implications for the political party organizations in Sweden. First and foremost, the political parties are considerably centralized organizations. They are far from those salons of MPs inside the parliament in the nineteenth century. While the party congress selects its programs and the party leaders, the executive board, the parliamentary party and the party leadership handle the day-to-day politics. The party leadership exercises quite large discretion, enough to decide policy issues. The party congress is, in reality, a ceremonial venue for approving the agenda prepared by the party leadership (Pierre and Widfeldt, 1994). Furthermore, the party leadership controls the financial resources of

the party. The control over the finances, including state subventions, is in hands of the executive board and the parliamentary party (ibid.). The electoral rules require the political parties to be a centralized organization because they need to 'sell' the party as a whole – not an individual politician – to constituents in Sweden.

Second, in Sweden the electoral rules create incentives for the rank-and-file candidates of political parties to follow the lead of their party leadership. The electoral campaigns are mainly carried out through mass media, such as newspapers and television, and the party leadership controls the financial resources to run those campaigns. Hence, each candidate in a multi-member district prefers 'free-riding' the party platform rather than cultivating the candidate's own costly support base. Although MPs keep regular contact with their own electoral district (Esaiasson and Holmberg, 1996, chapter 13), this does not necessarily mean they are fixed to the interests of their electoral districts. When asked, when opinions are conflicting, to choose either their party or their constituents, the majority of MPs choose their party (ibid, chapter 3).

Overall, the Swedish political system has been based on the closed-list PR system, and the characteristics of the electoral rules have created the centralized political party organizations and structured the party-based politics. The next subsection briefly looks at the features of the party system in Sweden.

Electoral rules, social cleavages, and inter-party competition

The Swedish party system can be characterized by its plainness. According to Bergström (1991, p. 8), Sweden's party system '*has been the simplest in any of the democracies* [italics in original]'. Sweden has never had any noticeable social cleavage along languages, religions, or ethnicity. Although there are native Sámis and Finns in the northern areas, those ethnic minorities are so small that they have no representation in the political domain. As a result, just two dimensions have accounted for the party system after the extension of suffrage: the Left–Right axis and the land–industry axis. On the Left–Right scale, the Left Party Communists (*Vänsterpartiet Kommunisterna*: VPK), the Social Democratic Party (*Socialdemokratiska Arbetarepartiet*: SAP), the Liberal Party (*Folkparteit Liberalerna*: FP), and the Conservative Party (*Moderata Samlingspartiet*: M) are lined up. The Centre Party (*Centerpartiet*: C) originated in the rural, agrarian party, the Farmers' Union, and is in the middle of the Left–Right ideological scale (Pierre and Widfeldt, 1992, pp. 781–782).

Reflecting the fewer social cleavages in Swedish society, the inter-party competition is characterized by the ideological and programmatic homogeneity among political parties. The party manifesto study by Klingemann, Hofferbert, and Budge (1994, p. 160) points out that 'the ideological structure of Swedish parties and policies is tighter than that in any other country [they] study'. The political parties try to appeal to the homogenous constituencies with similar policy programs and party platforms.

Another attribute of the Swedish party system *was* its 'one-party dominance' (cf. Pempel, 1990; Sartori, 1976). As Table 4.2 indicates, the Social Democratic Party dominated the administration, by itself or with a coalition partner, for 40 years (1936 until 1976). However, the Social Democratic Party was in a minority government position for most of the post-World War II era, except in a coalition government with the Centre Party (1951–1957) and a single-party government (1969–1970). There are several reasons why the Social Democrats managed to maintain the administration even in a minority status. First, they could tacitly count on the support from the Communist Party (VPK). Table 4.3 suggests that the Left's clout (SAP and VPK) accounted for the majority of the Second Chamber most of the time after World War II. Second, the peculiar electoral rules of the First Chamber secured the perennial dominance of the Social Democrats (Immergut, 1992a, 2002; Steinmo, 1993). While its income-graduated voting rights were abolished and electorates became identical to those of the Second Chamber, the First Chamber retained its indirect election system. Because one-eighth of its seats were replaced by the election of county and city councils in each year, the effect of popular swings in general elections was smoothed out in the First Chamber.[4] As a result, the Social Democrats held an overall majority from 1941 until the First Chamber was abolished (see Table 4.3). The Social Democratic dominance in the First Chamber stabilized its one-party dominance because 'the two chambers functioned much like two components of a unified parliament' (Särlvik, 2002, p. 250). If the two chambers could not agree on the bill, the certain agenda (all budgetary issues) was decided by the 'Joint Vote', in which the votes were counted together as if the two chambers were unified. In the 'Joint Vote', as Table 3.3 indicates, the Social Democrats kept the majority for a long period. The unusual bicameralism made the Social Democratic minority government stronger than it looked.

The constitutional and electoral reform in 1967–1969 transformed the mode of inter-party competition. Particularly, the abolition of the First Chamber ended the Social Democratic one-party dominance. Since

Table 4.2 The percentage of seats in the second chamber and the formal governing coalitions, 1921–2006

	Left Party (VPK)	Social Democrats (SAP)	Center Party (C)	Liberal Party (FP)	Conservative Party (M)	Christian Democrats (KD)	Green Party (MP)	Others	Minority Government	Majority Government
1921	5.6	40.4	9.1	17.8	27.0	–	–	–	(I): SAP (II): M	
1924	2.2	45.2	10.0	14.3	28.3	–	–	–	(I): SAP (II): FP	
1928	3.5	39.1	11.7	13.9	31.7	–	–	–	(I): M (II): FP	
1932	3.5	45.2	15.7	10.5	25.2	–	–	–	(I): SAP (II): M	
1936	4.5	48.7	15.7	11.7	19.1	–	–	–		(I): SAP, C (II): Grand Coalition
1940	1.3	58.3	12.2	10.0	18.3	–	–	–		Grand Coalition
1944	6.5	50.0	15.2	11.3	17.0	–	–	–	(II): SAP	(I): Temporary non party politician government
1948	3.5	48.7	13.0	24.8	10.0	–	–	–	(I): SAP	(II): SAP, C
1952	2.2	47.8	11.3	25.2	13.5	–	–	–		SAP, C
1956	2.6	45.9	8.3	25.1	18.3	–	–	–	(II): SAP	(I): SAP,C
1958	2.2	48.1	13.9	16.5	19.5	–	–	–	SAP	
1960	2.2	49.1	14.7	17.2	16.8	–	–	–	SAP	
1964	3.4	48.5	15.5	18.5	14.2	–	–	–	SAP	
1968	1.3	53.6	16.7	14.6	13.7	–	–	–		SAP
1970	4.9	46.6	20.3	16.6	11.7	–	–	–	SAP	
1973	5.4	44.6	25.7	9.7	14.6	–	–	–	SAP	
1976	4.9	43.6	24.6	11.2	15.8	–	–	–	(II): FP	(I): M, FP, C
1979	5.7	44.1	18.3	10.4	20.9	–	–	–	(II): M, FP	(I): M, FP, C
1982	5.7	47.6	16.0	6.0	24.6	–	–	–	SAP	
1985	5.4	45.6	12.3	14.6	21.8	0.3	–	–	SAP	
1988	6.0	44.7	12.0	12.6	18.9	–	5.7	–	SAP	
1991	4.6	39.5	8.9	9.5	22.9	7.4	–	7.2	M, FP, C, KD	
1994	6.3	46.1	7.7	7.5	22.9	4.3	5.2	–	SAP	
1998	12.3	37.5	5.2	4.9	23.5	12.0	4.6	–	SAP	
2002	8.6	41.3	6.3	13.7	15.8	9.4	4.9	–	SAP	
2006	6.3	37.3	8.3	8.0	27.8	6.9	5.4	–		M, FP, C, KD

Sources: Särlvik (2002, pp. 227–229); *European Journal of Political Research*, various years.

Table 4.3 The social democrats' parliamentary bases in the two chambers, 1932–1970

	Second chamber		First chamber		'Joint votes'	
Year	SAP majority	SAP+VPK majority	SAP overall majority	SAP+VPK majority	SAP overall majority	SAP+VPK majority
1932–1936						#
1937–1940		X				
1941–1944	X		X	X	X	
1945–1948		X	X		X	
1949–1952		X	X		X	
1953–1956		#	X		X	
1957–1958			X			X
1958–1960		X	X			X
1961–1964		X	X		X	
1965–1968		X	X		X	
1969–1970	X		X		X	

Notes: (a). X indicates a Social Democratic or a Social Democratic plus Communist majority; (b). # indicates Social Democrats plus Communists and the Bourgeois parties were evenly balanced.*Source*: Särlvik (2002, p. 250).

the electoral swing of public opinion came to be easily translated to a government composition, the bourgeois-party coalition government became a viable option for electorates in Sweden. In fact, the bourgeois parties have held office for four electoral terms since constitutional reform.[5] The fact that the bourgeois parties experienced the administration consolidated the bonds among them, and then the structure of inter-party competition shifted from Social Democratic one-party dominance to the two-bloc – the centre-left and the centre-right – competition in Sweden.

The reforms of the constitution and electoral rules also affected the party configuration. As the Riksdag was changed into a unicameral system, the electoral rules were reformed. As Table 4.1 shows, the new electoral rules ensure full proportionality. In the first stage, 310 seats are allocated to 28 multi-member districts as before, and the proper number of seats is assigned to each party's list with the modified Sainte-Laguë formula, in which the legal threshold is 12 per cent. In the second stage, additional 39 seats are allocated to all parties that exceed the legal threshold (4 per cent of the total national votes) as if the entire country is one district. If the sum of a party's number of multi-member district seats is less than what it would be entitled to nationally, the

party receives additional seats (Särlvik, 2002, pp. 252–253). When the district magnitude – the number of seats assigned to each electoral district – was relatively small before the electoral reform, established parties were privileged and newcomers were excluded from the party system. As the reform significantly improved the proportionality of the electoral system, new parties entered the realm of political competition. Although the New Democracy (*Ny Demokrati*), a xenophobic populist party, soon disappeared, the Christian Democrats (*Kristen Demokratisk Samling*: KD) and the Green Party (*Miljopartiet De Grana*: MP) established their foundations in the Riksdag. It seemed that the entry of these new parties added a new axis – libertarian versus authoritarian dimension – to the inter-party competition in Sweden (cf. Kitschelt, 1994).

Interest coordination: royal commission and remiss system

As the executive branch has a dominant position in the Swedish political system, it plays a primary role in coordinating conflicting societal interests. Most policy initiatives come from within the cabinet and the civil service. While requests to appoint a committee of inquiry to investigate a new policy issue also come from interest organizations, members of the Riksdag, and private individuals, a large part of those requests originate in public authorities. Then a cabinet appoints a royal commission to examine and form a new policy (Hancock, 1972, pp. 202–205; Larsson and Bäck, 2008, p. 236; Meijer, 1969).

The relevant minister assigns a formal set of directives to the commission and designates its chairman and members. Although many royal commissions are single-member commissions served by a civil servant, multi-member commissions usually accommodate party politicians and interest organizations as well as experts. While the representatives of a ruling party are appointed by the minister, those of opposition parties are usually appointed by the relevant party after the minister informs the party leaders that the party is invited to submit a name (Meijer, 1969, p. 109). The number of seats offered to the political parties in the commission reflects, by and large, the number of seats in the Riksdag. Both ruling and opposition parties are offered the opportunity to enforce their influence on a policy *within* the executive branch (Larsson and Bäck, 2008, p. 237).

Although it is hard to generalize a commission's role because it varies commission by commission, it has several functions in the Swedish political system. First, it accumulates the data and provides ample information for policy making. Although the chairman and commission members have no time to do research, the secretaries of

the commission – full-time civil servants – perform the research, either by herself or by cooperation with external experts, and then writes a commission report. The investigation can be a basis for discussion and policy recommendations in the commission (Meijer, 1969, pp. 112–113). Second, the important function of the royal commission is to create a consensus among vested interests. Not just multi-member commissions, but also single-member commissions usually negotiate with internal and external interests and try to reach a compromise. In multi-member commissions, however, any member of the commission disagreeing with the majority's recommendation is allowed to put this reservation to the commission's report (Larsson and Bäck, 2008, p. 236).

The next step of policy making is the *remiss* process. In the remiss process, the royal commission's report is sent to all government agencies and organizations involved in the relevant issue. They are asked to write comments on the commission's report and send them to the government. While government agencies are legally obliged to submit their comments, other organizations may or may not do so. After the remiss process, the relevant ministry drafts a bill and submits it to the Riksdag (Larsson and Bäck, 2008, p. 238).

The policy-making process within the executive branch ensures that broader voices of societal actors are heard by the core executives. The royal commission is an apparatus that accommodates the representatives of political parties and interest organizations and makes a consensus on a policy issue among them. The remiss procedure also explores the reaction of societal actors to the government proposal. However, it should be mentioned that the minority has no institutional foundation to force the government to reflect their voices in its proposal. Although it is sure that the government tries to achieve broader support in order to legitimatize the proposal and facilitate its implementation, this does not mean that the minority has a veto in the policy-making process.

Inter-governmental relations: centralized decentralization?

Sweden's local government – 20 county councils and 290 local municipalities in 2005 – are the most important actors in implementing welfare service policies. While local municipalities supply education, social care services, and public assistance for citizens, county councils primarily provide medical and health care services for inhabitants. These local governments spend about 20 per cent of GDP and employ about 25 per cent of the total labour force (Statistiska Centralbyrån, 2009). Their activities are mainly funded by proportional local income tax, and service charges and state subsidies supplement those tax revenues.

Although the tax rates are slightly different across local governments, on average those rates currently amount to about 30 per cent of inhabitants' incomes – 20 per cent in local municipalities and 10 per cent in county councils (Ministry of Finance, 2005).

The autonomy of local governments has been considered to be one of the most important features of democracy in Sweden. The first article of the Instrument of Government (*Regeringsformen*)[6] says:

> All public power in Sweden proceeds from the people. Swedish democracy is founded on the free formation of opinion and on universal and equal suffrage. It shall be realized through a representative and parliamentary polity and through *local self-government*. Public power shall be exercised under the law. (cited in Bäck and Johansson, 2006, p. 10, italics by author)

In addition, the Instrument of Government also prescribes the right of local governments to levy local taxes. Since the principle of 'local self-government' is highly valued in Sweden's political discourse, local governments count on the Instrument of Government when facing the interference of the central government. Inter-governmental relations in Sweden appear to be characterized by a higher degree of decentralization in the constitution.

In reality, however, the degree of autonomy local governments have from the central government is debatable (Häggroth, Kronvall, Riberdahl, and Rudbeck, 1999, chapter 3). The constitution does not specify to what extent it grants autonomy to local governments and prohibits the state from intervening in local matters. Therefore, there has been no agreement on the substance of 'local self-government' among policy makers and even academia.[7]

Furthermore, the central government – the state – has appeared to exercise rather strong control and supervision over local governance during the development of the welfare state. One representative example is the municipal boundary reform between 1952 and 1974. As industrialization and urbanization advanced, rural municipalities were depopulated and then faced the serious lack of economic resources, even though the state expanded the role of local municipalities in social welfare services. In 1952 the central government enforced the first boundary reform, which aimed to create municipalities with more than 3,000 residents. The reform reduced the number of local municipalities from 2,500 to 1,037. However, because of continuing depopulation in rural areas, many small municipalities were still unable to provide acceptable

social services to their inhabitants. The Social Democratic government voted, against the non-socialist parties' opposition, to drop its voluntary merger policy and adopt a compulsory municipal boundary reform to be finished no later than 1974. As a result, the number of local municipalities fell to 278 in 1974 (Häggroth et al., 1999, pp. 11–14). Municipal boundary reform was a redistributive policy to some extent because the reform equalized differences in level of social service across local municipalities (cf. Strömberg and Westerståhl, 1984, p. 35). The Social Democratic government forced local governments to create a 'fiscally independent' and 'functionally autonomous' municipality in order to defend the principle of equality.

Aside from municipal boundary reform, there have been various policy instruments with which the state controls the local governments. First, the legislation approved by the Riksdag imposes many social services obligations on local governments. Although it is reported that the legislation has recently been changing into a framework law excluding detailed regulations, such as the Social Services Act and the Health and Medical Services Act, the laws still control the activities of local governments. This is because the administrative courts usually opt for more benevolent interpretations than do the municipalities (Bäck and Johansson, 2006, p. 13).

Second, state subsidies for specific local activities played an important role during the development of social welfare services. The state enticed local governments to spend public resources on targeted areas through earmarked grants. Although the presence of those earmarked grants has declined in recent decades, the central government still steers local governments through economic policies, such as the 'tax freeze' on local income tax and the fiscal redistributive scheme (Bäck and Johansson, 2006; Feltenius, 2007).

Third, the state agencies, such as the National Board of Health and Welfare (*Socialstyrelsen*), monitor the implementation of government policies in local government. They provide benchmarks and guidelines for local governments, and often report on the differences of social services across them.

Finally, political parties have also integrated centre–local governmental relations. It has been common for a politician to hold a national and a local office simultaneously in Sweden. For instance, the majority of MPs held local office at the same time in the 1960s (Bäck and Johansson, 2006, p. 25). While this central–local tie through politicians was an important channel that facilitates communication between central and local governments, it was also the state's instrument to carry through its

policy at the local level. Although the indirect election through county and city councils was abolished by constitutional reform, the simultaneous election of the local assemblies and the Riksdag was established in order to maintain the political tie between central and local assemblies.[8] The hierarchically organized political parties have integrated the potentially centrifugal inter-governmental relations in Sweden.

Summary

This section claims that while the closed-list PR system created a centralized party organization and then party-centred politics, fewer social cleavages produced programmatically homogeneous political parties and a rather simple party system in Sweden. It also argued that Sweden's peculiar bicameralism perpetuated the Social Democratic one-party dominance. The rule of catch-all mass party developed the encompassing style of interest coordination within the executive branch that facilitates rational deliberation and compromise through the royal commission and the remiss procedure. However, the reforms of the constitution and electoral rules ended the one-party dominance of the Social Democrats and transformed the inter-party competition into the two-bloc competition. These characteristics of the Swedish political system should have some imprint on its elderly care policy. We explore those influences in later sections.

4.2 Elderly care programs in Sweden

Sweden's elderly care system is characterized by its universalism. The Swedish government declares that the objective of its elderly care programs is to allow older persons 'to be able to lead active lives and to influence the conduct of social affairs and their own everyday conditions, to be able to grow old in security and with their independence preserved, to be met with respect and to have access to good health care services' (Socialstyrelsen, 2008, p. 4). To achieve the above mentioned goal, the government is obliged to provide social services for all people who need help in their daily life, regardless of age, ethnicity, gender, and income level, under the Social Services Act (1982). All older people should have equal access to quality services ensuring their independent life under the legislation.

The coverage and volume of Sweden's public elderly care services is impressive in the international standard. In 2005, while 8.6 per cent of the 65-year-old and over population and 27.5 per cent of the 85-year-old and over population received home help services in their regular

housing, 6.4 per cent of the 65-year-old and over population and 25.2 per cent of the 85-year-old and over population were accommodated in special housing. Transportation services covered 19.4 per cent of the entire aged population in 2004 (Swedish Association of Local Authorities and Regions, 2007, p. 21). Not just the coverage of social care services, but their volume is also extensive. While the majority of home-help users receive services less than 25 hours per month, about 20 per cent of recipients enjoy those services more than 50 hours per month (ibid., p. 30).

Public care programs for the aged are mostly financed by tax revenues. As mentioned above, the responsibilities for elderly care services are divided among three levels of government. The central government sets out policy goals and mandates in accordance with legislation and subsidies. A central government agency, such as the National Board of Health and Welfare (*Socialstyrelsen*), monitors the implementation of care programs at the local level. County councils (*landsting*) provide citizens with health and medical care. While county councils used to provide long-term care in geriatric wards and home nurse visits for inhabitants, those functions were transferred to local municipalities by Ädel reform in 1992 (see below). The Social Services Act (1982) stipulates that local municipalities (*kommun*) are legally obliged to fulfil the needs of the elderly for social care services and housing. These medical and social care services are mainly funded by local income taxes (about 82–85 per cent), and the central government's subsidies cover about 10 per cent of those costs. Users' out-of-pocket fees only pay a small part of costs (5–6 per cent) (Socialstyrelsen, 2008, pp. 4–5).

The provision of social care services is based on the assessment of care needs by local municipalities. Those who require help turn to their local municipality, and then a municipal care manager assesses and determines the need. The service level, eligibility criteria, and range of services provided are varied across local municipalities. Although the Social Services Act (1982) prescribes a legal right to claim help and care services, it says that citizens can claim the right 'if their needs cannot be met in any other way' but it does not specify the conditions of 'any other way'. Hence, considerable discretion is left to local municipalities (Socialstyrelsen, 2008, p. 5).

Overall, it is broader coverage and higher volume that characterize publicly funded elderly care programs in Sweden. However, those universal care services are not achieved overnight. Neither have they been constant in the course of development and retrenchment of the

Swedish welfare state. The following sections chronologically depict the development and transformation of public elderly care programs in Sweden and illuminate the political logic behind development and changes.

4.3 The development of elderly care in Sweden

From poor relief to universal care: 1900–1950

During the twentieth century, the Swedish elderly care system evolved from poor-relief programs to high-quality, universalistic programs. As Figure 4.1 suggests, Sweden was already in the phase of 'ageing society' at the turn of the twentieth century.[9] The Swedish population was rapidly ageing in the late nineteenth as a huge portion of the younger population emigrated to North America. When the older people left in the country needed to be taken care of, the local poor relief offered a last resort to them. Since Sweden had no legislation and public care programs specific for the elderly then, the poorhouse accommodated the poor frail elderly along with the chronically ill, the retarded, the mentally ill, single mothers with small children, vagrants, and so forth (Trydegård, 2000a, p. 575).

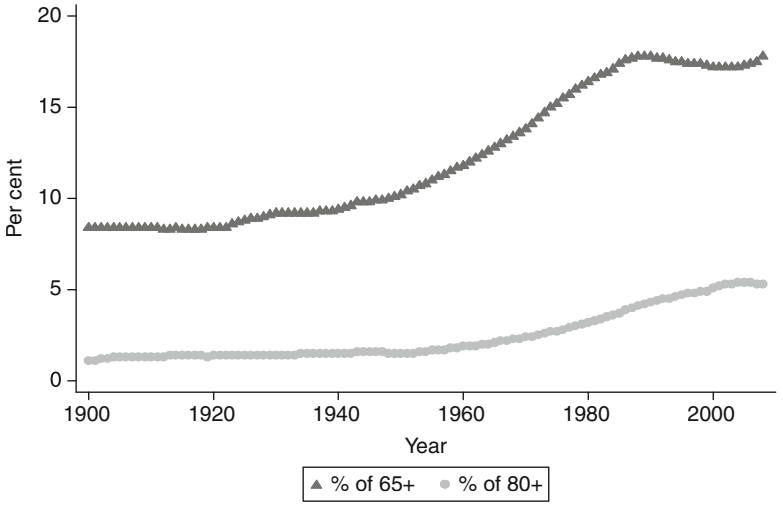

Figure 4.1 Demographic trend in Sweden, 1900–2008
Source: Statistics Sweden (2008).

In the early twentieth century, elderly care facilities began to be differentiated from poor houses. As more and more institutions were reserved for the elderly poor, the term 'old people's homes' (*ålderdomshem*) was becoming common around 1910. These old people's homes provided bed, board and care for the aged. When the public old-age pension was introduced in 1913, the pension scheme – although its benefit level was meagre – alleviated the burden of old people's homes to shelter the elderly poor and relieved the strain on local authorities for poor relief to some extent (Edebalk and Lindgren, 1994, pp. 136–137). Then, when in 1918 the Poor Law (*Fattigvårdslagen*) was revised, the new legislation obliged local municipalities to build old people's homes (Trydegård, 2000a, p. 578). Although these homes were still poor-relief based institutions, the number of beds accounted for about 5 per cent of the aged population (65 and over) in 1938. Furthermore, while the most clients of those old people's homes were without financial means, frail elders with financial resources began to apply for the homes by paying the full costs in the 1940s as their quality was improved (ibid., pp. 578–579).

The 'pensioners' home' (*pensionärshem*) was another important form of accommodation for the aged in the mid-twentieth century. Since the benefit levels of the public old-age pension were still low, many pensioners relied on poor relief to pay their rents. In addition, many aged people were dwelling in old-fashioned, poor-quality accommodation. To address these problems, large city municipalities began developing a board-and-lodging type of accommodation for the elderly in the 1930s. This policy intended to supply the old-aged people with better quality housing at lower rents. Following these urban cities' initiatives, the Riksdag decided to subsidize the 'pensioners' homes' in 1939 (Brodin, 2005, pp. 59–60; Edebalk and Lindgren, 1994, p. 137).

The Social Democratic government, which started to build the foundation of its long-term dominance, embarked on separating old people's homes from the poor relief scheme in the late 1930s. The Minister of Social Affairs (*Socialminister*), Gustav Möller, set up the Social Care Committee (*Socialvårdskommittén*) in 1937 and appointed parliamentarians, bureaucrats, and experts as its members in 1938 (SOU 1940:22, pp. 5–6). In essence, the committee claimed that social care policy should overcome out-dated characteristics developed under the Poor Law. In its reports, the Social Care Committee pointed out a number of deficiencies in the current elderly care institutions. For instance, as their remnants of workhouses and almshouses, old people's homes accommodated not just elderly people but also the mentally ill, the mentally retarded, and the chronically ill. This phenomenon was called 'the client mix'

(*klientelblandningen*) and problematized. The committee requested that the central and local governments build more psychiatric institutions and nursing care wards to separate their *de facto* health and mental care functions from old people's homes and reserve their facilities for old-aged people needing social care (SOU 1946:52, pp. 11–13). Furthermore, the Social Welfare Committee also suggested that the availability of old people's homes should be based not on their financial status, but their health and needs of care. This proposal intended to modernize social care policy in Sweden but it also reflected the fact that an increasing number of elderly were benefiting from the National Pension system and then accommodated in old people's homes by paying the full charge (ibid.). Overall, the royal commission, appointed by the Social Democratic government, proposed to universalize the availability of social care institutions for the aged.

Gustav Möller, in general, agreed with the Social Welfare Committee's proposals for old people's homes (Brodin, 2005, 62). As a result, the Riksdag adopted a guideline regarding the future development of elderly care institutions in 1947 (Proposition 1947:243). The guideline provided that old people's homes should be detached from the Poor Law and transformed into board-and-lodging facilities. The proposed old people's homes were supposed to be, regardless of economic means, open to all elderly people in need of care and provide them with the same standard of living as pensioners' homes. Ten per cent of the aged population was expected to live in the modern old people's homes. Although this new guideline demanded that 'the client mix' come to an end, it was hard to transform the old people's homes into modern accommodation for the aged because they had been *de facto* care facilities for the ill and the disabled at that time. Implementing this new guideline required the capacity of long-term somatic-care facilities to be expanded. Therefore, the government assigned a statutory responsibility for 'nursing homes' (*sjukhem*) to county councils in 1951 (Brodin, 2005, pp. 60–62; Edebalk and Lindgren, 1994, pp. 137–138). The Social Democratic government intended to limit the function of old people's homes to board and lodging and to expand the coverage beyond the poor elderly.

However, the goal of the guideline adopted by the Riksdag in 1947 was hardly perfected due to several reasons. First, although implementing the guideline required the massive construction of old people's homes, the overheating Swedish economy at that time did not allow local municipalities to increase the number of those homes rapidly. Second, as a result, the beds of old people's homes and nursing homes were not

enough to accommodate all older people in need of care. Third, an ideological change against old people's homes occurred among the public due to the campaign initiated by Ivar Lo-Johansson (see below). The Swedish elderly care policy began shifting to 'de-institutionalization' as early as the 1950s.

The dawn of home help

The 1950s saw an important change in Swedish elderly care programs: the development of home help services. It was Ivar Lo-Johansson who made elderly care a political issue. Lo-Johansson and the magazine *Pensionären,* published by Swedish Pensioner's Association (*Sveriges Pensionärsförbund*: SPF), started a media campaign against old people's homes in the late 1940s. Lo-Johhansson travelled around the entire country and explored life in old people's homes. He reported his experiences from the journey in books and newspaper articles and accused old people's homes of detaching the elderly from their familiar communities and degrading their human dignity. He also waged his campaign in radio broadcastings, an influential media tool at that time. Lo-Johansson's slogan, 'home nursing, instead of nursing home' (*hemvård i stället för vårdhem*), resonated with the public, and he succeeded in attracting much more attention to elderly care and creating sentiment among citizens against institutional care (Brodin, 2005, pp. 64–65; Edebalk and Lindgren, 1994, pp. 138–139; Trydegård, 2000a, pp. 582–583).

Under the shortage of institutional care facilities and the public sentiment against old people's homes, an important step was taken in Sweden's elderly care policy. The Red Cross in Uppsala started the first organized home help services for the elderly in 1950. The purpose was to delay the moment of elderly people moving into institutional care facilities. The Red Cross recruited middle-aged housewives, and those volunteers carried out domestic tasks, such as cleaning and cooking, with little recompense. Following the initiative by Uppsala, women's cooperatives began providing home help services for elderly people in Stockholm municipality in 1951. The practice of these local municipalities instantly gained currency among local governments and became widespread across the country. Furthermore, more and more local municipalities took over the task of service provision from voluntary organizations. As a result, home help services became available in 43 per cent of rural municipalities and 83 per cent of cities four years after the program was initiated in Uppsala (Edebalk, 1990, p. 17; Edebalk and Lindgren, 1994, p. 139; Trydegård, 2000a, pp. 582–583).

There are several reasons why home help services became common in Sweden in this period. First, those services turned out to be very popular among all social groups. Whereas old people's homes were still labelled as a poor relief scheme among the public, home help services were not. Not just working-class but also middle- and upper-class people supported home help services. Even the upper-income strata, who had been able to employ domestic workers before, were facing difficulties in finding those workers to take care of their relatives under the then-overheated labour market (Edebalk, 1990, p. 22).[10] Second, home help services alleviated the burden on old people's homes and nursing homes. As mentioned above, it was difficult for local governments to immediately expand the capacities of institutional care facilities under the post-war economic boom (Edebalk and Lindgren, 1994, p. 139). Third, home help services allowed local municipalities to utilize middle-age housewives as cheap labour that does not interfere with the 'regular' labour market. The local municipalities employed those housewives as, not full-time employees, but as hourly paid workers and had them engage in home-making activities for older people. Those workers were motivated to contribute to the society rather than to build a career, and their tasks were regarded as the extension of housewife's role. Home help services were convenient to local governments because they were able to recruit home helpers from the labour force reserve with low wages under the labour shortage (Brodin, 2005, p. 51; Szebehely, 1995, pp. 67–68).[11]

The state also endorsed the development of home help services. Under Lo-Johansson's media campaign against old people's homes, non-socialist opposition parties brought forth in the Riksdag several motions concerning elderly care, and some of them demanded other forms of support for older people and their relatives than institutional care. These social and political pressures urged the Social Democratic government to reconsider the guideline it adopted in 1947. Minister of Social Affairs Gustav Möller set up a new royal committee – Aged Care Committee (*Åldringsvårdsutredning*) – to review the entire public elderly care policy in 1952, publishing its report in 1956.[12] The report (SOU 1956:1) claimed that older people should be allowed to live in an ordinary living environment as long as possible, and home help services should be a crucial part of the Swedish elderly care system. The government proposition that passed the Riksdag in 1957 essentially confirmed the principles advocated by the Aged Care Committee. However, it did not assign to local municipalities any legal obligations nor state subsidies for home help services. The state was not ready to make a fiscal commitment to those services in this point (Brodin, 2005, pp. 65–71).

The expansion of public elderly care programs during the golden age of the welfare state: 1960s–70s

The 1960s and 1970s was a period of rapid expansion of elderly care services in general. While the Social Democratic government abolished state subsidies for the construction of old people's homes, it initiated the earmarked grants for home help services and the governmental loans for nursing homes. As a result, local municipalities widened home help services, and county councils enlarged the capacity of nursing homes. The volume and variety of elderly care services swelled during this period.

The Ministry of Social Affairs set up the Social Policy Committee (*Socialpolitiska kommittén*) to discuss the public responsibilities for the aged and the disabled in 1960. The committee argued that the state was required to play an active role in developing social care programs for older and disabled people. Industrialization attracted young workers to urban areas and left the aged in rural areas. Industrialization also allured more and more young women to the labour market. The depopulation of rural areas and the feminization of the labour force intensified the need for care outside a family, and these factors required society to step into the care provision. This argument justified that the state equalize the regional differences of quality and quantity of public care services across local governments because rural areas had more demands for elderly care but less resources to meet these demands. The committee recommended that the central government give the subsidies for home help services to local municipalities and the loans for the construction of nursing homes to county councils. The committee also suggested that the work of home help services be more professionalized in order to recruit younger women to those jobs (Brodin, 2005, pp. 75–77; SOU 1964:5).

The Riksdag confirmed most of the proposals by the Social Policy Committee in 1964 (Proposition 1964:85). First, as the committee recommended, the state loans for county councils were introduced to expand the number of beds in nursing homes. Second, the state's earmarked subsidies for home help services were established. The subsidies covered 35 per cent of personnel costs for those services. The main concern was the inequality of home help services across local municipalities, and the state subsidies were intended to solve regional imbalances. Third, the government expanded the state subsidies for improving the housing conditions of the aged and the handicapped. As home help services presupposed that elderly people were able to continue staying in their ordinary accommodations, the housing conditions needed to

be improved in order for those services to achieve their goals. Along with these policy measures, the proposition abolished state subsidies for building old people's homes (Brodin, 2005, pp. 77–78; Edebalk and Lindgren, 1994, pp. 139–140).

The Riksdag decision gave local governments strong incentives to allocate public resources to nursing homes and home help services. County councils and local municipalities were noticeably sensitive to the government subsidies. Since local municipalities stopped building old people's homes, the number of residents in old people's homes reached its peak in the mid-1970s and then began declining. Instead, as Figure 4.2 suggests, nursing homes managed by county councils rapidly expanded their capacity until the mid-1980s. Older people also had incentives to choose living at home with home help services or staying in nursing homes rather than residing in old people's homes. While living in old people's homes cost relatively higher board-and-lodging fees, those who lived in their own homes could enjoy government loans for their property, generous rent subsidies, and inexpensive home help services. Furthermore, staying in nursing homes was also cheaper for most pensioners than old people's homes because county councils charged them very low flat-rate fees, not as a board-and-lodging facility,

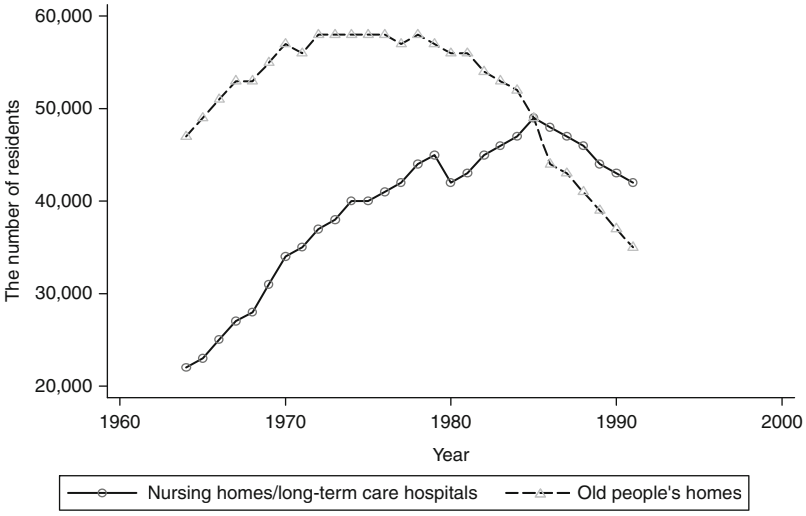

Figure 4.2 Nursing homes and old people's homes, number of residents
Source: Szebehely (1999, p. 52).

but as an in-patient treatment (Edebalk and Lindgren, 1994, p. 140; Szebehely, 1999). The Social Democratic state encouraged older people to stay in ordinary accommodations with home help services and to move to nursing homes after they became severely frail, and local governments followed this policy redirection faithfully.

The establishment of right and the decline of coverage: 1980s

In the 1980s the right to social care services for older people was established as an entitlement. In 1968, the Social Democratic government set up the Social Commission (*Socialutredningen*) to examine how to coordinate the statutory obligations of local municipalities to provide social care services for the elderly, children, alcoholics, drug addicts, and so forth. Although the administration shifted from the Social Democratic government to the non-socialist government composed of Liberal, Moderate, and Centre Party members during the deliberation process, the non-socialist coalition government proposed to the Riksdag the Social Services Act, which was based on the Social Commission's reports (Brodin, 2005, pp. 81–86).

The deliberation process of Social Services Act emphasized 'normalization' and 'autonomy'. To achieve these goals, local municipalities were supposed to facilitates older people to stay in communities through home help services. Furthermore, the government stressed the necessity to transform existing home help services into more professional social work. It argued that while existing home care had assisted common housework such as cleaning, cooking, and shopping, home help services should put more emphasis on rehabilitation (Brodin, 2005, p. 85).

The Social Services Act in 1982 obliged local governments to provide social care services for the aged. This legislation declared that 'the elderly have the right to receive public service and help at all stages of life', and '[a]ll who need help to support themselves in their day-to-day existence have the right to claim assistance if their needs cannot be met in any other way' (Socialstyrelsen, 2005). This law established the right to social care services and mandated local municipalities to offer those services to their inhabitants.

Paradoxically, while the statutory right to elderly care services was established, we can also see the *decline* of the coverage of home help services among older people during this period. The coverage rate reached its peak in the late 1970s, and it has been decreased since then (see Figure 4.3). It may be true that local governments – county councils and local municipalities – began to face the limitation of fiscal resources in this period. In a broader policy context, the post-war economic growth

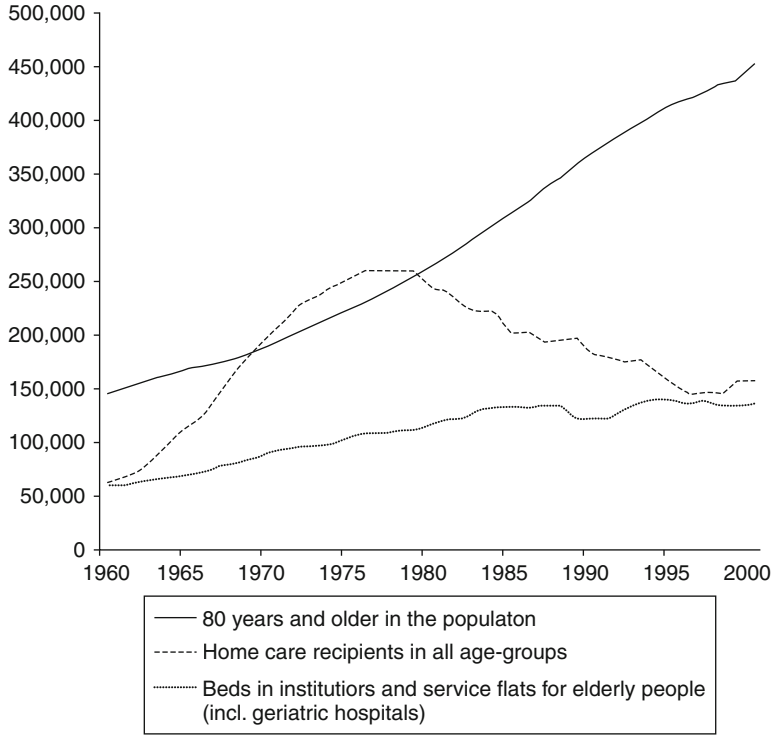

Figure 4.3 The number of recipients of elderly care services in Sweden, 1960–2000

Source: Szebehely (2005, p. 89).

was already ended, and the Swedish economy was confronting difficulties after the oil crises. As a result, the centre-right governments tried to restrain the increase of tax rates and curb public expenditures in order to restore the deteriorated balance of payments and the international competitiveness of Swedish industries (Greenwood, 1979, pp. 457–460). It led to that the non-socialist government agreed with local municipalities that they control the expansion of local public social services. The then Minister of Social Affairs, who was from the Liberal Party, announced that local municipalities were unable to rely on the financial supports from the State and should fulfil the goals of the Social Services Act through the reallocation of their fiscal resources (Brodin, 2005, p. 85). The era when local governments were able to expand public elderly care services without limitation was ended.

Another reason of the reduction of service coverage was that the nature of home help services started to be changed in this period. The home help services managed by local municipalities were not professionalized work in the 1950s and 1960s: middle-age housewives attended the house of older people once or twice a week and did some domestic tasks, such as cooking, cleaning, and shopping, with small remuneration. Since the labour market was tense due to the post-war economic growth, the state did not allow the policy adding further labour demands on the market. Those home help workers made up of middle-age women were cheap and had no danger to harm the labour market. However, the per-hour costs of home help personnel were rising during the late 1970s. Since much frailer older people were allowed to use home help services in order to keep staying in their ordinary livings, home helpers began providing more intense and physical care for those care recipients. This required home help workers to have professional skills and coordinate with home nursing services by county councils. To address diversified care needs, home care workers started to work as a team in this period. This also involved more administrative and coordination costs. In addition, as more and more women entered the paid employment, housewives as the reservoir of 'cheap labour' dried up (Edebalk and Lindgren, 1994, p. 141). These factors led to raising the per-unit costs of home help services, and then local municipalities targeted their resources on more severely disabled elders under the tightened budget constraints. As a result, whilst the number of home care recipients has been declined, the public resources devoted to elderly care services has been stable (see Figure 4.4).[13]

4.4 The transformation of elderly care system in Sweden I: Ädel reform

In 1992, the Swedish central government implemented the so-called 'Ädel reform' and reorganized public health care and elderly care services. This section assesses the magnitude of this reform, and illuminates how the state achieved this large-scale policy renovation in Sweden.

Ädel reform and its consequences

The Ädel reform (*Ädelreformen*) is the largest policy reform that has had considerable impacts on medical and social care for the aged in these decades in Sweden. The main factor behind this reform was that the division of responsibilities between health care by county councils and social care by local municipalities became vague, and it caused

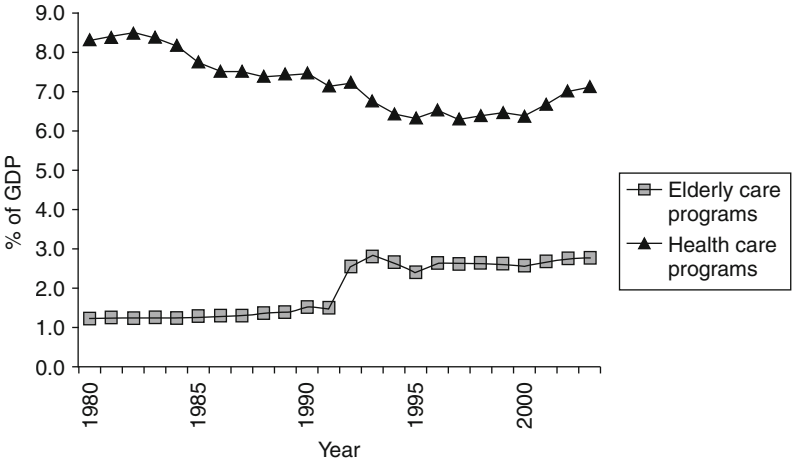

Figure 4.4 Public expenditures for elderly care and health care programs in Sweden, 1980–2003

Note: The definitional changes before and after the Ädel reform (1992) are not taken into account.

Source: OECD SOCX (2007c).

inefficiencies in elderly care programs. As home help services and home health services were developed in the 1970s and 1980s, more and more elders with extensive care needs continued to stay in their regular housings. As a result, municipal home helpers and county council assistant nurses began to perform similar functions in elderly care. However, the coordination between home help services and home nurse visits were not developed because of the boundaries between local municipalities and county councils. In addition, 'bed blockers' put a strain on the scarce resources of acute-care facilities, and exacerbated waiting time for in-patient care facilities. The 'bed blockers' are the older patients who have already finished their medical treatment but still stay in resource-intensive acute-care facilities because of the lack of availability to other forms of care. A large number of people with disabilities or dementia were living in long-term psychiatric or physical in-patient care wards before the Ädel reform was implemented (Ministry of Health and Social Affairs, 2007, p. 2).

The Ädel reform was intended to solve these problems. It reorganized the division of responsibilities between county councils and local municipalities. Under this reform, all responsibilities of health, medical and social care services for the aged, except the attendance by

physicians, were assigned to local municipalities. Home help services of local municipalities and home health care of county councils were put together as 'home care', and county councils' nursing homes (*sjukhem*) and long-term care hospitals (*långvård*) and local municipalities' old people's homes (*ålderdomshem*), service houses (*servicehus*), and group homes for dementia patients (*gruppboende för dementa*) were integrated under the label of 'special housing' in local municipalities. The Ädel reform also transferred 20,000 million SEK and 55,000 personnel from county councils to local municipalities.[14] Since the reform imposed on local municipalities the medical care costs of 'bed blockers' in hospitals, those budgetary resources were expected to alleviate the fiscal strains caused by the reform. Furthermore, the central government provided local municipalities with 3,000 million SEK in the form of incentive grants over a five-year period so that more special housing and group homes for dementia patients would be available to the elderly and disabled (Johansson, 1997, p. 136; Trydegård, 2003, p. 446).

The Ädel reform largely achieved its previously set goals. The National Board of Health and Welfare (Socialstyrelsen, 1996), which was assigned to evaluating the reform, reports that local municipalities' financial liability for 'bed blockers' reduced the number of them dramatically. As Table 4.4 shows, the absolute number and ratio of bed blockers was almost halved between 1991 and 1992.[15] As a result, the total number of beds in hospital care and geriatric care was reduced between 1992 and 1994 by 17 per cent and 30 per cent, respectively (Socialstyrelsen, 1996, p. 86). This downward trend caused by the Ädel reform continued throughout the 1990s. In 2004, for instance, among the 85-year-old and over population the average length of stay in hospitals was decreased from 10.7 days in 1994 to 7.9 days. Since the reform forced local municipalities to shoulder a greater part of geriatric care, county councils kept improving the efficiency of medical care sector after the reform: from 1994 to 2004, the number of in-patient care episodes was reduced by 10 per cent; the average length of stay in hospitals for all age groups also declined, from 7.0 days to 5.9 days, and the number of hospital

Table 4.4 Bed blockers in acute-care hospitals in Sweden, 1989–1992

	1989	**1990**	**1991**	**March 1992**	**Sept. 1992**
Total number of bed blockers	3964	3959	3512	1725	1491
% of bed blockers	15.4	15.0	13.9	7.0	6.6

Source: Styrborn and Thorslund (1993, p. 159).

beds further decreased by 25 per cent (Swedish Association of Local Authorities and Regions, 2007, p. 43). The Ädel reform had a tremendous impact on the entire medical care sector.

However, the Ädel reform presents not just a rosy picture but also some complications for health and social care programs. Since hospitals came to discharge older patients much earlier than before, more physically and cognitively impaired elders entered institutional and home-based care services in local municipalities. Due to the economic crisis and stagnated tax revenues, local municipalities were under severe budget constraints in the early 1990s, and therefore, they targeted their resources of social care services on the neediest elders. As Figure 4.3 suggests, while the number of beds in special housing was stable, the number of recipients of home help services continued dropping during the 1990s. According to Szebehely (1999, pp. 39–40), the total hours of home help services produced by local municipalities were stable between 1992 and 1997, but the number of care recipients declined by 25 per cent. These facts indicate that many older people with minor problems had been left without any help. In addition, although a 'bed blocker' is defined as the patient who has already finished medical treatment, it does not mean that bed blockers are healthy. In fact, one study shows that almost half of older patients who were listed as a 'bed blocker' died within 12 months after being so listed (Styrborn and Thorslund, 1993, p. 165). Through the Ädel reform, the state decided that older people are supposed to pass away in their communities, instead of hospitals.

How did the Swedish government carry through such large-scale policy reform? The reform interfered with a great deal of vested interests: county councils lost the bulk of their budgets and personnel; doctors gave up their commanding authority over home nursing care; district nurses and their aids had to change their employers; and local municipalities were forced to bear financial liability for bed blockers. It is unlikely that all of these stake holders were willing to change the status quo. The detailed political process of the Ädel reform is examined below.

The formation of policy idea: Elderly Care Committee

The debate over the division of labour and the boundary issues of responsibilities for elderly care services between local municipalities and county councils was already launched in the early 1980s. In 1980, the Ministry of Social Affairs set up the Elderly Care Committee (*Äldreberedningen*) to investigate the prioritization and coordination of community services for the aged. The purpose of this committee

was to examine how housing, social care services and health care services for the elderly should be organized so that older people live an independent and autonomous life. Sture Korpi, a state secretary of the Ministry of Social Affairs from the Social Democratic Party, served as a chairman, and six other ruling and opposition party politicians were official members of the committee. In addition, interest groups as well as some bureaucrats participated in the committee as an advisor (SOU 1987:21, p. 3).

Although the Elderly Care Committee published several reports, its final report (SOU 1987:21), 'Elderly care in progress' (*Äldreomsorg i utveckling*), set the agenda leading to the Ädel reform. The report brought up several issues in elderly care. It affirmed the necessity of a care-leave program to take care of relatives with terminal illness, demanded the improvement of living conditions in old people's homes, and proposed a new training system to integrate curriculums for social care and health care service staffs. The report also suggested that local municipalities take more responsibility for elderly care services, and that daycare and home medical care services therefore be transferred from county councils to local municipalities (Yamanoi, 1993, pp. 25–26). Although each party had its own agenda on elderly care,[16] political parties, by and large, agreed upon the necessity to reorganize the responsibilities for social care and primary care services for the aged between local municipalities and county councils.

Most interest groups, government organizations, and local governments appeared to support the idea of granting local municipalities more power over, and responsibility for, health and social care services for the aged. The Elderly Care Committee proposed that local municipalities be responsible for all social services and health care, including simple medical tasks, in ordinary living environments and special housing. Twenty-nine remiss answers expressed their opinions on social and health care services in ordinary living conditions, and 24 organizations supported the committee's proposal (Proposition 1987/88:176, pp. 39–40).

However, these stakeholders did not necessarily agree upon to what extent local municipalities should take over primary medical care. Out of 45 organizations that sent comments on the jurisdiction over elderly care programs, 26 backed the committee's proposal. They supported the idea that local municipalities take over the whole, or part of, primary care. For instance, the Swedish Association of Local Authority (*Svenska Kommunförbundet*), the peak association of local municipalities, maintained that it is better that local municipalities take the responsibilities

of the entire primary care system rather than of just part of home health care. It claimed that, otherwise, a new boundary dispute would be created between local municipalities and county councils. Örebro Commune also suggested, based on their experience, that local municipalities can bear the role of providing primary care. Furthermore, 14 organizations called for a more profound approach. For example, LO (*Landsorganisationen i Sverige*), the central organization of trade unions, argued that the entire care system for the aged should be brought together under a unified authority in the future, and preparation for the reform should be started immediately (Proposition 1987/88:176, p. 40). On the other hand, five organizations opposed the committee's proposal. Sundsvall Commune did not consider it urgent to reshape the responsibilities for health and social services, and stated that a clearer separation of responsibilities should be pursued instead. Norrbotten County Council also rebuffed the idea of unified care services by a local municipality (ibid, p. 40).

In May 1988, based on the Elderly Care Committee's report and its remiss answers, the Social Democratic government submitted to the Riksdag the proposition (Swedish Government, 1988), 'Elderly care on the eve of the 1990s' (*Om äldreomsorgen inför 90-talet*). The government bill prescribed that a more comprehensive elderly care system should be developed, and to achieve this goal local municipalities take care of home health care and nursing homes. To elaborate the responsibilities and the division of labour of elderly care services between local municipalities and county councils, the proposition stated that the government should establish a special committee and finish its deliberation within one year so that the new elderly care system be implemented in January 1991 (Swedish Government, 1988, pp. 1–2). In December 1988, the Riksdag approved the government proposition unanimously.

The coordination of interests: Ädel Committee

In November 1988, the Ministry of Social Affairs established a special committee to investigate the boundary issues on elderly care programs. It was called 'Ädel Committee' and composed of seven party politicians.[17] As Table 4.5 suggests, the composition of committee members balanced the power of their stakes. On the one hand, the member list reflected the partisan balance: while four members came from the then-ruling Social Democratic Party, the other three members were from opposition parties.[18] On the other hand, the member composition also ensured the equal weight of local municipalities and county councils.

Table 4.5 The list of members in Ädel Committee

Name	Post	Party Affiliation
Bengt Lindqvist	Vice Minister of Social Affairs	Social Democratic Party
Lars Eric Ericsson	Chairman of the Swedish Association of Local Authorities	Social Democratic Party
Anita Estberger	Opposition Councillor of County Councils	Moderate Party
Gunnar Hofring	Chairman of the Swedish Federation of County Councils	Social Democratic Party
Bo Könberg	Opposition Councillor of County Councils	Liberal Party
Gun-Britt Mårtensson	Councillor of Local Municipalities	Social Democratic Party
Ingrid Zetterström	Vice Chairman of the Swedish Association of Local Authorities	Center Party

Source: Ds 1989:27, p. 4.

In addition, the committee incorporated no experts and interest group representatives. In Sweden, while a royal commission usually consists of politicians, bureaucrats, experts, and interest group members appointed by ruling and opposition parties, the Ädel Committee's members were only party politicians. In the Swedish political system it is also rare for a minister to chair such a commission. These peculiarities indicate that the committee was the political venue in which the representatives of local governments negotiated with each other rather than investigate the issues.[19]

The Ädel Committee took longer to coordinate diverse and conflicting interests among stakeholders in the committee than the Ministry of Social Affairs initially expected. Bengt Lindqvist, Vice Minister of Social Affairs, intended to finish the deliberation of the Ädel Committee in February 1989, publish its report, and call for remiss answers in the spring, and submit a government proposition to the Riksdag in the autumn, so that a new elderly care system could be started in January 1991 (Kommunaktuellt, January 26, 1989, cited in Yamanoi, 1993, p. 49). However, the schedule was postponed: while the report of Ädel Committee was planned to be published in April 1989, the committee announced extending the schedule by one month (Kommunaktuellt, March 30, 1989, cited in Yamanoi, 1993, p. 52).

The reason why the schedule did not follow the plan of the committee's secretariat was that the participants did not agree upon where the boundary between elderly care and primary medical care should be demarcated. During the deliberation process in the Ädel Committee, the controversy over the administrative reform of elderly care was more intense between the representatives of local municipalities and those of county councils than along party lines.[20] For instance, Lars E. Ericsson, chairman of the Swedish Association of Local Authorities, who was from the Social Democratic Party, maintained that local municipalities should take all staff, including doctors and nurses, in social and health care services for the aged so that new boundary issues between primary medical care and elderly care would be avoided (Kommunaktuellt, January 26, 1989, cited in Yamanoi, 1993, p. 49). Since local municipalities were to take over home health care and nursing homes, they demanded to have all personnel involved in those services. On the other hand, Gunnar Hofring, chairman of the Swedish Federation of County Councils, who was also from the Social Democratic Party, claimed that while the administration of home health care and nursing homes should be transferred to local municipalities – and then care helpers and assistant nurses in county councils should be put together with home helpers in local municipalities – other medical staff should stay in county councils (Yamanoi, 1993, pp. 58–59). Whereas local municipalities wanted to annex the whole primary care system, county councils tried to minimize their loss.

The financial reallocation accompanying administrative reform was also the source of controversy between local municipalities and county councils. Under the new elderly care system, local municipalities would be obliged to pay for the care costs of patients in nursing homes and long-term somatic-care hospitals. It was estimated that 200,000 patients and 30,000 million SEK, which accounted for one third of county councils' entire budget, would be transferred from county councils to local municipalities. Whereas local municipalities demanded all budgets concerning these transfers, county councils expressed anxiety over them (Landstingsvärlden, No. 2, 1989, pp. 10–12, cited in Yamanoi, 1993, p. 59). According to Bengt Lindqvist, the fact that the reform would force county councils to give up the bulk of their financial resources was the main reason why the politicians of county councils opposed it.[21]

It was the executive board of the Social Democratic Party which settled the confrontation between local municipalities and county councils. Since Lars Ericsson and Gunnar Hofring were not able to reach

any agreement over the boundary issues, Ingvar Carlson, then prime minister, stepped into their controversy. He decided to what extent the functions of county councils' primary care and elderly care should be transferred to local municipalities.[22] In February 1989, the executive board of the Social Democratic Party determined its policy towards the Ädel reform. The resolution cleared up several disputes: local municipalities should take responsibilities for home health care and nursing homes; assistant nurses and care helpers in home health care and assistant nurses, care helpers, and nurses in nursing homes should be transferred from county councils to local municipalities; home health care in county councils and home help services in local municipalities should be integrated into 'home care' in the charge of local municipalities; local municipalities could employ other medical staff, except doctors, in home health care and nursing homes, or could buy those services from county councils; medical care involving doctors in home health care and nursing homes would stay in county councils; and local municipalities would be responsible for the payment for patients in long-term care hospitals and 'medically-ready-for-discharge' patients (a.k.a. 'bed blockers') in somatic acute-care and psychiatric hospitals. The party board also decided to implement the reform on January 1, 1992 (Landstingsvärlden, No. 4, 1989, p. 11, cited in Yamanoi, 1993, pp. 60–61). Although Gunnar Hofring issued a special statement opposing these decisions, the board of the Social Democratic Party finalized the skeleton of the Ädel reform.[23,24]

In May 1989, the Ädel Committee published its report, *Responsibility for Elderly Care* (*Ansvaret för äldreomsorgen*). The report (Ds 1989:27) essentially followed the outline determined by the executive board of the Social Democratic Party. The report proposed that local municipalities take care of nursing homes and home health care, and also take responsibility for medical tasks that do not involve doctors in ordinary living environments, special housing, and daycare services. However, the report left the affiliation of medical staffs in community care settings to local solutions: the report suggested that while local municipalities be able to employ medical care staffs, they also be able to purchase the services of rehabilitation staffs and nurses from county councils. The report also introduced the payment liability of local municipalities: to encourage local municipalities to develop alternative institutional care facilities (e.g., special housing), the government should oblige them to pay for the medical costs of patients in long-term geriatric care hospitals and for 'bed blockers' in psychiatric and acute-care hospitals (Ds 1989:27, pp. 14–21).

In remiss answers to the Ädel Committee's report, most organizations were supportive of the general idea that some kind of administrative reform for elderly care was necessary. However, government organizations, interest groups, trade unions, and local governments expressed diverging and conflicting opinions on specific issues. For instance, medical professionals' union – such as the Swedish Medical Association (*Sveriges läkarförbund*), the Swedish Society of Medicine (*Svenska läkaresällskapet*), and the Swedish Association of Registered Physiotherapists (*Legitimerade sjukgymnasters riksförbund*) – as well as the Swedish Federation of County Councils, were anxious about the transfer of certain health care functions to local municipalities (Proposition 1990/91:14, pp. 182–183). During the policy-making process of Ädel reform, according to Gunnar Hofring, physicians in geriatric hospitals, primary care, and nursing homes strongly opposed the reform (Yamanoi, 1993, p. 68). However, in general, those occupational interest groups did not exercise forceful influence on the outcomes of the reform.[25]

The decision-making process: the parliamentary debate

In October 1990, the government proposition, 'On responsibility for service and care for the elderly and the disabled, etc.' (*Om ansvaret för service och vård till äldre och handikappade m. m.*), was submitted to the Riksdag (Proposition 1990/91:14). When the government bill was proposed in the Riksdag, the Social Democratic government was a minority government (see Table 4.2), and therefore it needed to acquire support for the bill from opposition parties. However, all opposition parties were against the original bill (*Svenska Dagbladet*, October 25, 1990, cited in Yamanoi, 1993).

The government bill faced difficulties in the deliberations of the Social Committee. While the government bill would be discarded unless the Social Democratic government secured opposition parties' support for the bill by December 14, 1990, the opposition parties appeared determined to disapprove it. Whereas the Conservative Party was committed to decentralizing all primary care to local municipalities, the Centre Party was against the administrative reform of elderly care because it historically regarded the roles of county councils as important in providing health care services in rural areas.

The Social Democratic Party finally succeeded in attaining support for the bill from the Liberal Party three days before the deadline. The Liberal Party demanded several revisions of the bill. First, while the government bill proposed to oblige local municipalities to pay for the costs of patients only in long-term somatic-care hospitals, the Liberal

Party demanded the payment liability of local municipalities for 'medically ready-for-discharge patients' (a.k.a. 'bed blockers') in acute-care and psychiatric hospitals as well. Second, the Liberal Party also requested expanding the state subsidies for single rooms in special housing. Third, it also insisted that the government add to a state earmarked grant for group homes for dementia patients (Yamanoi, 1993, pp. 80–81). Daniel Tarschys, a Liberal Party MP and a chairman of the Social Committee in the Riksdag, negotiated with the Social Democratic Party, and both parties finally reached the agreement on the revisions of the government bill, since the Social Democratic Party accepted most requests of the Liberal Party.[26]

On December 13, 1990, the government proposition passed the Riksdag. Although the Social Democratic Party lost power in the general election in the autumn of 1991, the Ädel reform was enforced in January 1992 under the centre-right government.

The policy process of Ädel reform clarifies to what extent the state is autonomous from societal interests in Sweden. The centralized and disciplined political parties, underpinned by the party-vote oriented electoral system, allow the legislative branch to delegate its policy-making functions to the executive branch, and the latter forges a policy in the royal commission. Although the state incorporates divergent opinions through proportional representation inside the commission and the remiss system, it can generate 'rational' policy independent of societal interests because political power is concentrated on the party leaders, and they can control the rank-and-file members. In this case, the country council members of the Social Democratic Party and the Liberal Party followed the party decisions in the end despite their reservations against the Ädel reform. The minority factions are hardly able to impose their policy preferences on a finalized policy.

4.5 The transformation of elderly care system in Sweden II: privatization and decentralization

It was privatization and decentralization that characterized the course of elderly care development during the 1990s in Sweden. While for-profit organizations formerly were not allowed to provide social care services, many local municipalities now contract out, with public funding, elderly care services to private entities. In addition, the Ädel reform integrated geriatric health care and municipal social care services and liberalized the regulations on the out-of-pocket fees a local municipality charges upon service users, and then this deregulation

created inequality across different income strata and regional areas. Although political parties appear to have had a consensus on the privatization, the state has been swinging between the principle of equality and the principle of local self-government.

Privatization

The presence of private organizations has been growing in the provision of elderly care services since the early 1990s. The percentage of private sector employees in state-subsidized elderly care was expanded from 2.5 per cent in 1993 to 12.9 per cent in 2000 (see Figure 4.5). In elderly care, for-profit organizations are playing a bigger role in service provision than non-profit ones, and the four largest companies accounted for half of the contracted-out services in 1999 (Szebehely, 2005, p. 87; Trydegård, 2003, 453). The majority of local municipalities introduced a 'purchaser-provider model' and separated need assessment from care provision. Under this model, while public administration still monopolizes the assessment and qualification of care needs, public providers of home care and institutional care compete with private entities for the contracts from a relevant municipality. Furthermore, in Stockholm and its suburbs, care recipients are allowed to select a care provider from public care units and private entrepreneurs (Trydegård, 2003, pp. 453–454).

There have been no severe confrontations over the privatization of elderly care programs between the centre-right and the centre-left

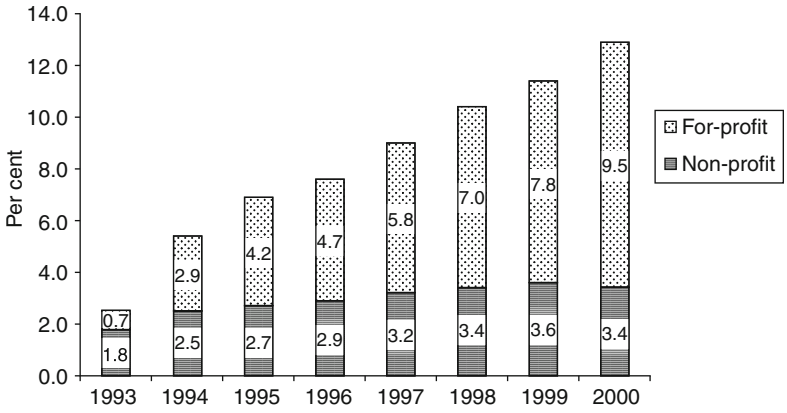

Figure 4.5 Personnel employed in the private sector of state-subsidized care for elderly people

Sources: Trydegård (2001, p. 116); Szebehely (2005, Figure 5.3).

political bloc. It was the Social Democratic minister of finance, Kjell-Olof Feldt, who vigorously advocated the public service sector reforms during the mid-1980s. He was concerned about the public sector's size and productivity, and led his ministry to promote the various types of 'quasi-market' solutions in social service provision. The Ministry of Finance and other experts also urged the 'free choice of service providers' by care recipients. In the late 1980s, it turned out that the Social Democratic government endorsed the quasi-markets as a method to reorganize social services (Blomqvist, 2004, pp. 144–145). Although the centre-right coalition government, which succeeded the Social Democratic minority government in 1991, liberalized the regulations over contract-out and private care provision, the Social Democrats prepared for the privatization of elderly care programs.[27] The privatization of elderly care services was probably a technocratic reaction to the contradiction between straining public resources and growing and diversifying care demands.

From decentralization to re-centralization?

The Swedish elderly care policy experienced several attempts at decentralization during the 1990s. First, as I depicted in the previous section, the Ädel reform decentralized the administrative authority of geriatric health care policy from county councils to local municipalities. Local municipalities now have considerable discretion over the integrated elderly health and social care policies. Second, the centre-right government liberalized legislative regulations on the user fees for elderly care services. For instance, while the state legislation had stipulated that a certain minimum guaranteed sum should be left for the user's pocket after a local municipality charges user fees for residents in institutional care facilities, the government abolished those regulations when county councils' nursing homes and other institutions were merged with local municipalities' care institutions (Feltenius, 2007, p. 464). Third, many earmarked grants were replaced with block grants. In 1993, the state abolished most of the earmarked grants (*specialdestinerade bidragen*) in favour of general block grants. While earmarked grants were criticized as inflexible and maladapted to each local condition, in line with new Local Municipal Act in 1992, block grants were considered to encourage local governments to use public resources more efficiently (Bergmark, 2001, pp. 32–33).

The greater discretion of local municipalities led to greater inequality across local governments. Under the severe economic crisis and stringent budget constraints in the early 1990s, many local municipalities raised

user fees of elderly care programs. Although the revenue from those user fees paid off small percentage of the entire care costs, those municipalities intended to dampen the care demands of people with modest needs for help (Szebehely, 2005, p. 91). As a result, the disparity of user fees became large across local municipalities. For example, according to research by the National Board of Health and Welfare (*Socialstyrelsen*) in 1996, the difference of users' out-of-pocket fees between minimal and maximal municipalities could be 3,200 SEK per month among people with the monthly income of 16,000 SEK and the usage of 35-hour home help service per month (Feltenius, 2007, p. 464). In addition, the local variation of care costs, coverage, and accessibility also kept growing during the 1990s. For instance, home help services for the most elderly (+80) showed a huge difference across local municipalities: in 1997, while the minimal municipality covered only 5 per cent, the maximal one covered 52 per cent (Trydegård, 2000b, Article 3, p. 14).

In the late 1990s, the central government seemed to slightly shift its policy emphasis from the principle of local self-government to the principle of equality. In 1996, the government reformed the revenue equalization system among local governments. The new tax equalization system guaranteed that all municipalities and county councils have, respectively, 115 and 110 per cent of the average tax base per resident. While local governments below the average level receive state grants, those above the average level contribute to the scheme. The new system limited the possibility of the municipalities with higher taxing capacity to levy lower tax rates on their inhabitants (Bergmark, 2006, pp. 18–19). In addition, the central government initiated a new type of targeted grants in 1997. Those grants were calculated based on the number of children, adolescents and elders. Although the grants were not combined to certain detailed regulations as before, they were aimed to help those municipalities with more demands to fulfil their needs in health care, education, and social care (Bergmark, 2001, pp. 32–35). Finally, in 2002 the Social Democratic government introduced a new regulation limiting the disparity of elderly care fees across local municipalities (see below).

Maximum fee reform

The Ädel reform triggered controversy about the user fees of elderly care services. The reform transferred nursing homes and home health care from county councils to local municipalities. Since the charging scheme was different between these two types of local governments, the reform created an imbalance on user's fees. That is, while county

councils charged care recipients flat-rate fees as medical care services, local municipalities imposed progressive fees on the residents of institutional care facilities.[28] The Social Democratic government recognized as a problem the discrepancy of charging systems between local governments, and then set up the Ädel Fee Commission (*Ädelavgiftsutredningen*) to form a new policy on the user fees of elderly care (Feltenius, 2005, pp. 207–209, 2008, p. 39).

The Ädel Fee Commission advocated the deregulation of the charging system in elderly care. The commission proposed to abolish state regulations on user fees and allow local municipalities to determine their own fee structure, which was expected to be income-differentiated. Deregulation was justified on the grounds that local municipalities were already free to choose their fee system in home help services. However, the commission also recommended that the state set up a new regulation on a 'guaranteed sum'. The guaranteed sum meant the minimum amount of money that local municipalities leave in a user's pocket after charging him or her service fees. Since the current care recipients with relatively high income in county councils would face the hike of user fees after the reform, the guaranteed sum was intended to mitigate the effects of excessive surcharge by local municipalities (Feltenius, 2005, p. 210).

However, the centre-right coalition, which defeated the Social Democratic government in the general election of May 1991, ignored the commission's recommendation on the guaranteed sum. The bourgeois government gave priority to the principle of local self-government and completely deregulated the charging system of municipal elderly care services. Although the proposed legislation prescribed that user fees should not exceed the amount depleting the sufficient reserves for personal needs, the amount of 'sufficient reserves' was left to the discretion of each local municipality (Feltenius, 2005, pp. 211–213).

The liberalization of charging systems in elderly care programs, as mentioned above, resulted in the increase of variation of user's fees across municipalities. Pensioners' organizations were fiercely critical of this deregulation. The pensioners' organizations brought up the user's fee issues in the Pensioner's Council[29] and meetings with the prime minister. The pensioners' organizations demanded several 're-regulations' on user fees in elderly care. First, they argued that the state legislation should regulate the amount of a guaranteed sum. Second, they insisted that the national legislation should also regulate maximum fees for elderly care services.[30]

Responding to the demands from the pensioners' organizations, the Social Democratic government, which returned to the administration

in 1994, set up the BOA Commission (*BOende- och Avgiftsutredningen*) in 1997. The representatives of pensioners' organizations as well as those of local governments participated in the BOA Commission, and its report suggested that the state should introduce a national benchmark of a guarantee sum and a statutory mandated maximum sum of user fees for elderly care services (SOU 1999:33). Although the pensioners' organizations essentially endorsed the commission's proposal, they still maintained that the legislation should regulate the amount of guaranteed sum because local municipalities could easily ignore the national benchmarking. On the other hand, the Swedish Association of Local Authorities strongly opposed both the national benchmarking and the statutory maximum fees. The association claimed that the national benchmark ignores the fact that local municipalities are considerably diverse while the introduction of the legally binding maximum fees violates the principle of local self-government (Feltenius, 2005, pp. 217–219, 2008, p. 39).

The government proposal that came out one year after the commission's report advocated the introduction of the guaranteed sum and the maximum fees, but it proposed them as 'recommendations' for local governments. The Ministry of Social Affairs conceded to the principle of local self-government. Since those recommendations imposed no statutory obligation on local municipalities, the report elicited severe criticism from pensioners' organizations.

Pressed by those grey interests, the Social Democratic government submitted a government bill that regulates the guaranteed sum and the maximum sum for home and institutional care services for the aged and the disabled. The bill proposed 1,476 SEK for home care services and 1,537 SEK for institutional care services as the legally binding maximum fees (Proposition 2000/01:149, 2001). Although the Social Democratic government was unable to attain the majority support for the bill at first, the bill eventually passed the Riksdag since the Green Party turned into its supporter due to pressure from the pensioners' groups (Feltenius, 2005, pp. 224–229).

Although the influence of pensioners' organizations mask partisan effects in the policy-making process of maximum fee reform, it turned out that the Social Democratic government prioritized the principle of equality over the principle of local self-government. In an interview with *Svenska Dagbladet* in March 2001, the Social Democratic prime minister, Göran Persson, articulated his party's stance in the following way:

> In the choice between municipal self-rule and an equivalent system of education, I choose an equivalent school-system. In the choice

> between municipal self-rule and an equivalent system of care for the elderly, I choose an equivalent system of care for the elderly. It's a principle of people's rights to be treated equivalent regardless of where they live in our country, regardless of the political majority within the municipality. (cited in Feltenius, 2007, p. 467)

Although the Social Democratic Party values both the autonomy of local governments and the egalitarianism of social services, it would choose the latter when forced to do so. On the other hand, bourgeois parties appeared by and large to honour the principle of local self-government. During the recent decades, as the government composition swung between the centre-left and centre-right bloc, the government policy on elderly care also oscillated between the principle of local self-government and the principle of equality.

4.6 Conclusion

This chapter argues that the relatively autonomous state supported by Social Democratic one-party dominance achieved universalistic social care services for the aged through steering local governments. When it came to the administration in the 1930s, the Social Democratic government tried to universalize old people's homes. And, once it turned out that home help services were popular among the public in the 1950s, the Social Democratic state redirected its policy emphasis to those services with state subsidies for local governments in the 1960s. The opposition parties also demanded the expansion of home help services when they realized that those services were popular. The political parties competed with each other to appeal to homogenous constituencies with universalistic social services, and the state materialized their policy goals through insulating policy-making process from societal interests with a series of royal commissions. The ruling elites – party politicians, civil servants, and representatives of the peak associations of occupational groups – gathered in the royal commissions and forged elderly care policy.

This chapter also claims that the centralized political parties underpinned by the party-vote oriented electoral system allowed the state to reform existing social and health care programs for the aged. The policy process of Ädel reform illustrated that the state was, regardless of the opposition from county councils and occupational groups, capable of transforming existing boundaries of elderly care services and transferring enormous fiscal resources and personnel from county councils to local municipalities. Since the party leadership can discipline its rank-

and-file members, the state is able to carry through large-scale reform. Although the state always tries to incorporate diversified societal interests and make a compromise, the minority has no actual instrument to block a new policy.

Finally, as Sweden's inter-party competition shifted from one-party dominance to two-bloc competition, the state's policy on elderly care has been swinging between the principle of local self-government and the principle of equality. While there has been a consensus on privatization among centre-left and centre-right parties, the increasing inequality across local municipalities triggered different partisan responses. The policy process of maximum fee reform demonstrated that while the bourgeois parties were inclined to appreciate the local self-government, the Social Democratic Party tended to esteem equality. As a result, government policy has come to be oscillating in parallel with the government partisanship.

5
Japan: 'MHW and the Japanese Miracle', in a Sense

The adoption of the public long-term care insurance (LTCI) system in 2000 changed the landscape of elderly care in Japan. Frail older people and their family members had fewer public supports for their care efforts before it was implemented. Most public elderly care programs were means-tested, and middle-class households experienced hardships in taking care of their frail parents (or grandparents) by themselves. Many middle-class citizens chose to put their relatives requiring constant care into hospitals for non-medical reasons.[1] The implementation of the Public Long-Term Care Insurance (LTCI) Law in 2000, as described in Section 5.2, changed the funding system of elderly care services. Long-term care insurance requires all citizens above 40 years of age to contribute insurance premiums to the social insurance scheme and allows all elders over 65 to use care services with subsidies from the scheme, depending on their level of dependency. This policy reform has *universalized* the usage of social care services among older people and significantly expanded the provision of elderly care services since it was implemented.

If the theory developed in Chapter 2 is correct, Japan *would not have* established a large-scale social insurance system and universalized the usage of formal social care services. Although Japan has no conspicuous social cleavages along religious, linguistic, and ethnic lines,[2] its previous electoral system – multi-member district (MMD) with a single non-transferable vote (SNTV) system – forced the members of the ruling Liberal Democratic Party (LDP) to pursue the personal vote over the party vote and made Japan's political system clientelistic. As a result, the LDP's one-party dominance prioritized the policy measures of particularistic benefits, such as industrial regulations and tax breaks for a specific industry, public work projects, and occupationally fragmented social

insurance (cf. Estévez-Abe, 2008). Universalistic social care programs are less likely to take place under such particularistic politics.

How can we understand the establishment of LTCI under clientelistic politics? This chapter points out that the development of Japan's public elderly care programs was achieved when the influences of particularistic politicians from the LDP retreated from the policy-making process of social welfare programs, and the state – the state bureaucracy in Japan's context – was able to manoeuvre elderly care policy. While it is widely known that the economic bureaucrats of the Ministry of International Trade and Industry (MITI) retained their relative autonomy from societal interests and managed the post-war economic growth in Japan (cf. Johnson, 1982), the welfare bureaucrats of the Ministry of Health and Welfare (MHW) had been embedded in societal interests connected to LDP politicians during the post-war period. Some LDP politicians specialized in social policy and exchanged their expertise and influences in welfare policy with financial and electoral support from welfare producer groups (e.g., Japan Medical Association: JMA). Although it has been welfare bureaucrats who actually managed the entire policy-making process and drafted legislation, Japan's social welfare policy has been dominated by particularistic benefits and fragmented occupation-based social insurance schemes reflecting the policy preferences of LDP politicians (cf. Estévez-Abe, 2008). Japan's bureaucracy has been extremely active but remarkably weak. Public long-term care insurance is an exceptional case in Japan's particularistic welfare politics.

This exception was caused by the crisis of the LDP's one-party dominance. The LDP was defeated in the Upper House election of 1989 because of the introduction of a consumption tax, and its devastating defeat and resulting minority status in the Upper House raised the policy influences of opposition parties – in this case the Clean Government Party and the Democratic Socialist Party (DSP) – supported by urban constituencies. These opposition parties put elderly care on the governmental agenda for the first time. Furthermore, the formation of the Hosokawa non-LDP administration and the LDP-*Sakigake*-Japan Socialist Party (JSP) administration also worked to loosen the constraints of societal interests relating to LDP politicians on welfare policy making. However, in Japan's centralized parliamentary system non-LDP parties had no capacity to materialize their policy agenda by themselves. Welfare bureaucrats actually moulded the long-term care insurance system. In the recent development of elderly care programs, the welfare bureaucrats took advantage of the window of opportunity opened by non-LDP

parties in order to streamline and modernize existing health care and social welfare programs.

However, it should be noted that the potential of welfare bureaucrats to impose universalistic social policy on the nation was still restricted by interest groups related to LDP politicians, even in the case of LTCI law. When we examine in detail the new system of long-term care for older people, we find on it many imprints of patronage-based politics. For instance, 'social hospitalization' – hospitalization of senior citizens for non-medical reasons – was retained even under the new system to secure the operation of small and medium-sized hospitals, even though extinguishing social hospitalization is one of the main reasons for introducing a new social insurance. Part of the financial resources for social hospitalization shifted from health care insurance towards long-term care insurance, but hundreds of thousands of elderly are still taken care of in hospitals for non-medical reasons. Another example is that the legal entities providing institutional care services for the frail elderly remain fragmented because each group of these institutions was an important stakeholder.[3] While the functions of those facilities are not necessarily differentiated, political reasons preserved the differentiation of institutional care facilities under different regulations. Furthermore, even under the new system private corporations are restricted to supplying only community care services for the aged. As is clear in these examples, the LTCI bill was a pack of compromises, and these compromises reflect the restraints of societal interests on the state in Japan's welfare politics.

This chapter describes Japan's bureaucracy-led policy process by following its history in elderly care policy and politics. This history illuminates how the centralized constitutional structure endows bureaucrats with the managing role of the entire policy process. First, this chapter looks at the key elements of constitutional, electoral, and intra-party institutions in Japan. Second, it describes the changes of public programs for frail older people before and after the LTCI bill was implemented in 2000. Third, it details the development and changes of elderly care policy in Japan.

5.1 The characteristics of the constitution, the electoral system, and party organizations in Japan

Japanese policy-making process is characterized by the political power highly concentrated on the cabinet by the constitution and the exceedingly decentralized power shared in practice among political

actors. Japan's constitution stipulates 'The Diet shall be the highest organ of the state power' (Article 41), and 'The prime minister shall be designated from among the members of the Diet' (Article 67). It provides that the cabinet must resign en masse or dissolve the House of Representatives (the Lower House) for a new election if this house passes a no-confidence resolution (Article 67), and the prime minister can dissolve the Lower House (Article 7). Although Japan's polity has a symmetrical bicameralism, except for over budget bills and the selection of the prime minister, these articles of the constitution unify the legislative and executive branches, and then make Japan's polity a typical example of a Westminster-style parliamentary system. The will of the cabinet always agrees with that of the Diet, and the prime minister enjoys unconstrained political power as long as the majority of the Diet supports him de jure.[4]

Japanese political institutions, however, did not afford the prime minister such a supreme administrative power *in practice*, at least not until the Koizumi administration in the 2000s. First, Japan's electoral system has undermined the political foundation of the prime minister as a party leader. The single non-transferable vote (SNTV) with multi-member district (MMD) system – Japan's electoral system of the Lower House before its reform in 1994 – required the ruling party (i.e., Liberal Democratic Party) to field several candidates in one district in order to obtain the majority in the Lower House. This system forced LDP politicians to compete with each other in the same district, and then prevented them from running a campaign under their party platform. Their electoral campaign highly depended, not on party label, but their personalized machines, and it made LDP politicians vulnerable to interest groups. There was no room for the president of the LDP to exercise its leadership under the SNTV-MMD system.

Second, the structure of the Diet has also impeded the concentration of executive power. The Diet law stipulates that a bill is required to pass a particular committee before it is sent to the floor (R. Ohyama, 2003, chapter 3).[5] Under its one-party dominance from 1955 until 1993, the LDP developed an intra-party system parallel to the committee system of the Diet. LDP politicians belong to several divisions of the LDP Policy Affairs Research Council (PARC), which corresponds to the Diet committees, and they build their career through these committees and divisions (Epstein, Brady, Kawato, and O'Halloran, 1997). LDP politicians can easily stop a policy proposal against their interests as long as they can control the majority of each division of the PARC. Although the bill approved by ruling parties is supposed to be rubber-stamped in

the Diet, the decentralized decision-making process endows LDP politicians residing in the PARC with veto power.

Third, a patterned policy-making process within the bureaucracy also strips the cabinet of the ability to make a top-down decisions. As is common in parliamentary systems, in Japan the Diet delegates its policy-making capacity to the cabinet and its ministries. Since the bureaucracy needs approval by governing parties of its policy proposal in order to enact it in the Diet, each ministry incorporates the interest groups connected to ruling parties into its deliberation process. Each ministry holds many types of deliberative councils according to its policy fields, and brings together in them the representatives of special-interest groups. The government bureaucracy negotiates with those interest groups inside and outside a deliberative council. Since formal and informal rules require a policy proposal to be submitted to and be accepted by those councils, the policy-making process within a ministry is extremely consensus-based.

These institutional characteristics decentralizing political power make Japan's political system look like 'consensus democracy' (Lijphart, 1999).[6] It is true that in the 1990s the policy proposal of public long-term care insurance was enacted under the tripartite coalition government among the LDP, the Japan Socialist Party (JSP) and *Sakigake* after the LDP's one-party dominance collapsed and a new electoral system was adopted in 1994. Nevertheless, the fundamental features of the policy-making process developed under post-war economic growth were still effective then. This section explains and exemplifies how Japan's previous electoral rules structured its policy-making and decision-making process.

Asymmetrical effects of the SNTV-MMD system

Japan's peculiar electoral rules have had significant effects on policy-making process and public policy itself. Especially, single non-transferable vote (SNTV) with the multi-member district (MMD) system – adopted for the Lower House in 1947 and replaced in 1994 – not only kept one-party dominance by the LDP for 38 years but also created factions within the LDP and made its rule look like a coalition government among those factions (cf. Ramseyer and Rosenbluth, 1993). Furthermore, this electoral system generated incentives for LDP politicians to concentrate their activities on specific policy areas and make connection with the bureaucracy to bring pork barrel projects to their constituents (McCubbins and Rosenbluth, 1995; Tatebayashi, 2004). However, since opposition parties had no support base large enough to

win multiple seats in one district, those opposition parties were centralized compared to the LDP, and the rank-and-file members of those parties waged their electoral campaigns under the party platform. In sum, the SNTV-MMD system created the form of party competition whereby the ruling party engages in the clientelistic competition, but the opposition parties do the programmatic competition.

The two houses of the Diet have different electoral systems. Until 1993, the members of the House of Representatives (Lower House) were elected by the SNTV-MMD system, and since 1996 have been elected by a combination of the single-member district (SMD) system and the proportional representation (PR) system. On the other hand, since 1983 the members of the House of Councillors (Upper House) have been elected by a combination of the multi-member district system and the proportional representation system (see Table 5.1).

The SNTV-MMD system was the core of Japan's political system because the Lower House is superior to the Upper House according to its constitution, and the MPs of the Lower House dominated the central position in the ruling party (i.e., LDP) and the cabinet. However, it should be added that the electoral system of the Upper House brought

Table 5.1 Japanese electoral systems

Law	Name of electoral system	District magnitude	Mean	Electoral formula	Number of ballots
The House of Representatives (Lower House)					
1947	Multi-member district system	Typically 3 to 5 (1, 2, 6)	3.98	SNTV	1
1994	SMD-PR dual system	1 (SMD); 7 to 33 (PR)	1; 18.18	Plurality; d'Hondt	2 (each for SMD and PR)
The House of Councillors (Upper House)					
1947	Multi-member district system	1 to 4 (Prefecture); 50 (National)	1.63; 50	SNTV	2 (each for prefectural district and national district)
1983	MMD-PR dual system	1 to 4 (MMD); 50 (PR)	1.62; 50	SNTV; d'Hondt	2 (each for MMD and closed-list PR)
2000	MMD-PR dual system	1 to 4 (MMD); 48 (PR)	1.55; 48	SNTV; d'Hondt	2 (each for MMD and open-list PR)

Sources: Kawato (2002, 179); House of Councillors (n.d.).

dynamism into Japanese politics since its multi-member-district aspect is dominated by single-member districts.[7]

The SNTV-MMD system is the electoral system with a district magnitude – the number of seats in a district – of, typically, three to five, where votes are not transferable to the candidates of the same party even if a voter's first choice already passed the post. Voters cast a single vote for candidates regardless of the district magnitude; for instance, in a district to which four seats are assigned, the top four candidates are selected as an MP (Kawato, 2002, p. 178). This electoral system creates several coordination problems for political parties (Cox, 1997, pp. 240–250). First, the political parties have to determine how many candidates they should field in each district. While a large party in a district with four seats may wonder whether it should ambitiously field three candidates or conservatively two, a small party may consider whether it should run a candidate there or support another party's candidate by withdrawing its own from the district. Second, a political party (or an alliance of parties) needs to divide their votes among their candidates optimally if they run more than one candidate in a district. Even if a party or an alliance has a support base large enough to elect two candidates in a four-seat district, it cannot win two seats when one candidate dominates the entire base.

Figure 5.1 clarifies the problems that political parties face under SNTV. In this example, the district magnitude is four, and there are four political parties (Parties A, B, C, and D). Let us assume that Party A can expect to receive 55 per cent of constituency support in an election, Party B can win 10 per cent, Party C can win 10 per cent, and Party D can win 25 per cent. Under this circumstance, political parties need to decide how many candidates they should field in this electoral district. For Party A, fielding three candidates appears to be an optimal strategy. While Party A can win three out of four seats in Situation J, where other parties do not create an alliance, it still can win two seats in Situation K, where Parties B and C make an electoral alliance. However, fielding an optimum number of candidates is always problematical for Party A because it cannot be absolutely certain of its support base ex ante. It might turn out that, if Party A fields three candidates and is supported by less than 30 per cent of the constituency it therefore will win only one seat in the election. Another problem is that Party A is required to divide its vote among three candidates more or less equally in order to get three out of four seats even under the most favourable situation. When one candidate is so popular that she/he collects all the votes of Party A, the party then underperforms in spite of its support base.

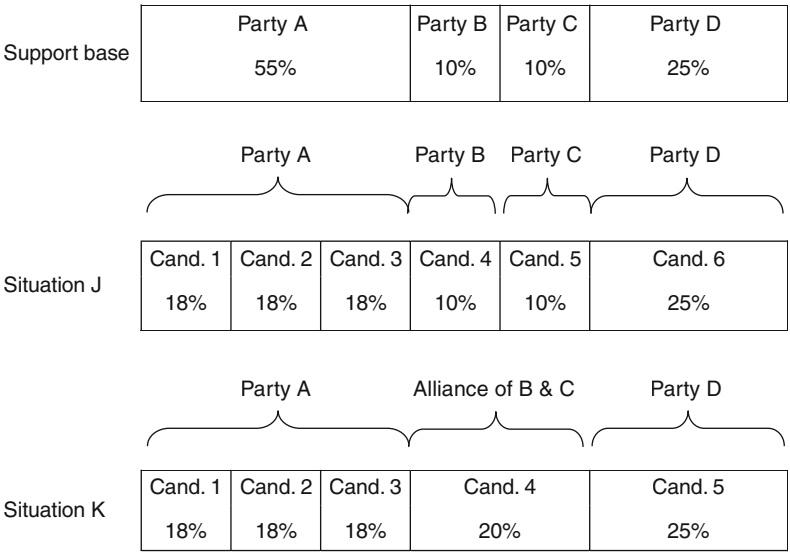

Figure 5.1 Coordination problems under SNTV in a four-seat district
Source: The author.

The LDP developed its practice of political patronage as the solution to the coordination problems the SNTV-MMD system generates. The SNTV-MMD system required LDP politicians to divide the vote of constituency so that each LDP politician can secure his/her seat in an election. The *vertical* and *horizontal* ways of vote division are a possible solution (Tatebayashi, 2004). The vertical vote division refers to the practice of politicians separating their electoral districts into several geographic areas – turfs (*Jiban*) – and nurturing the network of their personalized support groups in each turf. By focusing on his or her own turf, each LDP politician can secure the vote enough to win the seat unless other candidates poach upon that turf. In order to maintain the political machine on their turf, LDP politicians needed to bring benefits to their turf rather than to their district, not to mention general interests. Particularistic constituency services, such as public work projects, were the best strategy for vertical vote division because it was easier for LDP politicians to claim their credits for those services in their own turf than for generic public policy (Tatebayashi, 2004).

On the other hand, the horizontal vote division denotes that politicians carve out different policy niches for themselves. If LDP politicians

divide the vote of their constituency along occupational lines, each politician can secure the vote enough to win his/her seat in the electoral district. For instance, it was common practice under the SNTV-MMD system that one LDP politician honed his/her expertise in the farming industry while a colleague in the same district specialized in small business. LDP politicians competed with each other for their policy knowledge and their influence on the bureaucracy in a specific division of PARC because under the horizontal vote division the political influence on a particular ministry led to electoral leverage (Tatebayashi, 2004).

In either vertical or horizontal vote division, the electoral campaign based on party platform and generic policies was a less successful strategy for individual LDP politicians under the SNTV-MMD system. Dividing the vote through pork barrel projects or expertise in a specific policy field was the dominant strategy for LDP politicians. This situation generated by the electoral system enabled LDP politicians to divide the vote successfully, whereas opposition parties were unable to field a candidate in a coordinated way. It ensured the one-party dominance by LDP.

On the other hand, opposition parties developed a different strategy under the SNTV-MMD system during the one-party dominance of LDP. As exemplified above, the SNTV-MMD system requires a relatively big party to carefully calculate how many candidates it should field in each district. For the party's candidates go down together when it fields too many in one district, while the party as a whole underperforms when it fields too few. It is not impossible, but difficult, for an opposition party to attain multiple seats in an electoral district because the opposition party cannot use public policy as an instrument to cultivate and divide the vote. In fact, although the Japan Socialist Party (JSP), the largest opposition party, secured multiple seats in some districts (cf. Kohno, 1997), other opposition parties – the Democratic Socialist Party (DSP), the Clean Government (*Komei*) Party and the Japan Communist Party (JCP) – rarely fielded multiple candidates in one district.

Since the practice that the rank-and-file members compete with each other in the same district created patronage-based politics in LDP, opposition parties were free from clientelism. They had no 'pork' to be brought to their constituencies. The rank-and-file members of those opposition parties, unlike LDP members, waged their electoral campaign under the party platform because cultivating the personalized support base in a district is costly and does not pay off unless the candidate competes with a colleague of the same party. Overall, under the SNTV-MMD system during LDP's one-party dominance, while the

ruling party – LDP – was indulging in patronage-based competition, opposition parties were engaged in the programmatic competition.

Intra-party decision process in LDP

LDP's decentralized decision-making process also originated in the characteristics of Japan's political institutions. First, LDP's factionalized structure was maintained by the necessity for LDP politicians to compete with their colleagues in the same district under the SNTV-MMD system. Second, LDP required each ministry to win approval for a government-sponsored bill by a particular division of PARC because it ensured that every government proposal reflects the policy preferences of LDP politicians and facilitates their political patronage to their machine. Third, the LDP also demanded that all government bills be backed by the General Council of the LDP because this requirement creates the consensus on these bills among factions, which were generated and preserved by the electoral system.

The factionalized politics of the LDP were rooted in the fact that LDP politicians were forced to compete with each other in their electoral district under the SNTV-MMD system (Ramseyer and Rosenbluth, 1993). Since those politicians were not able to run their campaigns just based on the LDP's campaign platform, they needed to cultivate their own political machine (*Kōenkai*) (cf. Curtis, 1971). Establishing and maintaining the machine required enormous political resources (such as time, money, and personal ties), and the leaders of LDP factions supported their junior members through distributing money and posts. In exchange, the rank and file of the LDP served their faction leader to make him the president of the LDP and the prime minister. Since the president of the LDP had no device to control its rank and file, the LDP government appeared a quasi-coalition government of those factions. While these factionalized politics energized Japan's political scene and blocked the sclerosis of the LDP's one-party dominance, it prevented the president of the LDP from exercising its leadership (cf. Kitaoka, 1995).

The LDP's intra-party decision-making process, which corresponds to the structure of the Diet, has also impeded concentration of the executive power. While the Diet law stipulates that a bill is required to pass a particular committee before it is sent to the floor, under its one-party dominance from 1955 until 1993 the LDP developed an intra-party system parallel to the committee system of the Diet.[8] LDP politicians belong to several divisions of the LDP's PARC, and they review government-sponsored legislation prior to its submission to the Diet. LDP politicians can easily stop a policy proposal that is against their interests as

long as they can control the majority of each division of PARC. Although the bill, approved by ruling parties, is supposed to be rubber-stamped in the Diet, the decentralized decision-making process within the LDP endows LDP politicians residing in the PARC with veto power.[9]

The General Council of the LDP has also stripped the president of the LDP of his leadership under its factionalized politics. The General Council (*Sōmukai*) has been the practically most important decision-making organ within the LDP. It meets twice a week and gives final endorsement for a government-sponsored bill deliberated through the division of PARC. The LDP cabinet has been unable to submit its bill to the Diet unless the General Council approves its proposal. This council is composed of 40 senior LDP members, and it has been run customarily with unanimity rule (Ono, 2003, p. 84). This practice gave veto power to each faction of the LDP, and then ensured that the LDP is managed based on consensus among its factions.

In sum, Japan's electoral system created veto-prone political institutions within the ruling party (i.e., LDP). The SNTV-MMD system forced LDP politicians to compete with each other, and the intra-party competition led to the infamous factionalized politics. The PARC and the General Council guaranteed consensus among factions and the rank-and-file on each government-sponsored bill. The intra-party decision-making process has evolved under the LDP's one-party dominance for 38 years so that it fits with the incentives generated by the SNTV-MMD electoral system.[10]

Policy-making process in bureaucracy

The substance of public policy is determined within the bureaucracy in Japan. The ruling party (parties) of the Diet delegates its policy-making capacity to the cabinet, and the bureaucracy is supposed to behave as an agent of its minister. In the actual policy process, however, the cabinet – the prime minister and his ministers – rarely leads the policy process. A law-making process usually follows a bottom-up rather than a top-down process, and in the cabinet meeting the minister of each ministry tends to behave as an agent of his/her bureaucrats rather than their principal (Iio, 2007). Under LDP's one-party dominance, public policy had been formed through negotiation among bureaucrats, *Zoku* (tribe) politicians, and interest groups, and this patterned policy-making process continued in a slightly different way under the coalition governments – at least, until the Koizumi administration in 2000s. The decentralized policy-making process also strips the cabinet of the ability to make top-down decisions.

The ideas of new policy and policy reform usually originate inside the bureaucracy of the central government. The bureaucrats receive information from local governments and industrial lobbies (*Gyō-kai*), recognize social demands, and identify policy problems. Although the minister sometimes has his/her own agenda, usually the head of a department forms a policy idea, negotiates with relevant departments, and communicates with senior officials within the ministry. In the early phase of this process, the bureaucrats inform *Zoku* (tribe) politicians as well as their minister of the policy agenda. If the policy agenda concerns the jurisdiction of other ministries, the relevant department reconciles potentially conflicting interests with them (Iio, 2007, pp. 50–55).

It is common that the bureaucrats hold deliberative committee (*Shingi-kai*) meetings on policy issues before they draft bills. Each ministry has many deliberative committees within it. While some are permanent and stipulated by National Government Organization Law, others are ad hoc and function as a 'private' advisory body for the minister, the administrative vice minister,[11] or the chief of a bureau. There are various types of deliberative committees, and they serve several functions. First, a deliberative committee can contribute expertise to the policy-making process. The bureaucrats invite experts on a specific issue to a committee session, and let them discuss the topic. Since the bureaucrats do not necessarily have a solution to the policy issue they identify, the deliberative committee can help them to put together concrete policy proposals (Iio, 2007, pp. 121–123).

Second, a deliberative committee can legitimize the policy proposal the bureaucrats are forming. Since a deliberative committee selects its members from policy experts such as scholars, journalists, and practitioners, the bureaucrats can claim that their policy proposal is endorsed by authority even though they administer the committee session, lead its discussion, and write a draft report as its recommendation. Furthermore, the bureaucrats can, and do, choose those experts in an arbitrary manner so that their advice conforms to the bureaucratic interests. This is the reason why a deliberative committee is called '*Kakure-Mino*' (a convenient cover) (Iio, 2007, pp. 121–123).

Third, a deliberative committee can be the venue where the bureaucracy reconciles conflicting stakeholdings among various interest groups. Deliberative committees established by the central government's bureaucrats certainly have the function of 'cover' for them. Nevertheless, some deliberative committees embrace a broad range of interest groups, such as employer organizations, industrial lobbies, professional organizations, trade unions, and consumer groups, and

the bureaucrats try to build a consensus among those interest groups. One reason why the bureaucrats seek approval from vested interests is that those interest groups have ties to ruling parties. For instance, a policy proposal is unable to pass through the review process in the division of the LDP's PARC unless the interest groups supporting the LDP's *Zoku* politicians accept the proposal. Another reason is that the bureaucrats are highly dependent on those interest groups when they implement policy. For example, the Ministry of International Trade and Industry's (MITI) famous 'administrative guidance' (*Gyousei-Shidō*) could not be maintained without cooperation and support from trade groups (*Gyou-Kai*) (cf. Johnson, 1982; Okimoto, 1989), and the Ministry of Health and Welfare (MHW) could not implement health care policy without the Japan Medical Association's (JMA) explicit or implicit consent. These ministries do not have their own wherewithal for policy implementation. Unlike the Swedish Royal Commission and the remiss process, the vested interests assembled in a deliberative committee have actual 'teeth' in Japan.

This bureaucracy-led policy-making process is a strategic equilibrium between LDP politicians and the state bureaucracy under the SNTV-MMD electoral system and the LDP's one-party dominance. Under the SNTV-MMD system, while rank-and-file LDP politicians were motivated to bring particularistic benefits to their constituencies, they had no interest to lead the entire policy-making process. Since actually directing the law-making process is a time-consuming and costly activity, LDP politicians preferred to delegate the policy-making and policy-implementing process to the state bureaucracy and monitor the outcomes. Since the LDP's rule was secured under the SNTV-MMD system, the party leaders were satisfied with the bureaucracy-led policy process as long as it kept Japan's economy and society intact. They did not need to appeal to the general public with generic public programs. The LDP's rank-and-file members were also content with the bureaucracy-led policy process as long as the state bureaucrats cooperated with them to provide particularistic benefits and serve their electoral interests. It is true that many Japanese political scientists pointed out that the influence of LDP politicians in the policy-making process was strengthened during the 1980s. However, while those politicians – *Zoku* politicians – were monitoring the distribution of benefits, they did not intend to lead the entire policy-making process with a top-down approach. The state bureaucracy could enjoy its own discretion unless it undermined the vested interests connected to those *Zoku* politicians. Iio (1995) calls this phenomenon 'political bureaucrats and bureaucratic

politicians', and whereas the state bureaucracy engaged in steering the general public policy, the LDP's *Zoku* politicians monitored the details of public policy generated by the bureaucracy so that this policy did not offend their electoral interests.

To sum up, a patterned policy-making process within the bureaucracy also decentralizes the authority to decide public policy. Since bureaucrats need approval on policy proposals by governing parties in order to enact them in the Diet, each ministry incorporates into its deliberation process the interest groups associated with ruling parties. Each ministry holds many deliberative committees in its organization, and brings together in those committees the representatives of special interests. The state bureaucracy negotiates with those interest groups inside and outside the councils. Since formal and informal rules require a policy proposal to be submitted to and accepted by those deliberative councils, the policy-making process within a ministry gives vested interests de facto veto power.

5.2 Elderly care in Japan

The Japanese long-term care system was changed after public long-term care insurance was introduced in 2000. While in the previous system the social welfare system and medical care system shared the social role of providing institutional care for the aged, the long-term care insurance system was established to integrate fragmented institutional care services and expand community care services so that frail older people can sustain their independence in either institutions or communities. Although it is quite doubtful that long-term care insurance ensures an independent life for frail older people, it has surely extended the availability of social care services to the middle class.

Placement system and 'social hospitalization'

Although the bulk of social care had been provided by the informal care sector (i.e., family), before the Long-Term Care Insurance (LTCI) Law was implemented the placement (*Sochi*) system and medical care system had provided social care services for the frail elderly in the formal care sector. The 'placement system' refers to the social welfare system where public administration, such as a local municipality, has the authority to refer vulnerable persons to institutions and other welfare services. This system allows local governments to distribute scarce elderly care services, such as 'special nursing homes' (*Tokubetsu Yōgo Rōjin Hōmu*),[12] to frail older people, based on the assessment of their economic means and the

availability of physical and financial support from their relatives. Under this system, local governments place older people to approved institutions, pay full treatment fees to those institutions, and collect out-of-pocket fees from users according to their ability to pay. In addition, the providers of long-term care services for the frail elderly were limited to local governments and social welfare corporations in this system.[13] The placement system had managed Japan's social welfare system including elderly care ever since the U.S. occupation era (cf. Kitaba, 2005).

Health care facilities have been substituted for nursing homes because by its means test the placement system virtually excluded middle-income and upper-income citizens from using public social care services. This phenomenon, which has been called 'social hospitalization' (*Syakai-teki Nyūin*), began in the 1970s when the LDP government made medical services for 70 year-olds and older free of charge (see below). Even after it imposed flat-rate, out-of-pocket fees on the aged in 1983, middle-income and upper-income frail older people never stopped pouring into hospitals.

There are several reasons why social hospitalization prevailed in Japan after the 1970s. First, social care services for frail older people were extremely scarce. The number of nursing homes was very limited, and there were practically no home-care services available for the middle class. Second, while people have not been ashamed of hospitalizing older relatives without medical reasons, sending them to public nursing homes has been stigmatized because those nursing homes originated in the poor relief system. Third, medical facilities were a much cheaper alternative to special nursing homes for the middle-income and upper-income strata. As Table 5.2 suggests, while medical care facilities charged older patients flat-rate fees (21,000 yen for medical treatment and 18,000 yen for bed and board per month in 1994), special nursing homes charged them more than hospitals if they had a decent pension and/or economically reliable relatives (Kōsei-Syō Kōreisya Kaigo Taisaku Honbu Jimukyoku, 1995, p. 34). As a result, in 1993, whereas 270,000 out of an aged population of 16.9 million (65 years and older) were accommodated in special nursing homes under the placement system, 280,000 of the this population were hospitalized for more than six months under the health care insurance system (Kōsei-Syō Kōreisya Kaigo Taisaku Honbu Jimukyoku, 1995, p. 67).[14] This feature of long-term care policy has boosted medical care costs and aggravated the financial conditions of public health insurance system. In sum, medical care has historically played a big role in social care services for frail older people in Japan.

Table 5.2 Long-term care system before and after 2000

	Before 2000		After 2000
	Placement system	**Health insurance**	**Long-term care insurance**
Service recipient	Low-income, living alone or other requirements	Those aged 70 years old and over and those between 65 and 70 with disabilities	Those aged 65 years old and over
Eligibility for service	Care needs and conditions of family structure, income, etc.	Care needs	Care needs
Co-payment	According to ability to pay	530 yen/visit, 1200 yen/day of hospitalization	10% of service fee
Service providers	Public welfare facilities	Medical care facilities	Public or private care facilities, medical facilities
Freedom of choice by user	No	Yes	Yes

Source: The author modified Abe (2007, p. 38).

Long-term care insurance system

The LTCI law established a novel social insurance system and transformed the previous social welfare system into a fee-for-service system in accordance with the medical care system. The public long-term care insurance covers not just institutional care but also home-based and community-based care services. For-profit and non-profit organizations are now allowed to enter the social care market and provide their care services for the aged while the price of each care service is determined by the government. As a result the LTCI law created the quasi-market for elderly care in Japan.

Long-term care insurance is the social insurance scheme which insures the population 65 years and older against the social risks of disabilities and frailty. The population over 40 years old contribute to the system by paying the insurance premium through their pension or health insurance. Local municipalities bear the role of insurer under the long-term care insurance system, and they collect insurance premiums, assess the care needs of applicants, and reimburse 90 per

cent of the costs of care services for service providers. Care services are provided on a fee-for-service basis, based on the contract between users and service providers. Users are free to choose care services, depending on their necessities and preferences for services. While the benefits of the long-term care insurance can be used for either institutional care or community care services, there is no care allowance for family carers. Although for-profit organizations can offer community care services for the aged, the providers of institutional care are restricted to medical corporations and social welfare corporations.[15] The costs incurred in the long-term care insurance system are funded by insurance premiums, government subsidies, and co-payments of care service users. Aside from the co-payments of service users, while insurance premiums cover 50 per cent of the entire costs, central and local governments fund the rest (50 per cent).[16] Elderly citizens can claim their entitlement to institutional and community care services, depending on the severity of their care needs. Each municipality assesses the disabilities of each applicant and decides the level of his or her assistance or care required (Abe, 2007, p. 39).

What is changed and what is not under the long-term care insurance?

It is certain that the long-term care insurance system has structurally changed the provision of formal social care services for frail older people in Japan. Public expenditures for social care services for the aged jumped after the LTCI law was implemented in 2000. As Figure 5.2 indicates, while institutional and community care services for the aged accounted for less than 0.1 per cent of GDP in 1980, those services made up 1.34 per cent of GDP in 2006. Furthermore, the long-term care budget doubled from 2000 to 2008 (3,627.3 billion yen in 2000 to 7,350.5 billion yen in 2008) (Kōsei Rōdō Syō, 2008, p. 231).

Not only were public expenditures for elderly care services multiplied, but the volume of social care services for the aged has been expanded, and the actual number of care recipients also increased. While in 2000 2.4 per cent of the aged population (65 years old and over) were staying in institutional care facilities and 4.5 per cent were receiving home and community care services, in 2007 3.0 per cent were being taken care of in institutional care facilities and 10.0 per cent were using community-based care services. As these numbers suggest, especially the coverage of home-based and community-based care services has been growing rapidly since the LTCI law was implemented. Corresponding with the expansion of long-term care service, its employees have also been

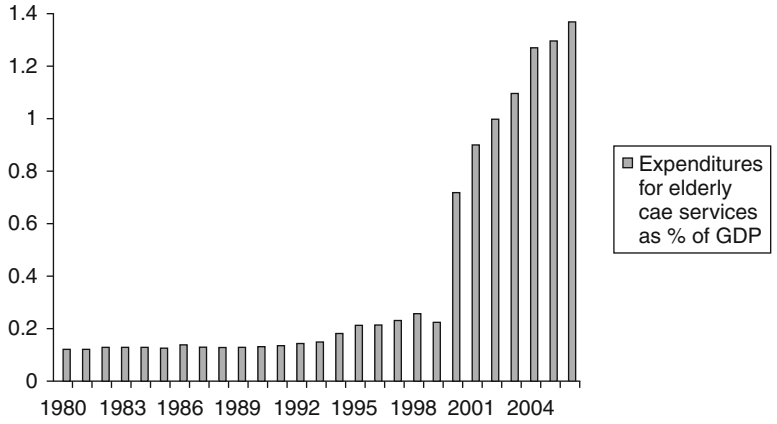

Figure 5.2 Time trend of elderly care expenditures in Japan, 1980–2006

Sources: 1980–2003: OECD (2007) SOCX; 2004–2006: Elderly Care Services: Kōsei Rōdō Syō (2008); GDP: Naikaku-Fu (n.d.).

augmented in these decades. Although the number of care workers in institutional care facilities – special nursing homes, facilities of health care services for the elderly, convalescent beds in hospitals – has also gradually grown under the long-term care insurance system, the number of care workers in community care services has markedly increased since 2000.

However, the effects of the introduction of long-term care insurance are somehow exaggerated. Many of the characteristic of the previous elderly care system are left in the new system, and those features remaining in the current system reflect the traits of Japan's political institutions depicted in the previous section.

First, the jump of public expenditures for elderly care in 2000, which Figure 5.2 indicates, reflects the fact that the expenditures for 'convalescent beds in hospitals' (*Ryōyou-Gata Byōsyou-Gun*) were just transferred from health care insurance to long-term care insurance (see Figure 5.3). The 'convalescent beds in hospitals' were established in 1992 as a policy response to the pervasiveness of 'social hospitalization', and they are a medical care facility that is slightly improved as an institutional care facility.[17] Although only about a half of convalescent beds in hospitals were relocated to the scheme of long-term care insurance, those beds accommodated about 100,000 elders and accounted for 13.7 per cent of the entire long-term care insurance budget in 2000 (Kōsei Rōdō Syō, 2001). Due to this fiscal manipulation, the health care expenditures for

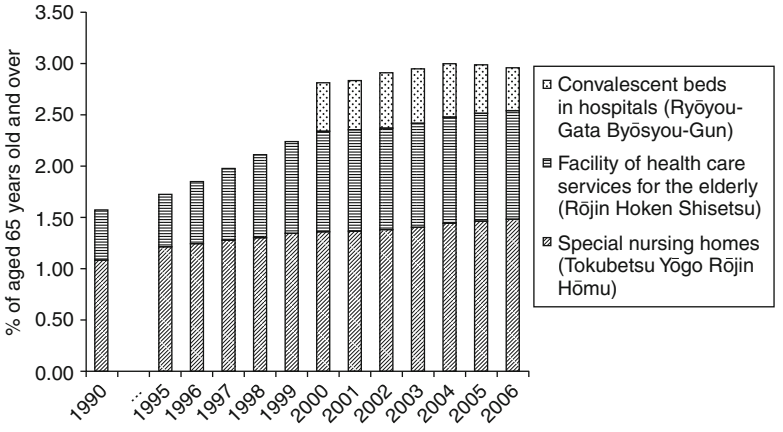

Figure 5.3 Percentage of old age people in care institutions

Sources: Total Aged Population: Kōsei Rōdō Syō (n.d.); 1990–1999: Kōsei Rōdō Syō (2007); Kōsei Rōdō Syō (various years-b); 2000–2006: Kōsei Rōdō Syō (various years-a).

the aged have been actually restrained since long-term care insurance was introduced in 2000.

Second, and related to the first point, a large part of 'social hospitalization' was left intact even after the LTCI law was implemented. In 2006, while 250,000 convalescent beds were covered by health care insurance, 130,000 convalescent beds were paid for by long-term care insurance.[18] One study, conducted by the Central Social Insurance Medical Council (*Chūikyō*), suggests that about half of the patients accommodated in convalescent beds have almost no need for medical treatment, and about 30 per cent require medical treatment only once a week (Ebata, 2007, p. 92). Another study, by Iryō Keizai Kenkyū Kikou, illustrates that about 30 per cent of older patients in convalescent beds are able to be taken care of in other care facilities or residencies (ibid.). Since these patients are hospitalized without medical necessities, they are in 'social hospitalization' by definition. The convalescent beds in hospitals are still popular among frail older people, though their residential environments are inferior to other care facilities. This is because special nursing homes have a limited number of rooms and sometimes require new applicants to wait several years for move-in; the volume of community-based care services are not enough to allow severely frail elderly to stay in their homes, and hospitals are relatively easy places to find accommodation. Japan cannot solve the problem of 'social hospitalization' even ten years after the LTCI bill was enacted.

Third, the supply structure of institutional care services hardly has been changed. Although the revised version of the Social Welfare Law now allows for-profit and non-profit organizations to engage in home-based and community-based care services, the ownership and management of special nursing homes is still monopolized by social welfare corporations (*Syakai Fukushi Houjin*), and the ownership of facilities of health care services for the elderly and convalescent beds in hospitals is limited to medical corporations (*Iryō Houjin*). Although for-profit and non-profit organizations can now provide frail older people with some kind of residential care services – such as group homes for the elderly, care residences, and private nursing homes – social welfare corporations and medical corporations have several advantages over other types of corporations. While these two types of legal entities are highly regulated by the government, they receive many preferential tax treatments for their revenues and assets. When the Japanese government introduced long-term care insurance, the welfare bureaucrats generated the impression that the new social insurance system encourages competition among care service providers and improves the quality of care services through this competition. However, the impression has never been brought to fruition at least in institutional care services.

In sum, the implementation of the LTCI law has expanded the provision of long-term care services for frail older people without drastically changing the previous structure of institutional care services. It is true that the enactment of the LTCI law was the major policy reform that broadened the coverage of home care and community care services and improved the accessibility of social care services to middle-income and upper-income older citizens. However, it is paradoxical that the problem of 'social hospitalization' was left to the new system and the supply structure of institutional care was untouched under the reform process of long-term care in Japan, because the introduction of new social insurance system was intended to wipe out 'social hospitalization' and bring market competition into long-term care services. The following section tries to untangle the political logic that drove policy reform and kept the status quo.

5.3 The politics of elderly care policy in Japan

This section describes how Japan's elderly care policy evolved into long-term care insurance. It starts with a brief history of charitable and poor relief institutions for the indigent aged during the pre-World War II period. This section, then, illustrates how the Elderly Welfare Law was

enacted in the 1960s. It subsequently describes the enactment of Free Medical Care for the Elderly in the 1970s, the policy reform concerning health care for the aged under the administrative reform in the 1980s, and then the law-making process of the LTCI Law from the formation of the policy proposal, through the deliberation at the advisory council of the MHW, until the passage of the bill in the Diet.

Elderly care institutions before the World War II

As in many other countries, elderly care institutions originated in charitable institutions managed by religious organizations in Japan. While in 1874 the Meiji government began a poor relief program (*Jukkyū Kisoku*) for the helpless destitute, including the feeble aged, its benefit levels were highly limited and it did not stipulate any official care institutions such as shelters and asylums. It was local benefactors and nonprofit organizations who assumed most of the burden of caring for frail elderly people without social and economic resources in pre-war Japan. During the Meiji period, Catholic, Protestant, and Buddhist organizations were playing a bigger role in sheltering the needy. Their care institutions usually accommodated all types of clients, including helpless orphans, the disabled, the frail elderly, and so on, and therefore it was rare for those institutions to be specifically allocated for the aged. This 'client mix' was common at that time (cf. Iwata, 1979).

While asylums for the aged (*Yōrōin*) were consolidated as a recognized institution around 1900, central and local governments rarely subsidized them. However, their overall conditions were gradually ameliorated in the early twentieth century. First, the Imperial House encouraged deference to elders and vouchsafed imperial donations to care institutions. For instance, in 1925 the Home Ministry (*Naimu Shō*) founded a quasi-public organization and built a large-scale asylum for the aged with imperial donations. Second, as the Poor Relief Act took effect in 1932, the financial situation of elderly care institutions were significantly improved. This law modernized the previous meagre poor relief system established in 1874 and obliged the governments to aid the needy without any help from relatives. Although the law provided that outdoor relief should be given to benefit recipients, it also allowed public administration to accommodate those recipients in various kinds of shelters if they were incapable of living by themselves. The asylum for the aged was stipulated as one type of such shelters in the law. The central and local governments began subsidizing these asylums for constructing and improving their facilities and offered livelihood assistance for their accommodated residents. Nevertheless, it should be noted

that the presence of these elderly care institutions was still extremely limited in the Japanese society then: in 1935, they sheltered only 2,062 out of 33,849 frail elderly benefit recipients under the Poor Relief Act (Momose, 1997, pp. 47–50).

While elderly care institutions had been gradually developed in pre-war Japan, as depicted above, World War II had devastating effects on them and their residents. About 1941, the food situation began deteriorating and, as a result, the mortality rate of the residents became quite high. For instance, in the biggest asylum for the aged at that time,[19] while its yearly death rate had been around 20 per cent before the war, it reached 56.8 per cent in 1944 (Momose, 1997, p. 55). In addition, many of the asylums in city areas were burned down in air raids by the Allies. Furthermore, the cash benefits under the Poor Relief Act and most assets of asylums vanished as a result of inflation during and right after the war. The state, elderly care institutions, and the society as a whole struggled to restore their pre-war conditions for a while after 1945. The Japanese state was unable to direct its efforts towards elderly care policy until the late 1950s.

The enactment of the Elderly Welfare Law

After the war, Japan's political system – the LDP's one-party dominance – was consolidated in 1955 (cf. Kitaoka, 1995), and the Diet passed the Elderly Welfare Law (*Rōjin Fukushi Hō*) in 1963. This law was purported to 'lay out the future direction of social policy for the aged by stipulating the principles concerning elderly welfare' (T. Ohyama, 1964, p. 1). In reality, however, it was a pack of small service programs for the aged: it obliged local municipalities to offer medical checkups for inhabitants aged 65 and over with state subsidies; it renamed 'asylums for the aged' (*Yōrōin*) as 'nursing homes for the elderly' (*Yōgo Rōjin Hōmu*); it institutionalized 'special nursing homes' for the physically and mentally frail elderly, home helpers for older people living alone, and state subsidies for 'community senior centres' (ibid., pp. 56–62). Although many of these programs had already been itemized in government budgets before its enactment, the law incorporated these small programs into the legal system in Japan. The policy process of the Elderly Welfare Law tells us the capacity and limitation of prudent welfare bureaucrats to establish and develop elderly care services under the LDP's one-party dominance.

The policy idea of enacting a law specifically for elderly social services got rolling in 1958, when Shintarō Seto, an experienced non-career bureaucrat, was appointed as director of the Institutions Division of the

Social Affairs Bureau of the Ministry of Health and Welfare (MHW). The Institutions Division held jurisdiction over various shelters – including asylums for the aged – under the Public Assistance Act.[20] There were several factors as to why the Institutions Division embarked on drafting a new law in this period. First, after the period of post-war turmoil, elderly care institutions were increasing the number of their residents and some of them started accommodating older people for a fee in the early 1950s. Since the division was regulating strictly means-tested asylums based on the legal ground that they shelter benefit recipients under the Public Assistance Act, a new law was needed to regulate paid care facilities. Second, more and more residents in those care facilities became so physically and mentally frail that it seemed necessary to establish a new care facility and ward for those feeble elders. Asylums for the aged were a living place for the indigent aged rather than their place for receiving care (T. Ohyama, 1964, p. 29). Third, some local governments, ahead of the national government, began home help services for the aged as their own program. For instance, Nagano prefecture initiated its 'domestic carer program' in 1956, and Osaka city started its 'domestic helper program' in 1958. Several other cities, then, followed the lead of these local governments (Mori, 1972, pp. 31–32). The Institutions Division intended to establish home helper services as a national policy.

As a prerequisite for the enactment of the law, Seto and his colleagues succeeded in including a series of small programs for the aged in the national budget. First, 'low-fee old age homes' (*Keihi Rōjin Hōmu*) were authorized in 1961 to receive government subsidies to accommodate older people somewhat above the income threshold under the Public Assistance Act. This budget request allowed care facilities to receive government subsidies outside the public assistance system, and then it made the stand-alone 'elderly welfare expenditure' appear as an item of the central government's budget for the first time (J.C. Campbell, 1992, p. 109; Okamoto, 1993, p. 115). Second, the welfare bureaucrats persuaded the Ministry of Finance (MOF) to earmark budgets for 'community senior centres' and 'home helpers for the aged' (*Rōjin Katei Hōshiin*) in 1962. The latter program subsidized prefectures and municipalities to send home helpers to families receiving public assistance where a senior member is incapacitated due to feebleness, physical and/or mental disabilities, sickness, and so on (Kitaba, 2001, 209). Although the budget scale of these programs was quite limited, they became a rationale for the MHW to enact a new law.

What characterized the policy-making process of the Elderly Welfare Law was the virtual absence of serious opposition towards these small

elderly service programs and the new law (J.C. Campbell, 1992, pp. 110–111). The director of the Institutions Division, Seto, negotiated with concerned parties inside and outside the MHW and carefully avoided offending any of them. For instance, the MHW planned to establish a new type of care institution for the physically and mentally frail elderly as a 'nursing care old-age home' (*Kango Rōjin Hōmu*), but the Japan Medical Association (JMA) was against the name because it confuses social care institutions with medical facilities. The MHW temporarily named it as a 'special nursing home' during the law-making process and the name persisted in the enacted law (Kōsei-syō Shakaikyoku Rōjin Fukushi Ka, 1974, p. 10). For another example, while the original draft obliged every municipality to have the home helper program, the Ministry of Home Affairs rejected the policy idea that local municipalities should hire regular public employees as home helpers.[21] Although Seto and his colleagues intended to develop the home helper program as a spearhead of community care services, the enacted law – in the end – just stipulated that municipalities be *allowed* to delegate their home help services for the aged to social welfare corporations and other organizations (ibid., pp. 6–9). That is, the enacted version reduced the home help program to a voluntary program in municipalities and relieved them from hiring their own helpers. Due to these and many other compromises, the Elderly Welfare bill was easily approved by the LDP's PARC, several deliberative committees, and the Diet in 1963.

However, it also marked the law-making process that there was little political driving force towards the enactment of the Elderly Welfare Law. It is true that the bill had several supporters outside the MHW. The proprietary association of asylums for the aged requested a new law concerning elderly welfare services from the mid-1950s on (Okamoto, 1993, pp. 100–112). Mitsu Kōro, a female councillor of the Upper House and the chairwoman of the Committee of Aged Issues in the LDP's PARC, was enthusiastic about the enactment of the law. She was closely working with the Institutions Division of the MHW and presented her own outline of the law in 1961 (Kōsei-syō Shakaikyoku Rōjin Fukushi Ka, 1974, pp. 32–33). Seto also obtained the support from Hanji Ogawa, the chairman of the LDP's Organization Committee – which is responsible for constituent organizations – by securing the budget for old people's clubs.[22] Nevertheless, these individual political supports did not add up to the LDP's thrust to the development of elderly care services as a political party. For instance, in 1962 the LDP's Policy Council rejected Kōro's motion when she proposed to submit her own bill to the Diet as a private member's bill (ibid., pp. 32–33). For another example, a welfare

bureaucrat, who engaged in the policy-making process, testified that no LDP politicians – except Kōro – seriously promoted the enactment of the Elderly Welfare Law when welfare officials approached them (Okamoto, 1993, p. 120). Seto and his colleagues ended up achieving support from the governing party by limiting the budget scale of new programs to a minimum and resolving any potential conflicts with interest groups and other government bureaus before proceeding to the LDP's decision-making process. The LDP approved the bill as the MHW's discretion rather than the LDP's own political will.

The lack of political force propelling the enactment of the Elderly Welfare Law imprinted significant consequences upon the later development of elderly care services. Since the MHW had no choice but to constrain the budget size of small elderly service programs written into the law – in order to obtain a green light from the MOF and the LDP – the quality and quantity of these services remained underdeveloped for a long time. Although Seto and his colleagues succeeded in establishing a new division within the Social Affairs Bureau – the Welfare of the Aged Division (*Rōjin Fukushi Ka*) – to administer the new law and satisfy their bureaucratic interests, subsequent directors of the new division struggled to expand the budget for elderly care services beyond bureaucratic incrementalism (cf. Kōsei-syō Shakaikyoku Rōjin Fukushi Ka, 1974). For instance, as Figure 5.4 shows, the number of home helpers for the aged was considerably restrained until the 1990s. While the home help program started with 250 helpers in 1962, the number did not reach 10,000 until 1978. During the 1960s, when a director of the new division requested more budgets for the home help service, the MOF responded to his request by saying 'never increase even one helper' (ibid., p. 21). Even though welfare bureaucrats were tactical enough to institutionalize welfare service programs for the aged, they were incapable of expanding these programs without determined support from the governing party. And, aside from a few individual politicians, the LDP did not as a party put a high priority on elderly care policy. Since the lagging policy development led to the highly limited supply of institutional and community care services, medical care started substituting for social care services for the frail elderly in the next decade.

Free medical care for the elderly

Many of the later policy problems in elderly care originated in the introduction of Free Medical Care for the Elderly (*Rōjin Iryōhi Muryōka*). The LDP government revised the Elderly Welfare Law and made medical treatment more accessible to the aged in 1973. Since older people are

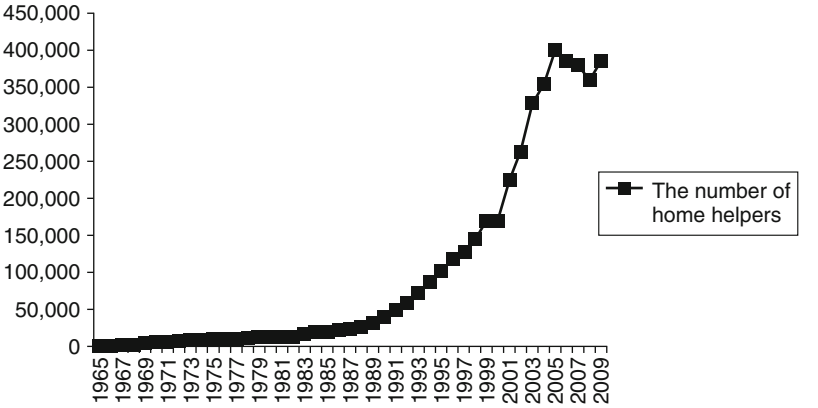

Figure 5.4 Time trend of home helpers in Japan, 1965–2009
Source: Kōsei Rōdō Syō (2011, p. 98).

affiliated with National Health Insurance run by each municipality after they retired from their employee health insurance,[23] they had to pay for 30 or 50 per cent of medical fees as their co-payment. Free Medical Care for the Elderly was a welfare program covering the co-payment part (with some income limitation) of all patients above 70 years old. The cost of the coverage was shared by local municipalities (one sixth), prefectures (one sixth), and the central government (two thirds). This new program guaranteed most elderly patients to receive virtually free medical treatment (Yoshihara and Wada, 1999, pp. 231–235).

The adoption of Free Medical Care for the Elderly did not reflect the policy preferences of either LDP politicians or welfare bureaucrats, but it was led by the initiatives of local governments. Sawauchi-mura, a tiny village in Iwate prefecture, started the public program guaranteeing free medical care for infants and the elderly by paying for the portion of co-payments from the village's budget in 1960. Although Sawauchi-mura's initiative did not have an immediate impact on national policies, many local governments followed the precedent later under the atmosphere of reconsidering economy-first policies after the high economic growth during the 1960s. As the side effects of rapid economic growth (such as industrial pollution) came to the surface, the progressive politicians associated with opposition parties, such as the JCP and the JSP, swept the mayoral and gubernatorial elections of big cities in the late 1960s and the early 1970s. Those cities and prefectures that opposition party politicians came to control were called 'progressive local

governments' (*Kakushin Jichitai*), and those progressive mayors and governors aggressively expanded welfare programs. Reducing the financial burden that elderly people were bearing for their medical treatment was one of their progressive agendas.

Many of those progressive local governments decided to subsidize the co-payments of elderly patients. In fact, once Ryoukichi Minobe, the governor of Tokyo Metropolitan City, supported by the JCP and the JSP, adopted the free medical care program for the elderly in 1969, four other prefectures followed in 1970, 28 in 1971, and all but three of 47 prefectures waived at least some parts of the health care costs of the aged in 1972 (J.C. Campbell, 1992, pp. 122–132). Free Medical Care for the Elderly was only embraced by the LDP government due to the strong presence of opposition parties at that time and the popularity of the policy.

The welfare bureaucrats were never enthusiastic about Free Medical Care for the Elderly. Kenji Yoshihara, a former administrative vice minister of health and welfare, recalls:

> Free Medical Care for the Elderly was welcomed by the public and the local governments that preceded the central government because it provided medical care service for the most part of 70 years old and over without fee, even though there was some means-tests. Inside the Ministry of Health and Welfare, however, there were cautious and negative opinions about the fact that the central government starts this system. (Yoshihara and Wada, 1999, p. 234)

There were several concerns about this program among the bureaucrats. First, making medical care free would sharply increase the number of elderly patients because the new scheme was still on a fee-for-service basis and had no limitation on access to medical care. Second, the new program would put fiscal pressure on other welfare programs because it was funded by general revenues. Third, the surge of older patients would aggravate the fiscal condition of National Health Insurance because it paid a non–co-payment part of medical costs for the elderly and had a larger number of older citizens than did employee health insurances (Yoshihara and Wada, 1999, p. 234).

These concerns eventually became a reality. Although older people were accused of misusing medical care facilities, this program also created a huge risk of system abuse among medical practitioners. Since the provision of medical services is fee-for-service based and doctors have strong autonomy in their medical practices, the managers of

medical care facilities have an incentive to oversupply medical services. Free Medical Care for the Elderly got rid of any budgetary constraints on access to medical treatment for the aged. After this program was implemented, a number of 'geriatric hospitals' (*Rōjin Byōin*) were established to accommodate frail older people in order to authorize a huge amount of medicine and medical tests on the patients for the sake of profits (Ohkuma, 2010b, Episode 4). As Figure 5.5 suggests, after the enactment of Free Medical Care for the Elderly, medical care costs for the aged grew in a much faster pace than did the entire health care cost. Welfare bureaucrats tackled the ballooning health care expenditures for the aged in the following decades.

The 'administrative reform' and the 'Japanese-style welfare society'

The change of policy trend can be found in the late 1970s. While Free Medical Care for the Elderly was enacted with many other welfare packages under the remnant of rapid economic growth in 1973, the first oil shock in the same year made it extremely difficult to expand social welfare programs in the following years.[24] Whereas the lower economic growth after the oil shock reduced tax revenues, social expenditures responding to the remarkable rates of inflation and public work expenditures stimulating the sluggish economy enlarged the entire budget size. As a result, Japan's public finance came to face a fiscal crisis in the late 1970s. The MOF, and Prime Minister Masayoshi Ōhira intended to reduce budget deficits and recover a balanced budget by launching a

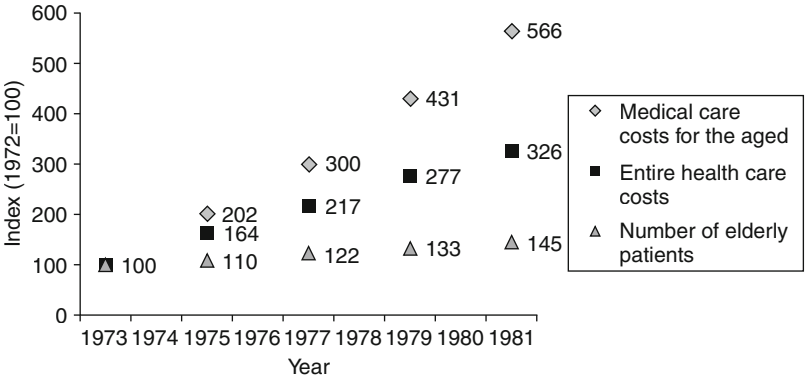

Figure 5.5 Time trend of health care for the aged
Source: Yoshihara and Wada (1999, p. 291).

value-added tax, and proposed the introduction of a 'general-consumption tax' (*Ippan Syōhi Zei*) in the general election of 1979. However, since not only opposition parties but also many LDP politicians attacked it, Ōhira had no other choice but to drop his proposal during the campaign. After the 'defeat' of the general election,[25] the LDP government announced recovering the fiscal balance through 'administrative reform' (*Gyōsei Kaikaku*) and spending cuts without tax increases (Kato, 1994; Ohara Syakai Mondai Kenkyu-Jo, 1981; Yoshihara and Wada, 1999, pp. 267–270).

The 'administrative reform' emerged due to the setback of tax hikes. After the Diet passed the no-confidence motion against the *Ō*hira cabinet due to the severe internal strife between LDP factions (*40-nichi Kōsō*), Prime Minister Ōhira dissolved the Lower House and went ahead with simultaneous elections for the Lower House and the Upper House in 1980.[26] Since the prime minister's sudden death due to a heart attack during the campaign consolidated the LDP and allowed it to collect sympathy votes, the LDP won both elections by a big margin (Ohara Syakai Mondai Kenkyu-Jo, 1981). Prime Minister Zenkō Suzuki, who succeeded Ōhira, appointed Yasuhiro Nakasone, one of the LDP faction leaders, as director-general of the Administrative Management Agency, and agreed with him to advance a major administrative reform campaign together. To deliberate policies cutting public spending through administrative reforms, Prime Minister Suzuki established the Second Temporary Commission on Administrative Reform (*Rinchō*) and appointed as its chairman Dokō Toshio, a former chairman of the Federation of Economic Organizations (*Keidanren*), one of the largest employer organizations. As this appointment suggests, *Rinchō* was the arena strongly reflecting the interests of big business and the capitalist class. This commission was put under the jurisdiction of the Administrative Management Agency and assigned the task of reviewing all public programs across offices and ministries. While employers' organizations had not been against the adoption of general-consumption tax, they were extremely cautious about the increase of the corporate income tax. Therefore, this commission repeatedly called for 'fiscal reconstruction without a tax hike' (*zōzei naki zaisei saiken*) its catch phrase, and recommended many policy measures that included the reduction of welfare spending, for a decisive cut in public expenditures (J.C. Campbell, 1992, pp. 221–234; Miyamoto, 2008, pp. 104–111; Yoshihara and Wada, 1999, pp. 268–275).

We can also find the ideological change of views on the welfare state and social welfare programs in the late 1970s. Although conservative

pundits had already started the assault on the expansion of the welfare state in the mid-1970s (cf. Gurūpu 1984, 1975; Murakami and Rōyama, 1975), this anti-welfare view became prevalent among conservative LDP politicians in the late 1970s. For instance, a pamphlet published by the LDP claimed that Japan should distance itself from European-style welfare states like Britain and Sweden because their high-level welfare decayed the spirits of their nations. It said:

> That the welfare state provides individuals with thorough benefits certainly promotes the tendency that those individuals live a self-indulgent life. In that sense, the Swedish-style lonely life after retirement is the consequence of high benefits, and it becomes possible only when the well-developed welfare state supports that life-style. (Jiyū Minsyu Tou [Liberal Democratic Party], 1979, p. 26)

This is the path Japan should avoid, the pamphlet said. For that purpose, it argued that Japan should maximize the freedom and power of private institutions such as individuals, families, and corporations. Specifically, it maintained, Japan should have the system that leaves the role of risk-sharing to families and workplaces and take full advantage of Japan's higher rate of three-generational cohabitant households as the provider of elderly and child care. It called this system the 'Japanese-style welfare society' (*Nihon-gata Fukushi Syakai*).

A governmental report also advocated the Japanese-style welfare state. 'The new seven-year plan on economy and society' (*Shin Keizai 7-kanen Keikaku*) stated that since Japan had already caught up with advanced industrialized countries in Europe and the United States, it should seek its own way: the Japanese-style welfare society, based on individual self-help and solidarity among families and communities (Keizai Kikaku Chō [Economic Planning Agency], 1979, p. 11). Although the emphasis on self-help, mutual assistance, and care in the family are not necessarily unique to Japan (Hori, 1981, p. 49), the Japanese-style welfare society was used as an ideology justifying reforming social welfare programs in the 1980s.

The political enthusiasm for 'administrative reform' and the prevalence of the 'Japanese-style welfare society' set up the context for major welfare reforms, such as reform of the public pension system and of health care insurance.[27] In fact, as Figure 5.6 indicates, the growth of social expenditures was notably restrained during the 1980s. The budgetary expansion of elderly care services had to wait until the 1990s.

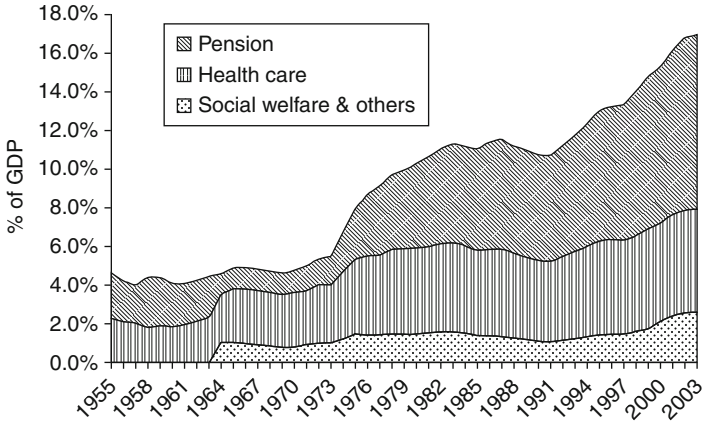

Figure 5.6 Time trend of social expenditures by items

Sources: Social Expenditures: Kōsei Rōdō Syō (2008); GDP: Economic and Social Research Institute (n.d.).

The enactment of the Law of Health and Medical Services for the Aged

Ironically, the campaign of administrative reform, carried out by conservative politicians and big business, opened the window of opportunity for welfare bureaucrats to reform the free medical care system for older people in line with their policy preferences. While from the outset welfare bureaucrats had been unenthusiastic about free medical care for the aged because it allowed them no control over the doctor's discretion, it also began troubling them by squeezing the budget of the MHW. As Figure 5.5 indicates, the medical care costs for older patients grew at a remarkably fast pace after Free Medical Care for the Elderly was implemented in 1973, and put enormous burdens on the budgets of central and local governments. The national treasury burdens of health care expenditures, including free medical care costs, accounted for about half the budget of the MHW in 1980. Then the MOF repeatedly demanded that the MHW reform free medical care for the aged and restore their co-payment from 1975 on. In addition, local governments requested the MHW to address the sharp increase of medical care costs for the aged since older citizens were concentrated in National Health Insurance, which is managed by each municipality, and its funding was notably exacerbated (Yoshihara and Wada, 1999, pp. 291–292).

Responding to these requests, the MHW set up a 'private' advisory board on elderly health and medical issues for the Welfare Minister ('*Rōjin Hoken Iryō Mondai Kondankai*') and wrote a report recommending that the aged be separated from National Health Insurance and transferred to a new funding system. Welfare Minister Tatsuo Ozawa, one of the welfare-and-labour *Zoku* leaders in the LDP, proposed this policy as his 'private' idea in 1977.[28] While local municipalities and the All Japan Federation of National Health Insurance Organizations supported this proposal, the Japan Medical Association (JMA), which is the doctors' organization and the strongest lobby in welfare policy, opposed the idea since it was afraid that the separate funding scheme for the aged would lead to cutting health care expenditures for the aged.[29] In addition, the Ministry of Finance also disapproved of the idea because it did not plan to reform the current fee-for-service based medical treatment for the aged. As a result, Ozawa's plan was aborted during his tenure (Yoshihara and Wada, 1999, pp. 293–296).

The next welfare minister, Ryūtarō Hashimoto, who was a powerful welfare *Zoku* as well, also proposed his 'private' policy idea in 1979. This proposal was that the national government adjust the budgets across health insurance carriers based on their financial capability and the number of the aged affiliates.[30] While the JMA supported this proposal because it would not threaten the existing fee-for-service based medical system for the aged, the MOF also espoused it because it would considerably lower the government burden of medical care costs for the aged. Although the National Federation of Health Insurance Societies (*Kenpo Ren*), which is the national organization of big companies' health insurance societies, opposed the proposal because those health insurances cover only young employees, the MOF included Hashimoto's proposal and co-payments in the 1980 budget proposal. However, the public was in strong opposition to restoring the co-payments without reforming the status quo. Since the election of the Upper House was scheduled in 1981, the LDP was reluctant to advance the unpopular reform of medical care system for the elderly and passed it over the next year's budgetary process in the end (Nakamura, 1980; Yoshihara and Wada, 1999, pp. 293–296).

Since the LDP's leaders[31] signed the memorandum that agreed to implement a new program in the 1981 fiscal year, welfare officials did not miss this opportunity to reform free medical service for the aged. In March 1980, the MHW consulted the Advisory Council on Social Security ('*Syakai Hosyō Seido Shingi Kai*') on health and medical care for the elderly.[32] Although the advisory council was displeased with

the MHW because it asked for a report without any concrete policy proposal, the council agreed to deliberate the issue on the condition that the MHW submit a proposal during the deliberation process. Then, in May 1981, the MHW established the Medical Insurance for the Aged Headquarters (*'Rōjin Hoken Iryō Taisaku Honbu'*), which was headed by the administrative vice minister and composed of full-time career bureaucrats, and started drafting a proposal for the new system. They rigorously negotiated with several bureaus in the MHW as well as with the welfare-and-labour *Zoku* politicians in the LDP, the MOF, and special interests, and then submitted the outline (*'Taikō'*) of the Law of Health and Medical Services for the Aged to several deliberative committees (J.C. Campbell, 1992, pp. 288–290; Yoshihara and Wada, 1999, pp. 296–298).

The Health and Medical Services for the Aged bill had several points that departed from the free medical care for the aged at the time. First, the bill reintroduced the co-payment of medical fees by the aged. However, this aspect was mainly symbolic rather than substantial for the spending cut because it proposed just 300 yen (later 500 yen) for the first out-patient visit per month and 300 yen a day for hospitalization with some exemption for low-income elderly. Second, the bill proposed creating a new payment system for the aged, 70 years and older. Although the outline intentionally left its details to a government ordinance, the new system would basically pool contributions from health insurance careers and cross-subsidize 70 per cent of medical costs for the aged. The 30 per cent left should be covered by government funding. This fiscal adjustment intended to improve the financial condition of National Health Insurance and lower the fiscal burden of the national government.[33] Third, the bill set up 'health services' (*Hoken Jigyō*), such as health education, health consultation, health examinations, and preventive medicine. These health services were targeted at adults over 40 years old and assumed by local municipalities with the central government subsidies. While Free Medical Care for the Elderly was aimed at covering only cure-oriented medical treatments on a fee-for-service basis, this bill expressed welfare officials' preferences for a more preventive and comprehensive approach for old-age health problems. In addition, the outline proposed to establish the Council on Health for the Elderly (*Rōjin Hoken Shingi-kai*) as a new deliberative committee attached to the MHW to discuss the details of medical treatment fees for the aged, contributions from health insurance careers, and co-payments (J.C. Campbell, 1992, pp. 290–294; Yoshihara and Wada, 1999, pp. 297–302).

The Health and Medical Services for the Aged bill faced serious challenges after the MHW passed the proposal to the deliberative committees. Although the National Federation of Health Insurance Societies (which was supposed to bear the contributions to the new payment system for the aged) accepted the submission of the bill to the Diet, the JMA fiercely opposed the bill because it could undermine the current fee-for-service based medical treatments for the aged. Since the details of medical treatment fees for the aged was left to a newly established deliberative committee in the MHW, the JMA's concerns were not necessarily paranoia. To placate the JMA, the ruling party conceded that the Council on Health for the Elderly, the new deliberative committee, should not be engaged in the medical treatment fees for the aged, and amended the bill along with the claims of the JMA. As a result, the Lower House passed it over to the Upper House (J.C. Campbell, 1992, pp. 294–296; Yoshihara and Wada, 1999, pp. 300–306).

However, this concession further complicated the enactment process in the Upper House. Although the National Federation of Health Insurance Societies had approved the bill during the deliberation process of the Lower House, it expressed solid opposition to the bill once it arrived at the Upper House. The four big business associations[34] pressed Rokusuke Tanaka, the chairman of the LDP's PARC, to amend the bill. These big business groups were discontented with the modification of the bill in the Lower House because it killed the possibility to alter the fee-for-service based reimbursement of medical treatment for the aged and to restrain the growth of health care costs. The four bosses of the welfare-and-labour *Zoku* and the welfare bureaucrats worked out a further compromise for those business interests, and slightly alleviated the burdens of the amount of cross-subsidization to National Health Insurance from other employees' health insurances. In the end, the bill was enacted in August 1982 (J.C. Campbell, 1992, pp. 294–296; Nihon Keizai Shimbunsya, 1983; Yoshihara and Wada, 1999, pp. 308–310).

Before this law was implemented in February 1983, an important regulation was added to its detailed rules. The welfare officials claimed that older people tend to have a chronic disease and suffer from an impairment caused by the ageing process, so the health care and medical treatment fees for the aged should take this factor into consideration. Based on this rationalization, the MHW defined the hospitals in which 60 per cent of their beds are occupied by patients aged 70 years and older as 'geriatric hospitals' (*Rōjin Byōin*), and proposed a new inclusive payment system of medical treatment fees applied to them.[35] In exchange, the staffing requirements for geriatric hospitals were relaxed.

Although the deliberation process faced severe difficulties due to resistance from the JMA, a lump-sum per capita payment scheme (*'Marume'*) was introduced to geriatric hospitals since the compromise allowed many of those hospitals to compensate for the drop in the reimbursement of medical treatment fees with the savings from their personnel costs (J.C. Campbell, 1992, pp. 300–301; Yoshihara and Wada, 1999, pp. 310–312).

The Health and Medical Services for the Aged law was the attempt of welfare bureaucrats to streamline the health care system and strengthen their control over the system under the circumstances of 'administrative reform'. As the law declared 'self-help' and 'solidarity' as its basic principle, it was intentionally written so that it would conform to the trend of administrative reform. Since the MHW legitimatized its bill by the rhetoric of administrative reform, it succeeded in initiating financial adjustments across fragmented health insurances, encroaching on the fee-for-service based medical care dominated by the JMA, and establishing new public, though small, programs which were prevention-oriented rather than cure-oriented.

The revision of the Law of Health and Medical Services for the Aged

The Health and Medical Services for the Aged law already had been revised in 1986. Although the main purpose of this revision was to raise the burden rate of employees' health insurance for the subsidizing of medical bills of the elderly, the revision also had an implication for long-term care policy in Japan. It brought up the concept of 'intermediate facility' (*Chūkan Shisetsu*), and established the 'facility of health care services for the elderly' (*Rōjin Hoken Shisetsu*).

When the idea of 'intermediate facility' appeared, it referred to the facility whose functions fall between *hospitals* and *nursing homes*. Although the policy idea to create a facility providing both medical and custodial care for the aged goes back to 1963 (when the 'special nursing home' was included in the Elderly Welfare Law), it did not come to fruition because the idea came from the Institutions Division of the Social Affairs Bureau, which was in charge of social welfare and public assistance, and then it interfered with the jurisdiction of the JMA and the Medical Bureau. On the contrary, the 'intermediate facility' was originated by the concerns and interests of health care officials in this time. First, they intended to save under-utilized beds in hospitals by converting small and medium-sized hospitals into the intermediate facilities. This conversion would also contribute to covering the

insufficient capacities of special nursing homes. Second, the intermediate facilities were supposed to reduce costs for both medical care and nursing homes. Welfare officials planned to offer medical services in them under a fixed-charge system rather than a fee-for-service basis. In addition, if the intermediate facilities satisfied the demands for special nursing homes, the conversion from hospitals to intermediate facilities would save the national treasury by reducing the subsidies for the construction of special nursing homes.[36] Welfare officials tried to solve several problems in the old-age health care issue by creating a new facility, combining a hospital and a nursing home (J.C. Campbell, 1992, pp. 304–307).

These policy proposals were never straightforwardly enacted as a law and, as usual in Japan, the MHW made further concessions to interest groups. The JMA criticized the proposal by saying 'we should not discriminate against elders' (Syūkan Syakai Hosyō, 1985). It insisted in the Council on Health for the Elderly that the facility of health care services for the elderly should be put under the jurisdiction of Medical Care Law, and that all issues related to it – not just medical treatment in the new facility –should be discussed in the Central Social Insurance Medical Council (*Chūikyō*), which is a deliberative committee under the strong influence of the JMA. The JMA was afraid that the new 'intermediate facility' would undermine the current fee-for-service based medical treatment. In response to their concerns, the LDP and the MHW adjusted their bill and allowed *Chūikyō* to decide the new facility's medical treatment fees and operational standards concerning medical care (Yoshihara and Wada, 1999, pp. 343–345).

Resistance also came from the social care camp managing special nursing homes. The officials of Welfare of the Aged Division in the MHW, social welfare scholars, and proprietors of special nursing homes organized in the Japanese Council of Senior Citizens Welfare Service (*Rōshikyō*) felt threatened by the new intermediate facility since it could encroach upon their turf. As the result of their opposition, the emphasis on the new facility shifted from substitutive nursing homes towards rehabilitative facilities that return older people to their community after a certain period. In addition, it was confirmed that special nursing homes would continue to be constructed. The 'intermediate facility' was to be put between *hospitals* and *communities* rather than between *hospitals* and *nursing homes* (J.C. Campbell, 1992, p. 308).

The establishment of the Facility of Health Care Services for the Elderly (*Rōjin Hoken Shisetsu*) further fused medical care policy with social welfare policy for the aged.[37] As a medical care facility, the new

facilities can accommodate older people based on a contract with them rather than placement (*Sochi*) by a local government. Their health and medical service fees are fixed and covered by health insurance with some co-payments (50,000 yen per month in 1988). These conditions made the facilities accessible to the middle class. Furthermore, the new facilities provide frail older people with better residential environments than do most 'geriatric hospitals' (*Rōjin Byōin*).[38] Welfare bureaucrats tried to transcend the limitations of special nursing homes and geriatric hospitals.[39] In this time, due to the effects of social hospitalization, welfare officials came to be unable to draw up medical care policy without taking the elderly care issue into consideration, and the revision of the Health and Medical Services for the Aged Law opened the gate to the policy idea that the social insurance system should satisfy the growing demands for long-term care.

Consumption tax and 'Gold Plan'

The sudden expansion of institutional and community care services for seniors came not from the MHW's campaign, but from an external factor: the introduction of 'consumption tax' (*Syōhi Zei*). Despite two severe setbacks during the Ōhira cabinet and the Nakasone cabinet, in the late 1980s the MOF was still seeking to introduce a large-scale value-added tax into Japan's tax system for the purpose of stabilizing the revenue structure of the national treasury. It decided to propose the 'consumption tax' under the Takeshita cabinet. While Prime Minister Nakasone had emphasized correcting an 'unfair taxation system' through the indirect tax,[40] Prime Minister Takeshita and the MOF chose the fiscal problems of aged society as their pretext to bring forth the indirect tax. In his first policy speech during the extraordinary parliamentary session in 1987, Takeshita announced that his cabinet 'will seek the tax system providing the stable foundation of tax revenues for approaching ageing of society' (cited in Kitaoka, 1995, pp. 262–263). Then the MOF and the MHW published the 'Overview on the Burdens and Benefits of Social Security at the Beginning of the Twenty-First Century' (*21-seiki Syotō ni okeru Syakai Hosyō no Futan to Kyūfu no Tenbō*) on a conjoint basis, and warned the nation that the current tax system, putting heavy burdens on salaried employees through direct tax, would be unable to sustain the social security system in the twenty-first century (Kato, 1994, pp. 195–196; Ohara Syakai Mondai Kenkyu-Jo, 1989).

However, the MOF in general, and the 'overview' specifically, failed to specify the relationship between the aged society and the indirect tax and how the increase of tax revenue would be used for social

security. That is why LDP politicians as well as opposition parties require the government to propose a concrete policy addressing the problems of society's ageing. Responding to those requests, the MHW and the Ministry of Labour jointly submitted to the Diet the so-called '*Welfare Vision*', or '*The Basic Idea and Purpose of the Programs Realizing the Longevity-Welfare Society*' (*Chōju-Fukushi Syakai wo Jitsugen suru tameno Shisaku no Kihon-teki Kangaekata to Mokuteki*). Although the report was filled with vague expressions, it proposed some moderate but concrete numerical goals. The 'Welfare Vision' might help LDP politicians placate opposition parties. While the Democratic Socialist Party (DSP) and the Clean Government (*Komei*) Party demanded new programs for the frail elderly, the LDP promised the DSP and the Clean Government Party that the government would promote community care services for the frail elderly in three years and give 'temporary cash benefits' to low-income seniors meanwhile (Masuda, 2003, pp. 27–28). The Takeshita cabinet enacted the bill introducing the consumption tax in the end.[41]

However, Prime Minister Takeshita was forced to resign his office during the turmoil of the securities trading scandal.[42] Unfavourably to the LDP, Prime Minister Sousuke Uno's sex scandal was revealed immediately after he succeeded Takeshita. As a result, the LDP was severely defeated by opposition parties in the Upper House election of July 1989, and lost its majority in the Upper House for the first time in decades.[43] Since the consumption tax was extremely unpopular among the public, it was recognized as one of the main reasons for the huge defeat of the LDP (Kitaoka, 1995, pp. 265–267).

Since the general election was scheduled in 1990, the LDP determined to show to the public that the tax revenue from the consumption tax is actually used for the enhancement of social welfare programs. LDP leaders requested the MHW to plan concrete programs enhancing social welfare. Then the MHW published in December 1989 the 'Gold Plan' or the 'Ten-Year Strategy on Health and Welfare for the Aged' (*Kōreisya Hoken Fukushi Suishin Jukkanen Senryaku*). As Table 5.3 indicates, the plan was to significantly broaden the capacities of institutional and, especially, community care services in the next ten years.[44] Furthermore, LDP leaders intervened in the 1990 budgetary negotiation between the MOF and the MHW and raised the budget allocation to elderly care services more than the MHW requested (J.C. Campbell, 1992, pp. 245–246).

The hike of indirect taxes led to the unexpected expansion of long-term care services for the aged. Since the unpopular policy – the introduction

Table 5.3 Contents of 'Gold Plan'

Type of service	1989	1999
Home helper	31,405	100,000
Day-service centres	1,080	10,000
Short-stay beds	4,274	50,000
Small local Centres	–	10,000
Special nursing homes	162,019	240,000
Facility of health care services for the elderly	27,811	280,000
Care house	200	100,000
Senior centres	–	400

Source: Kōsei Syō (1990).

of an indirect tax – put the LDP in a vulnerable position in the Upper House, the government needed to concede to the demands of opposition parties. As a result, the DSP and the Clean Government Party set the expansion of elderly care support as a governmental agenda item. Furthermore, the constituencies' rebellion against the LDP forced the party to promise that the revenues from the tax hike would be used to prepare for the ageing population, and the promise resulted in the 'Gold Plan'. This infrastructure development of elderly care services paved the way for long-term care insurance.

The enactment of LTCI law I: formation of policy idea

The policy idea that a social insurance system should satisfy the growing demands for elderly care services came from within the MHW. The scarcity of long-term care services for the frail elderly was widely recognized by the late 1980s as a policy problem among young career bureaucrats. Those welfare officials thought that the current placement (*Sochi*) system based on the general tax revenue was unable to provide care services for the frail elderly in a flexible way and follow the growing care demands in the future, and therefore they sought an alternative to the placement system (cf. Kōsei Syō Seisaku Bijon Kenkyūkai, 1988).[45] For instance, Nishikawa (1987) proposed that the government provide the frail elderly with 'long-term care benefits' through the public pension system and let them cover the care costs of residents in institutional care facilities. As another instance, in a round-table discussion, four career bureaucrats put out several ideas to cover the costs of long-term care through a social insurance system: including long-term care in health insurance payments, paying care allowance from the pension system, obligating citizens to buy private long-term care

insurance, and so on (Zenkoku Syakaifukushi Kyōgikai Syakai Fukushi Kenkyū Jōhō Sentā, 1989).

At the beginning of the 1990s, the MHW set up the Study Group of the Total Plan for the Elderly (*Kōreisya Tōtaru Puran Kenkyūkai*) and appointed Toshiharu Okamitsu, director of the Health and Welfare Department for the Elderly, as the head of this inside study group. The policy paper the study group wrote for internal circulation candidly pointed out various problems elderly care policies were facing at the time. The most important point was the limitations of the placement system. The paper strongly criticized the placement system on the grounds that it was unable to respond to the increasing demand for elderly care. Since the placement system originally came from public assistance and then depended on general tax revenue, it did not flexibly expand the capacity of care facilities. The principle of ability to pay, on which the placement system was based, virtually excluded middle-class citizens from using special nursing homes due to the heavy out-of-pocket expense. Since middle-class frail elders substituted hospitals for nursing homes, social hospitalization was rapidly exacerbating the health insurance budgets. To address these problems the policy paper proposed that the government should regard the frailty of older people as a social risk in the aged society and establish a social insurance system for the frail elderly (Kōsei Syō Rōjin Hoken Fukushibu, 1993).

Although these ideas were still in primitive form, it was welfare bureaucrats who formed a policy securing long-term care services in the rapidly ageing society. The welfare officials were aware of the following problems: limitations of the placement system due to fiscal constraints; the inequitable pricing scheme across hospitals, facilities of health care services for the elderly, and special nursing homes; and the predicted upsurge in the demand for elderly care. The MHW sought a policy solution to these problems and continued to lead the policy-making process under coalition governments.

The enactment of LTCI law II: agenda setting

The advent of new political dynamics played a crucial role in setting the issue of long-term care for the aged as a policy agenda. In August 1993, the LDP, which had continued one-party dominance for 38 years since 1955, lost the general election due to the defection of dozens of its members, and Hosokawa's non-LDP coalition government was formed. Prime Minister Hosokawa nominated Keigo Ōuchi, the chairman of DSP, as the minister of MHW. As it pushed the LDP government to expand elderly care services when the consumption tax was introduced, the

DSP was keen on long-term care for the aged. Soon after taking office, Ōuchi directed the officials of MHW to set up the 'Advisory Panel on Vision for Elderly Welfare' (*Kōreisyakai Fukushi Bijon Kondankai*).

While the advisory panel had no imminent task at first, its report was forced to bear the role of justifying the hike of indirect taxation. At a midnight press conference in February 1994, Prime Minister Hosokawa abruptly announced the abolishment of the current consumption tax and introduction of a new 'National Welfare Tax' (*Kokumin Fukushi Zei*). This proposal meant to raise the value-added tax from 3 per cent to 7 per cent. However, since there was no negotiation among the governing coalition parties prior to the announcement and, therefore, many of them as well as the public severely criticized the proposal, the prime minister dropped his tax reform plan immediately. Furthermore, because the administration had no concrete proposal for developing welfare programs despite the name – welfare tax – the advisory panel's report was used as the government's overview and plan on social security benefits and burdens in the future.[46] The report, *Vision for Welfare in the 21st Century (Niju-Ichi Seiki Fukushi Bijon)*, proposed that the government hold down the ratio of social security costs to gross national income through expanding social care services and restraining medical care costs. In addition, the report recommended that the government create the 'New Gold Plan' and 'new long-term care system' so that everybody could receive necessary long-term care services (Kōsei Syō Daijin Kanbō Seisaku Ka, 1994). The political turmoil concerning the indirect tax set the elderly care issue as a policy agenda again.

In response to the advisory panel's report, the MHW also undertook serious action on the elderly care issue. While it had already set up its 'Project Team on Elderly Care Problem' in November 1993 and written a report sorting out the potential issues of long-term care insurance for internal circulation (Kōsei Syō Rōjin Hoken Fukushibu, 1994), the administrative vice minister decided to establish the Long-Term Care for the Aged Headquarters (*Kōreisya Kaigo Taisaku Honbu*). It was officially headed by the administrative vice minister but actually was run by a counsellor for minister bureau (*Shingikan*) and, importantly, four career bureaucrats were appointed as its full-time members.[47] Since the number of national public officers is highly restricted, this was not an easy move for the MHW. This personnel transfer suggests that the MHW determined to propose a new program and enact the bill concerning long-term care for the aged (Masuda, 2003, pp. 33–35).

Meanwhile, the non-LDP coalition government collapsed, and the LDP, JSP, and *Sakigake* formed a coalition government in July 1994.

These three parties elected Tomiichi Murayama, the chairman of JSP, as prime minister. The new cabinet influenced the trajectory of the long-term care policy in an important way because it decided to raise the consumption tax rate by only 2 per cent and cancel out the tax hike with the reduction of the income tax and individual residential tax. While the MHW had a choice to create a new elderly care system funded by the increase of the consumption tax before, this tax reform killed this option and left a new social insurance system as a viable policy option to the MHW (Masuda, 2003, pp. 38–39).

The headquarters organized the 'Study Group on Elderly Care and Self-Support System' (*Kōreisya Kaigo Jiritsu Shien Shisutemu Kenkyūkai*) in order to formulate and promote a policy concept for a new elderly care system. The group was composed of scholars and experts on health care, social care, social welfare, economics, and so on, and it excluded the representatives of interest groups. The MHW aimed at communicating the significance of elderly care issues to the public rather than adjusting vested interests through this study group (Masuda, 2003, pp. 40–41). The group published a report and publicly proposed long-term care insurance as a solution for the problems of elderly care. This report presented 'self-reliance support for the aged' as the principle of new long-term care policy, and claimed that a social insurance system is desirable for the new elderly care system from the viewpoint of 'risk sharing'(Kōreisya Kaigo Jiritsu Shien Shisutemu Kenkyūkai, 1994). Although the group included some scholars who used to be critical of the MHW (Ohkuma, 2010b, Episode 21), the welfare bureaucrats intended to use this group to get their policy proposal authorized by experts.

The welfare officials were successful in bringing a new elderly care system funded by social insurance into a governmental agenda. The report of the Study Group on Elderly Care and Self-Support System was accepted well in the mass media. In addition, several newspapers and the government conducted public opinion surveys showing that the majority of citizens were favourable towards the idea of public long-term care insurance (Masuda, 2003, p. 40). The awareness of elderly care already had been raised enough among citizens to accept a new social insurance system. Furthermore, the Advisory Council on Social Security (*Syakai Hosyō Seido Shingi Kai*) publicized its report in September 1994 advocating the introduction of public long-term care insurance for the first time among official government deliberative committees (Sōri-Fu Syakai Hosyō Seido Shingi Kai Jimu Kyoku, 1994).[48] While the direction of the new long-term care system for the aged was determined, owing to the welfare officials' and others' efforts, the concrete design of the

new system was left to negotiations with other ministries, politicians of ruling coalition parties, and special-interest groups.

The enactment of LTCI law III: interest coordination

The Council of Health and Welfare for the Elderly (*Rōjin Hoken Fukushi Shingi-kai*) was the venue where welfare officials intended to accommodate and adjust various interests in order to draft the LTCI bill. Whereas the MHW succeeded in making interest groups accept the idea to create a new social insurance system providing long-term care services for the frail elderly, it failed to adjust the conflicting interests among special-interest groups. It was the ruling coalition parties – the LDP, *Sakigake*, JSP – that reconciled the contradicting claims from diverse interest groups and brought up the LTCI bill in the Diet.

The Council of Health and Welfare for the Elderly was established as a new deliberative committee attached to the MHW for the purpose of discussing the LTCI bill in September 1994. The council was composed of some scholars and the representatives of business organizations, trade unions, medical profession groups (doctors, dentists, pharmacists, and nurses), health insurance carriers (National Federation of Health Insurance Societies and National Health Insurance), local governments, social welfare corporations, and elders. The MHW officials intended to facilitate substantive coordination among these interest groups in this deliberative committee.

Welfare bureaucrats had various concerns over the claims from vested interests, and they negotiated with those interest groups inside and outside the deliberative committee. First, they were concerned that the vested interests protected under the current means-tested social welfare system would oppose the replacement of the placement system with the social insurance system. Since the MHW failed to reform the placement system of child day care facilities in 1993 because of the fierce opposition from the All Japan Prefectural and Municipal Workers' Union (*Jichirō*) and the JSP, the welfare bureaucrats were cautious about *Jichirō's* response to the long-term care services funded by social insurance. The endorsement from *Jichirō* was crucial because it was an important constituency of JSP, whose chairman was the prime minister of the coalition government at that time. The welfare officials persuaded *Jichirō* that long-term care insurance would expand the financial basis for elderly care services and allow local governments to make those care services universal. As a result, *Jichirō* and JSP later became strong supporters of long-term care insurance (Wada, 2007, pp. 74–75).[49]

In addition, welfare bureaucrats were careful about obtaining consent to abolish the placement system from the proprietors of special nursing homes, who were organized in the Japanese Council of Senior Citizens Welfare Service (*Rōshikyō*) and the Japan National Council of Social Welfare (*Zensyakyō*). Since the construction costs of special nursing homes were highly subsidized and their running costs fully covered by public spending under the placement system, the social welfare corporations managing special nursing homes had a stake in the existing system. On the other hand, the social welfare corporations wanted their own discretion over the management of special nursing homes because the placement system highly regulated them and tied their hands in exchange for paying running costs. They expected that their management would be deregulated under long-term care insurance. The representatives of special nursing homes agreed to give up the placement system and create a new social insurance system for elderly care services with the following conditions: first, the new system guarantees the stable management of special nursing homes; second, the ownership and management of special nursing homes continues to be limited to social welfare corporations; third, the new system improves the personnel requirements of care. The MHW accepted those conditions.[50]

Second, welfare bureaucrats closely communicated with the JMA, which was agreeable with the plan establishing a new social insurance system for elderly care. Since medical care expenditures had been under severe downward pressure, the JMA was seeking a new funding source for health care and the doctors' active engagement in the new system. The MHW's original scheme of long-term care insurance, indeed, included some medical care services, such as home visiting nurses and health care services facilities for the elderly (Wada, 2007, p. 66). Nevertheless, the JMA's preferences did not necessarily agree with the MHW's proposal. While the MHW intended to separate 'medicalized' long-term care services from hospitals and merge them with existing social care services, the JMA demanded that medicine and doctors play a larger role in elderly care services (Masuyama, 1998; Tadika and Kikuchi, 2006). Since the JMA mainly consisted of owners of small clinics, it envisaged that primary care doctors should play a pivotal role in care management and community care services. In addition, the JMA asked the MHW for solicitous treatment for small and medium-sized hospitals when they convert their beds into convalescent beds (*Ryōyō-gata Byōsyou-gun*). This is one of the reasons why social hospitalization was preserved under long-term care insurance.

In February 1995, while the MHW continued to negotiate with the vested interest groups, the Council of Health and Welfare for the Elderly started deliberating the new long-term care system. The first phase of the discussion at the council centred on whether the new system should rescind the current placement system and introduce the contractual system based on social insurance. The advocates of the new system – the supporters of welfare officials – argued that the placement system had imposed a stigma on the beneficiaries of social welfare. They also insisted that the elderly care system based on social insurance give all citizens the right to receive elderly care services since all people would pay social insurance premiums (Kōsei-Syō Kōreisya Kaigo Taisaku Honbu Jimukyoku, 1995, p. 55). In the end, almost all members agreed to adopt a social insurance system as a new system of elderly care.

The council issued an interim report, *On the Establishment of the New Elderly Care System* (*Aratana Kōreisya Kaigo Sisutemu no Kakuritsu ni tsuite*) in July 1995. While this report proposed the adoption of a social insurance system for elderly care, it obscured the specifics of the new system by using vague terminology. It reflected the fact that the representatives of interest groups did not agree on the specific contents of the general scheme: the scope of coverage, the degree of subsidies to insurance budgets from general taxation, the employers' share of the social insurance contribution, the insurance premium burden, the individual payment, the insurers, the types of service providers, and so forth. The embodiment of these points was carried over to the following sessions of the council.

However, the MHW failed to reconcile the conflicting claims from interest groups in the rest of discussion. The council restarted its deliberation in September 1995, and established three subcommittees with the following themes: types of services, the contributions and benefits of social insurance, and the improvement of care facilities and manpower. In January 1996 the council published its second report, without agreement among interest groups on the skeleton of the new system. The report juxtaposed pros and cons of many issues, such as insurers, beneficiaries, burdens, and cash benefits. The representatives of local governments rejected the idea that they serve as an insurer of the new scheme. The representative of business interests (*Nikkeiren*) was in opposition to imposing the employer's contribution on companies and putting it to the LTCI bill. While local governments promoted the idea to institutionalize the care allowance for family care givers, a feminist scholar disapproved of such institutionalizing.[51] There was a consensus on very few issues within the deliberative committee.

Those conflicts were not eliminated even in the final report publicized in April 1996. This report still embraced the compilation of different opinions on several controversial points. Especially the report was incapable of determining who would take the role of insurers. Whereas welfare officials proposed that local municipalities bear the role of an insurer, local governments strongly opposed the claim that each local government should manage long-term care insurance. Since each local municipality was managing its national health insurance and then suffering from resultant huge deficits, local governments thought that long-term care insurance would cause similar problems. Welfare bureaucrats were unable to alleviate their fiscal concerns.

The tripartite coalition among the LDP, *Sakigake*, and JSP stepped in and coordinated the conflicts between the welfare officials and the municipalities. The ruling coalition parties organized a task force on social welfare policies and kept discussing the scheme of long-term care insurance in parallel with the deliberation of the Council of Health and Welfare for the Elderly. Because the draft of the LTCI law written by the welfare bureaucrats was not approved by local governments and, therefore, the Social Affairs Division of the LDP's PARC, in June 1996 the MHW was forced to give up submitting the bill to the Diet. Instead, the leaders of the ruling coalition parties agreed to submit the LTCI bill to the next session of the Diet after they assuaged the concerns of local governments. Since long-term care insurance lost its momentum and was almost aborted, this agreement among ruling coalition parties was an important step for its enactment.

The ruling coalition parties set up the 'Working Team on the Establishment of Long-Term Care Insurance' and continued to negotiate with local governments. While the working team held a public hearing in several cities during the summer of 1996, the team members worked out the plan alleviating the burden of local municipalities as an insurer of long-term care insurance behind the scenes. They promised the municipalities that the central government would subsidize the administrative costs of long-term care insurance and allocate funds to compensate for financial deficits it might generate. As a result, the LTCI bill was submitted to the Diet in September 1996 and enacted into law in December 1997, after one year of deliberations (Masuda, 2003, pp. 75–77; Wada, 2007, pp. 94–98).

5.4 Conclusion

The LDP's one-party dominance was an important constraining factor of public elderly care services in post-war Japan's welfare politics.

The LDP – composed of particularistic politicians structured by the SNTV-MMD electoral system and motivated to pursue the personal vote in their own district – did not prioritize the expansion of universalistic elderly care programs. LDP members – except a few welfare *Zoku* politicians in the Social Affairs Division of PARC – valued particularistic benefits such as public work projects and agricultural subsidies more highly than social welfare policy.

Comparing the development of home help services for the aged between Sweden and Japan makes this point. In both countries, local governments pioneered the home help service as their own program in the 1950s, and then the central government tried to make it a national policy. On one hand, during the 1960s and 1970s in Sweden, local governments succeeded in expanding and universalizing home help services for the aged by using both housewives as hourly paid workers and the state subsidies (see Chapter 4). On the other hand, the size of government subsidies for the home help program was significantly restricted by the MOF, and the provision of home help services was strictly limited to lower-income households during the same periods in Japan (see Figure 5.4). As a result, in 1971, for every 100,000 persons Japan had just eight home helpers, whereas Sweden had 800 (Mori, 1972). Without the political support from the ruling party, the state bureaucracy was unable to develop a universalistic care policy.

The establishment of long-term care insurance is the product of the alliance between the welfare bureaucrats and the political parties supported by urban constituencies. In Japan's politics, elderly care programs were abruptly expanded only when the political parties that are centralized and supported by urban constituencies seized the policy influences on government decision making: free medical care for the aged under the authority of progressive local governments in the 1970s; the 'Gold Plan' during the turmoil of the consumption tax; and the presence of the JSP and *Sakigake* in the tripartite coalition government during the formation of LTCI law. The LDP, from time to time, tried to placate urban constituencies with the expansion of welfare programs when faced with serious challenges from opposition parties such as the JSP, DSP, Clean Government Party, and JCP (cf. Calder, 1988). While LDP politicians were, except for a few members, half-hearted at most for the LTCI bill, JSP's and *Sakigake's* members in the ruling coalition's task force on social welfare policies pushed until the end the submitting of the LTCI bill to the Diet.

However, those non-LDP parties under one-party LDP dominance had no detailed policy plan. It was the welfare bureaucrats who led and managed the entire political process concerning elderly care policy in

Japan. Since the ruling parties delegated their policy-making functions to the bureaucracy under Japan's parliamentary system, the welfare officials were administering a broad area of welfare programs and were able to write the bill they wanted – unless ruling parties rejected their plan. As both the case of Free Medical Care for the Elderly and the Law of Health and Medical Services for the Aged suggest, the welfare bureaucrats did not necessarily seek to 'maximize' their budget in elderly care policy. Rather, they tried to expand their administrative control over the policy implementation, such as medical treatment fees ('*Shinryō Housyū*'), in order to put into practice the policies that they believed improve older people's well-being. The long-term care insurance was one policy solution to make it possible for welfare bureaucrats to streamline the ballooning expenditures for health care insurance and put the social insurance budget under their control.

The politics of elderly care programs also illustrates the nature of gradual changes in Japan's policy process. Although most of the vested interests supported the idea of meeting the growing demands for elderly care with social insurance in general, they did not agree with the MHW on the details. As a result, the LTCI bill obtained through intensive negotiations with special interests became a compilation of entrenched interests. For instance, even though the extinction of social hospitalization was one of the main reasons to introduce long-term care insurance, this hospitalization program was preserved in convalescent beds of hospitals because the welfare officials allowed small and medium-sized hospitals to keep their convalescent beds for the aged under relaxed regulations. In addition, although at the early phase of policy-making the MHW seriously considered unifying three existing types of institutional care facilities – special nursing homes, facilities of health care services for the elderly, and geriatric hospitals – into the 'long-term care facility' (Kōsei Syō Rōjin Hoken Fukushibu, 1993; Wada, 2007, pp. 69–71), it soon gave up this idea and promised social welfare corporations could retain their privilege to monopolize ownership and management of special nursing homes under the new system. The MHW accepted the requests from vested interests, since they were well-organized and connected to the LDP's welfare-and-labour *Zoku* politicians. In Japan's welfare policy-making process during the period examined here, vested interests were influential because they had actual 'teeth' through the ruling party politicians. The welfare officials were so tactical that they fended off the resistance of those interests and managed to change the status quo of welfare programs. However, as a

result, the policy reforms were inclined to be a pack of compromises in the Japanese policy-making process.

In sum, the recent development of elderly care policy was triggered by political parties supported by urban constituencies, but actually handled and achieved by the welfare bureaucracy. Japan's parliamentary system allowed the bureaucrats to lead the entire policy process. However, the policy change was highly constrained by the interest groups connected to the LDP's particularistic politicians.

6
The United States of America: Evolution without Revolution

The U.S. elderly care policy is both stringent and generous *at the same time*. On the one hand, the eligibility of public elderly care programs is highly restricted since Medicaid – means-tested health care assistance for lower-income individuals and families – is the primary public funding source for long-term care in the United States. There is no federal program available to all elderly citizens in need of long-term institutional and/or community care services. On the other hand, once a senior citizen is qualified for Medicaid, it covers the individual's entire costs of institutional care, including bed and board as well as nursing care. And elderly patients can easily deplete their income and assets so as to be eligible for Medicaid because the costs of nursing home stays are remarkably high. Although the stigma of 'welfare' forces many middle-class Americans to face a difficult choice, Medicaid is now functioning as a *de facto quasi-universalistic* elderly care program in the United States.

This awkward cohabitation of austerity and leniency of U.S. long-term care policy is not an intentional product of conscious policy decisions by policy makers. As shown in later sections, elderly care policy has always been peripheral to health care policy, and no policy entrepreneur has ever designed the entire picture of elderly care programs in the United States. It is highly doubtful that even Medicaid's coverage over nursing homes was seriously deliberated in the U.S. Congress when it was enacted under the 'Great Society' policy of the 1960s. Furthermore, there has been no comprehensive policy reform concerning long-term care since the enactment of Medicaid. While long-term care attracted politicians' attention in the late 1980s and early 1990s, any attempt to expand public programs for elderly care were aborted in the end. However, the absence of large-scale policy reform does not necessarily

mean that the U.S. long-term care programs have maintained their status quo. In fact, U.S. long-term care policy has evolved. The expenditures of Medicaid for long-term care have been increased, more types of elderly care services, including home and community-based care, have become available, and the long-term care industry – nursing homes, home care services, elder law attorneys, and private long-term care insurance – has thrived in recent decades.

The theoretical argument developed in Chapter 2 explains the austere aspects of U.S. public long-term care policy. In the United States, extraordinarily individualistic political competition, underpinned by its personal-vote oriented electoral system, encourages congresspersons to seek particularistic benefits for their constituents. Since they have to compete with opponents in both primary and general elections, their electoral campaigns cannot rely on the party platform and therefore requires a highly personalized political machine for the sake of (re-) election. To maintain their political machines, congresspersons are urged to bring particularistic benefits to their electoral districts and special-interest groups contributing to their coffers. Those individualistic congresspersons have fewer incentives to appeal to the general public and more incentives to please their constituents with particularistic benefits than, for instance, do the politicians in Sweden (see Chapter 4). The individual congresspersons retain their policy-making power inside the Congress, instead of delegating it to the executive branch, using it as leverage for particularistic benefits. Since political parties have weaker discipline, it is difficult for either the executive branch or the party leadership to whip the self-seeking behaviours of congresspersons and coordinate the benefits and expenses of social protection programs in an equitable way. The state – the federal government – is deeply embedded in societal interests.

These characteristics of U.S. politics do not deny the possibility that universalistic social policy legislation can be enacted in the Congress. Especially, the president and ambitious party leaders have incentives to advocate generic public programs appealing to broader constituencies because the president is elected by the general public. The president and the party leaders can enact their policy proposals as long as they placate stakeholders connected to congresspersons and build a super-majority coalition in the Congress. In reality, however, it is hard to imagine that universalistic social policy does not offend any existing interests.

Although this present study's theory spells out the logic of Congress's inaction regarding elderly care, it does not account for the actual changes of elderly care policy in the United States. How can we understand those

incremental changes? Since the expected effects of comprehensive policy reform are conspicuous to politicians and interest groups, such reform is less likely to pass the Congress due to the reason exemplified above. By contrast, a small, incremental change – especially when attached to a large omnibus bill – is less noticeable and easier to get enacted in the fragmented U.S. polity. In fact, myopic congresspersons have incentives to attach a small amendment to a bill in order to claim credit for it when facing their constituencies, and those congresspersons are prone not to foresee the outcomes of those small amendments. Current elderly care programs in the United States result from the accumulation of those small, inconspicuous, and incremental changes.

This chapter describes the evolution of elderly care policy in the post-war United States. Section 6.1 exemplifies how individualistic political competition supported by the personal-vote oriented electoral rules structure the American policy-making process. It looks at the Constitution, electoral system, legislative institutions, and intergovernmental relations. This section will reveal that the intentions of the Founding Fathers are admirably materialized in today's U.S. polity. Section 6.2 describes the characteristics of public and private elderly care programs in the United States. Then, Section 6.3 overviews the legislative history of long-term care during the post-war era in the United States. It will show that the emphasis of policy makers has shifted from public programs to private solutions since several attempts to expand public roles in long-term care collapsed. Section 6.4 summarizes the argument of the entire chapter.

6.1 The characteristics of political institutions in the United States

The U.S. political system is the mirror image of the Swedish system: it is characterized by a vertically and horizontally fragmented polity and highly decentralized political parties. As designed by the architects of its Constitution (Hamilton, Madison, and Jay, 1961, No. 47), the United States has strict separation of powers among the executive branch, the legislative branch, and the judicial branch. Unlike in a parliamentary system, the executive branch and the legislative branch do not rely on each other: while Congress does not select the president from among its members, the president cannot dissolve the Congress. Since the codependent relationship between the executive branch and the legislative branch – common in a parliamentary system – is severed under the U.S. Constitution, the presidency does not place its existence on the

confidence of the Congress, whereas the latter keeps its policy-making function within itself. Furthermore, the U.S. Constitution stipulates a quite strict bicameralism. It is difficult to say which is superior to the other: while only the U.S. Senate is allowed to ratify treaties and approve presidential appointments (e.g., Supreme Court judges), the U.S. House of Representatives has the sole power to introduce a revenue bill. Through forcing each government branch to check and balance each other, the framers of the Constitution aimed at protecting the U.S. polity from the rule of tyranny.

The electoral system is also contributing to the fragmentation of political authority in the United States. Since the separation of powers would be nullified if one centralized party dominated all governmental branches, its individualistic electoral system is more important in preventing the concentration of political power. The United States uses a single-member district (SMD) system with a primary election for selecting the president, representatives, and senators. This system requires a candidate to defeat colleagues of the same party first and then to challenge a rival party's candidate for election. While this system makes it extremely hard for party leaders to control the candidacy of their own party, it forces each candidate to run her electoral campaign by her own resources. Since each candidate cannot solely count on the party platform and party finances to get (re-)elected, she needs to cultivate personal votes and build her own political machine. As a result, a political party looks like a congregation of autonomous legislators, and party leaders rarely monopolize important political capitals such as campaign finances, a campaign platform, personnel affairs, and policy decisions.

The autonomy of each legislator and his or her responsiveness to constituency allow interest groups to influence the policy-making process in Congress. Since the legislative branch retains its law-making function rather than delegating it to the executive branch or to party leadership, re-election oriented, individualistic congresspersons are required to coordinate each other's interests within the Congress. The committee system is a solution to such interest coordination among egalitarian legislators. It creates order in the potentially chaotic preference aggregation process through facilitating division of labour among legislators (cf. Shepsle, 1979). This 'division of labour' provides interest groups with opportunities to block unfavourable policy proposals. Each standing committee has its own jurisdiction, and it exercises strong authority in its respective jurisdiction. Since each committee controls agenda-setting power on its turf, interest groups do not need

to dissuade the majority of legislators from voting for a certain bill on the floor in order to stop it. All they have to do is to persuade the majority of committee members to abort the bill, to persuade an influential committee chairperson not to deliberate it, to entice committee members to amend it with the clauses negating its original intention, and so on. Re-election oriented legislators are usually attentive to those demands of vested interests because they need to maintain their political machine under the personal-vote oriented electoral system.

The above features – the separation of powers, electoral rules, weak party leadership, and the policy-making process open to societal interests – have created individualistic political competition in the United States. Whereas legislators in Sweden and Japan delegate interest coordination and policy-making functions to the executive branch, in the United States congresspersons themselves produce legislation by negotiating with each other through the deliberative process full of veto players. Not the party but the individual legislator is the main actor in the U.S. political system. As a result, the state – the federal government – is deeply embedded in societal interests under the U.S. polity.

Electoral rules and legislators' behaviour

Under the current U.S. electoral rules, the president, representatives, and senators are directly elected by the people in single-member district (SMD) system with primary elections (see Table 6.1). The 435 members of the House of Representatives are elected by a plurality rule from districts apportioned according to their population, and serve a two-year term. All of the representatives face re-election at the same time every two years. The 100 members of the Senate are elected by the states, each of which is assigned two seats, and serve a six-year term. Obviously, the Senate's seats are malapportioned according to population and skewed to small states. Finally, the president is elected by the Electoral College. It is composed of popularly elected electors assigned to each state according to its population size. Every above office requires a potential candidate to win the primary election to obtain a party candidacy in the following general election.

Since a candidate for each office is required to compete with intra-party competitors in the primary election, running for the office is a personal enterprise rather than a party's business. For instance, one of the most important criteria to be a successful candidate is whether she can attract money enough to operate a credible campaign by herself. In fact, congressional challengers – not incumbents – rarely win the election if they do not spend a substantial sum of money for their campaigns. According to Jacobson's (2009, p. 47) estimates, 'the

Table 6.1 The U.S. electoral systems

	Name of electoral system	District magnitude	Number of districts	Assembly size	Length of term	Others
President	SMD with primary	1	1	–	4 years	Election through the Electoral College
House of Representatives	SMD with primary	1	435	435	2 years	Number of districts of each state is proportional to its population
Senate	SMD with primary	1	50	100	6 years	Each state has two senators

Source: The U.S. Government (n.d.).

minimum price tag for a competitive House campaign under average conditions today is probably closer to $800,000.' A House candidate needs to prepare for a considerable amount of money by herself. Needless to say, running for the Senate or the presidency demands the ability to accumulate far more funds. Building a good campaign organization is also a personal endeavour for each candidate. A successful campaign requires a candidate to organize professional campaign strategists, gather intelligence, execute an effective advertising campaign, identify and rally supporters, and get them to the polling place on election day (Jacobson, 2009, pp. 87–93). The candidate has to take care of those tasks because – unlike legislators in Sweden – she cannot solely rely on her party organization.

Under the personalized political competition and weak party discipline in the United States, how are politicians – especially congresspersons – motivated to behave? David Mayhew (1974), a prominent American political scientist, argues that congresspersons have incentives to engage in the following three activities: 1) advertising, 2) credit claiming, and 3) position taking. First, *advertising* is 'any effort to disseminate one's name among constituents in such a fashion as to create a favourable image' (p. 49). Although building a favourable brand as a congressperson is the ultimate goal, just getting her name known across the electoral district is a stepping stone for a successful congressperson. Second, *credit claiming* is 'acting so as to generate a belief in a relevant political actor (or actors) that one is personally responsible for causing the government, or some unit thereof, to do something that

the actor (or actors) considers desirable' (p. 53). The key point here is that congresspersons seek *individual* accomplishment rather than party or governmental accomplishment to please their constituencies. To achieve this goal, congresspersons engage in constituency services or 'casework' and try to bring particularized benefits to their supporters.[1] Third, *position taking* is 'the public enunciation of a judgmental statement on anything likely to be of interest to political actors' (p. 61). For example, a vote cast and public statement for or against a war is an important position taking, which can ruin her candidacy or bestow the office on her.

Among these three activities of congresspersons, the practice of credit claiming has the most significant implications for policy-making and the style of distributive politics in the United States. The president can claim credit for governmental achievement and public goods, which benefit and impose a burden on the general public, because the president is elected by the entire population. On the contrary, congresspersons – the members of the House and the Senate – find it hard to claim personal credit for those goods. Nobody believes her if a congressperson says 'I'm responsible for the improvement of the inflation rate and the unemployment number.' Hence, congresspersons have a strong incentive to supply particularized benefits for their constituents. One of the most important forms of those particularized benefits is *pork-barrel legislation*. Through this type of legislation, congresspersons seek to carve out federal projects and funding and then 'bring home the bacon' to their constituencies. Other examples of particularized benefits congresspersons engage in are providing their constituents with special treatment in industrial regulations, creating tax-loopholes to benefit them, and so on. Since these particularized benefits are only available to incumbent congresspersons, the incumbency has a significant advantage in the primary and general elections (Lowi et al., 2008, pp. 186–192; Mayhew, 1974).

Of course, the above argument does not necessarily deny the possibility that the U.S. Congress enacts legislation providing public goods for the general public. In fact, several scholars show that the Congress can supply public goods serving the general interest, with the agenda-setting power of the majority party (Cox and McCubbins, 1993), through log-rolling, using pork-barrel projects (Evans, 2004), when a program's general beneficial impacts are salient (Arnold, 1990), and so forth. However, recognizing that the personal-vote oriented electoral system motivates legislators to bring particularized benefits to their

constituency is important for understanding how difficult it is for the U.S. political system to produce public goods.

Committee system and its legislative consequences

The Congressional committee system is the core institution of the legislative process in the United States.[2] It is a division-of-labour system and allows individual legislators to exercise disproportionate influence in specific policy areas important to them. Each standing committee has its own jurisdiction and legislative authority. Through policy specialization and division of labour, the committee system facilitates interest coordination among legislators and serves their demands, which is to serve their constituency's demands.

All policy areas are compartmentalized into policy jurisdictions, and each standing committee is responsible for a particular jurisdiction. Virtually all bills are assigned to a standing committee, depending on the subject of the legislation. Except for the committees of appropriation and rules in both chambers, the jurisdiction of each standing committee is arranged according to the functions of the executive branch's organization. Since legislators keep engaging in the deliberation of a particular policy issue, they are encouraged to cultivate expertise and specialty in the policy field (Lowi et al., 2008, pp. 204–205).

The committee system is important because each committee holds a life or death authority over a bill under its jurisdiction. First, a committee functions as a gatekeeper. Although any congressperson can submit a bill to the legislature, the bill is automatically assigned to an appropriate committee, which then decides whether the bill should be brought to the floor. In fact, during a typical session of the House, while almost 8,000 bills are submitted during each session, most of them abort within the respective committee (Lowi et al., 2008, p. 206). Second, a committee holds the proposal power. The committee with jurisdiction for a certain bill can take no action on it, amend it with discretion, or even write the committee's own legislation. Obviously, these rules allow committee members to adjust any policy proposals in line with their policy preferences, and then grant them enormous power in their respective jurisdictions (ibid.).

Third, a committee holds ex-post adjustment power in the legislative process of the Congress. After either the House or the Senate passes a bill, the bill needs to be deliberated and passed by the other chamber to be enacted under U.S. bicameralism. When the other chamber passes a bill different from the one passed by the first chamber, and the latter

does not accept the different bill, the two chambers hold a conference committee composed of members of both chambers. This conference committee discusses the differences between these two versions and produces a compromised bill. In most cases, conferees are selected from the committees having jurisdiction over the original bill. Thus, committee members can monitor the bill even after they have released it to the floor (Lowi et al., 2008, p. 206; Shepsle and Weingast, 1987).

Fourth, a committee has the power of legislative oversight over policy implementation by the bureaucracy. Even if a bill is passed Congress and approved by the president, the law is not necessarily implemented according to the original intention of the Congress. In fact, bureaucrats in the executive branch might not do what the law stipulates unless there is some oversight over the implementation. Congressional committees keep an eye on the implementation process in various ways, such as holding hearings in the committee's session (Lowi et al., 2008, pp. 206–207).

Through the above authority, committees exercise substantial influence on policy under their respective jurisdictions, and then each congressperson brings benefits to her own constituency by belonging to the committee relating to their interests and cultivating expertise in it.

Although the distribution of influential committee posts and authority can have detrimental effects to cooperation among egalitarian congresspersons, a seniority system contributes to the coordination among them and augments the autonomy of standing committees. Since the membership of popular committees, such as the House Committee on Appropriations[3] and the House Ways and Means Committee,[4] and the number of chairpersons are limited, the committee system requires rules that organize legislators hierarchically. To solve this coordination problem, the Congress has developed the seniority system: chairmanships and influential posts are assigned to individual legislators on the basis of the length of terms each congressperson has served. A typical case is the allocation of committee chair posts: it was a customary rule to assign chairmanship to the most senior member in each committee. Although the seniority rule was modified under the Republican Revolution during the 1990s, senior members can still expect to get chairmanship or ranking membership in each committee. Through automating the promotion process in the Congress, legislators insulate each committee from the influences of party leaders and ensure its autonomy and authority over the respective jurisdiction (cf. Epstein et al., 1997; Polsby, Gallaher, and Rundquist, 1969).[5]

Since relatively autonomous congressional committees have the power to control a policy proposal under their respective jurisdiction, interest groups can more readily influence the law-making process by targeting their resources on the committee members having jurisdiction over their interest. Since the members of congressional committees hold the agenda-setting power, they do not need to conduct a conspicuous political campaign to protect their contributors. All they have to do is to put aside policy proposals unfavourable to their constituency. Interest groups appear to consider this power to be worth millions of dollars of campaign contributions.

The separation of powers and de facto super-majority rule

The framers of the U.S. Constitution created the separation of powers among the president, the Congress – the House and the Senate – and the Supreme Court, and intended to make them check and balance each other (Hamilton et al., 1961, No. 47). As a result, the Constitution bestows on the president the power to veto legislation enacted by Congress, and on the Congress the power to override the veto by two-thirds majority. Obviously, this constitutional establishment – the checks and balances between the executive branch and the legislative branch – has significant impact on the law-making process in the U.S. political system. This constitutional arrangement potentially generates legislative stalemate – 'gridlock' – between these two branches.

Although 'gridlock' is a common phenomenon in U.S. politics, American political scientists do not necessarily agree on the causes and effects of executive–legislative gridlock. Many political scientists and pundits have attributed gridlock and the lower productivity of law-making in the Congress to the condition of 'divided government'. That is, the U.S. polity is inclined to face gridlock and diminish its legislative productivity when different parties dominate the executive and the legislative branch. On the contrary, legislative productivity increases under unified government (cf. Sundquist, 1981; Sundquist, 1988). This conventional wisdom sounds reasonable, but its assumption is unjustifiable in the U.S. politics. Whereas the above claim concerning divided versus unified government assumes that a political party is a definitive legislative vehicle to enact a bill and able to discipline their legislators in the Congress, American political scientists themselves have demanded such a centralized, responsible political party in the Congress as an ideal goal (American Political Science Association's Committee on Political Parties, 1950). It is not a reality. Furthermore, Mayhew (2005) empirically shows that a unified opposition to divided

government makes no important difference in terms of the enactment of important legislation. He reveals that most important legislation passed the Congress with bipartisan and super-majority support during the 1947–1990 period. It appears that the U.S. Congress has lower legislative productivity *regardless of a unified or divided government* and requires congressional leaders to fashion an over-sized coalition among legislators to enact a bill.

Although I refrain from delving into the debate among American political scientists here,[6] the point is that legislative stalemate is the outcome of various institutional settings. First, the Senate's procedural rules allow minority factions to filibuster a bill they oppose and require a cloture vote of three fifths of the Senate to end the filibuster. Second, the difference of electoral districts creates distinctive policy preferences among the president, members of the House of Representatives, and members of the Senate. As discussed above, while the Electoral College of the president election and the districts of the House election are apportioned according to population, the electoral districts of the Senate are malapportioned and skewed toward the small states. Third, the Senate has a longer electoral cycle than the House, and as a result senators are less responsive to the swing of public opinion than are representatives. Due to these reasons, the policy positions of the median voter of the House and the president are usually distant from that of the 60th senator, whose vote is pivotal to passing a bill in the Senate, on a certain policy dimension. This institutional arrangement creates a status-quo bias in the legislative process of Congress because enacting a bill requires the situation where all pivotal voters – the president, the median voter of the House, and the 60th senator – prefer the bill to the status quo (cf. Krehbiel, 1998).

Summary

This section argued that the particularistic voter–politician linkage underpinned by the personal-vote oriented electoral system created individualistic political competition. Although the party leadership has been increasing its influences over the rank-and-file legislators in recent decades, not political parties but individual politicians have been the main actor in the U.S. political process. Since the individualistic political competition requires each congressperson to bring particularistic benefits to her constituency, the U.S. Congress has developed the committee system as the political device to allow individual legislators to distribute the national wealth to their constituencies in a 'fair' way through the division of labour and the seniority rule. The characteristics of the U.S. polity are also crucial to its policy process. The horizontal separation of

powers – the strict bicameralism, the presidential veto, and the custom of filibuster in the Senate – demands that important legislation create a bipartisan and super-majority coalition among legislators, and then it creates a status-quo bias in the law-making process. Under these conditions, universalistic social care services are less likely to flourish in the United States.

6.2 Elderly care programs in the United States

There has been no consistent 'long-term care policy' at the federal government level in the United States. Although the executive bureaucracy and Congress have addressed malpractice and poor quality in nursing home care, tackled waste in Medicaid expenditures for nursing homes, expanded home- and community-based care (HCBC) services by making Medicaid mandates more flexible, all of these reforms were carried out in an ad hoc way. As a result, current elderly care policy is a patchwork of past amendments to various laws, and many tasks of public long-term care provision are left to state governments' discretion.

Public programs for long-term care

There exist various public programs funding long-term care services in an uncoordinated way in the United States. Medicaid is the largest public funding source for diverse long-term care services. In 2005, Medicaid paid for almost half – 48.9 per cent – of public and private long-term care spending for both the younger and older populations (Long-Term Care Financing Project, 2007). Medicare covers a stay in skilled nursing facilities and the usage of home health care services but its conditions on those benefits are highly restrictive (see below). Furthermore, the Older Americans Act (OAA) and the Social Services Block Grant (SSBG) support home- and community-based services (HCBS) but their roles in the entire long-term care financing are limited. Each of these federal programs has distinct eligibility criteria, program structures, covered services, and financing methods (cf. O'Shaughnessy, Stone, and Gabe, 2007).

Medicaid is a means-tested health care assistance for low-income individuals and families, jointly funded by federal and state governments. Medicaid, which was established through amendments to the Social Security Act during the 'Great Society', mandates state governments to provide health care benefits for certain persons who meet financial, categorical, and functional eligibility criteria. Due to these mandates, Medicaid is called an entitlement program, and the federal funding for each state is determined by the number of people participating in the

program and services provided (federal matching funds) (see Health Care Financing Administration, 2000).[7]

Since its enactment, Medicaid has been a primary public program funding long-term care services. It covers, as a mandatory service, nursing homes stays, intermediate care facilities (ICFs), and intermediate care facilities for people with mental retardation (ICFs/MR). As a result, for instance, Medicaid has paid for almost half of the nation's nursing home care costs since the mid-1970s (see Table 6.2). Medicaid also allows states to provide HCBS – such as personal care, homemaker support services, and adult daycare services – for certain eligible individuals with long-term care needs as a waiver program (see below).[8] Since Medicaid bears a huge burden of long-term care financing, the Medicaid spending for long-term care services is the large item among Medicaid programs: Medicaid expenditures for long-term care services accounted for more than 30 per cent of the entire federal and state Medicaid budgets during the 1993–2005 period (cf. Burwell, Sredl, and

Table 6.2 Nursing home care expenditures in millions by source of funds, 1970–2005

		Private			Public		
Year	Total	Out of pocket	Private health insurance	Private funds total	Medicaid	Medicare	Public funds total
1970	4,040	2,102	10	2,304	940	143	1,736
	(100)	(52.0)	(0.2)	(57.0)	(23.3)	(3.5)	(43.0)
1975	8,493	3,397	41	3,818	4,270	220	4,676
	(100)	(40.0)	(0.5)	(45.0)	(50.3)	(2.6)	(55.1)
1980	19,023	7,071	220	8,089	10,242	307	10,934
	(100)	(37.2)	(1.2)	(42.5)	(53.8)	(1.6)	(57.5)
1985	31,603	12,075	1,030	14,964	15,439	454	16,639
	(100)	(38.2)	(3.3)	(47.3)	(48.9)	(1.4)	(52.7)
1990	52,623	19,021	2,939	25,754	24,105	1,700	26,869
	(100)	(36.1)	(5.6)	(48.9)	(45.8)	(3.2)	(51.1)
1995	74,082	20,845	5,837	31,679	34,084	6,690	42,403
	(100)	(28.1)	(7.9)	(42.8)	(46.0)	(9.0)	(57.2)
2000	95,262	28,685	7,883	41,098	41,996	10,132	54,164
	(100)	(30.1)	(8.3)	(43.1)	(44.1)	(10.6)	(56.9)
2005	121,862	32,286	9,139	45,925	53,479	19,175	75,937
	(100)	(26.5)	(7.5)	(37.7)	(43.9)	(15.7)	(62.3)

Note: Percentages are shown in parentheses. Numbers and per cents may not add to totals because of rounding; $ amounts shown are in current dollars.

Source: Centers for Medicare and Medicaid Services (n.d.).

Eiken, 2006). Medicaid is a de facto public long-term care program in the United States.

Although Medicaid was established as a means-tested health care assistance for *poor* people, it does not necessarily mean that Medicaid covers the costs of institutional and community care services only for the lower-income strata. First, the income threshold for institutionalized patients is less stringent than other categories under the rules of Medicaid eligibility. If they are living in medical institutions, individuals and couples who have monthly income up to 300 per cent of the Supplemental Security Income (SSI) payment can be eligible for Medicaid as 'categorically needy' (Centers for Medicare and Medicaid Services, 2005, p. 2). Since 300 per cent of the monthly SSI payment amounts to $2,022 for an eligible individual and $3,033 for an eligible individual with an eligible spouse in 2009, many pensioners do not need to worry about their income when they apply to Medicaid.[9] Second, even if an applicant has too much income and assets to be eligible as 'categorically needy', he or she might be eligible for Medicaid as 'medically needy'. Since the law allows states to provide the aged and the disabled with Medicaid at the state's option, those who are institutionalized to nursing homes can be eligible for Medicaid in many cases once they deplete their assets.[10] Because the costs of nursing home stay are expensive (the average cost for a nursing home stay was $68,985 per year in 2007),[11] many middle-class patients become eligible for Medicaid shortly after they are admitted to a nursing care facility. In fact, Medicaid pays the costs of more than half of all nursing home residents (Congressional Budget Office, 2005, p. 8).

Whereas Medicaid, which was created to serve lower-income people's welfare, has assumed a substantial role in supplying long-term care services, Medicare, which was established as public health care insurance for the aged, has played a less conspicuous role in long-term care in the United States. Although Americans themselves often misconceive this, Medicare does *not* meet chronic care needs of the nation's aged and disabled population. It covers skilled nursing facility (SNF) care for those who need skilled nursing and/or rehabilitative services following hospitalization of at least three consecutive days, but Medicare covers just up to 100 days SNF services (O'Shaughnessy et al., 2007, p. 39). Furthermore, Medicare can also finance home health services, but it requires recipients to be confined to their homes – 'homebound' – and their physician's certification requesting daily skilled care or rehabilitative services related to the previous hospitalization

(ibid.). Since Medicare is designed to provide benefits for a recipient so that he or she recovers from acute illness or hospitalization, it does not cover the long-term care needs resulting from chronic illness or disabilities.

Although there are some other federal programs addressing long-term care, these programs are too small to affect the entire long-term care demands in the United States. The Older Americans Act authorizes grants to states to provide broader long-term care services, including homemaker services, nutrition services, caregiver support services, and so on. However, the funding for those services under the authorization of this act is only about $1.2 billion (O'Shaughnessy et al., 2007, p. 40). Similarly, the Social Services Block Grant authorizes grants to states for broader social services, including HCBS. The impact of this grant is also limited.

Home and community-based services and Medicaid waiver programs

Although experts have for a long time pointed out its institutional bias, Medicaid is currently the largest funding source for home and community care services. While the original Title XIX of the Social Security Act, which stipulates the Medicaid programs, obliges state governments to use Medicaid funding for institutional care services in most cases, Section 1915(c), which was added to the Social Security Act in 1981, permits states to provide long-term care services under community settings for those who would qualify for institutional care under Medicaid. Section 1915(c) is termed HCBS waiver programs because it waives the mandates for states to provide the Medicaid benefits for all eligible recipients in an equitable way. Under the authority of HCBS waiver programs, state governments are allowed to target various home and community care services in specific categories such as the aged, the disabled, mental retardation and developmental disabilities (MR/DD), and so on. State governments can select specific HCBS programs and targeted groups, and can use the Medicaid funding for them as a state's option under the authorization of the Department of Health and Human Services (HHS) (cf. Shirk, 2006).

Due to these HCBS waiver programs, Medicaid spending on long-term care services in community settings has been rapidly growing in the past two decades. While Medicaid expenditures for HCBS accounted for only 13 per cent of the total Medicaid long-term care services spending in 1990, HCBS spending accounted for 41 per cent in 2006. By contrast, Medicaid spending for institutional care services has been constrained

in the 2000s (Kaiser Commission on Medicaid and the Uninsured, 2009, p. 2).

However, the expansion of Medicaid HCBS waiver programs has not necessarily led to a shift from institutional care towards community care among frail older people. The bulk of the spending for Medicaid HCBS waiver programs goes to younger disabled people, especially people with mental retardation. The spending for people with mental retardation or developmental disabilities made up more than 70 per cent of Medicaid expenditures under HCBS waiver programs in 2002 (Shirk, 2006, p. 4).

It is less likely that severely disabled seniors who are eligible for the Medicaid coverage for nursing home care opt for home and community care, especially because the Medicaid payment for institutional care covers bed and board as well as nursing care costs. HCBS waiver programs do not pay for housing and meal costs. In addition, since the type and size of HCBS waiver programs are determined by state governments, those services might not be available to a senior citizen, depending on where he or she lives. These policy features lead to a peculiar picture of long-term care provision for older people in the United States: as Table 6.3 suggests, while the coverage of institutional care services has been comparable to other advanced industrialized countries, that of home care services is much lower than the average of those countries. For most senior Americans, it is a natural route to be admitted to a nursing home, spend down their assets there, and receive benefits from Medicaid while residing in the institution.

Table 6.3 Coverage of institutional and home care services for aged 65 and over

	Year	% of 65+ receiving long-term care in an institution	Year	% of 65+ receiving home care benefits
United States	1973–1974	4.5		
	1985	4.6	1992	3.0
	1995	4.2	1996	5.3
	1999	4.3	2000	2.8
Aveg. of other OECD countries*	2000	4.5		9.0

Note: *Unweighted average of selected OECD countries.

Source: Author created based on OECD (2005, p. 41).

'Universalism within targeting'

Medicaid is now functioning as a de facto institutional care benefit for the middle-class in the United States. It covers nearly half of the nation's nursing home residents, and therefore it is least likely that all of those recipients are 'poor' people. According to Waidmann and Liu (2006, pp. 3–4), about 19 per cent of nursing home residents had been eligible for Medicaid before being admitted to nursing homes, and had received full benefits in their community settings. Although they might have depleted their income and assets through spending for medical and home care services prior to their admission to nursing homes, this group can be called 'poor'. However, another 19 per cent of nursing home residents become eligible for Medicaid at the same time of, or within one year of, nursing home admission, and 4 per cent become qualified for Medicaid after a year or more of entering nursing homes. As the depletion of their income and assets due to expensive nursing home care costs resulted in their enrolment in Medicaid as 'the medically needy', it is difficult to categorize these nursing home residents as 'poor'.

Although Medicaid requires its recipients to 'spend down' their income and assets, it does not necessarily mean that they have to exhaust all of their resources to be eligible. There are two ways that middle-class – not 'categorically needy' – senior citizens qualify for Medicaid: 'spending down' their income and assets or transferring their financial assets to someone. First, as discussed above, when nursing home care costs are high enough, an applicant can be qualified for Medicaid once he or she has reduced countable assets to the eligible level even if his or her income is higher than 300 per cent of the maximum SSI payment. While those countable assets, such as savings accounts, stocks, or other equities, cannot exceed $2,000 for an individual and $3,000 for a couple,[12] an applicant's primary residence (i.e., home) is not included in this calculation.[13] In addition, the law has clauses that protect the spouse of Medicaid recipients from impoverishment due to this 'spending down' process. Medicaid law allows a 'community spouse' – who is a spouse of an institutionalized Medicaid recipient and lives in the community – to retain a certain amount of assets. The amount ranges from $20,880 to $104,400 in total countable assets in 2008, depending on the state of residence. All of a community spouse's income is not taken into his or her institutionalized spouse's Medicaid eligibility calculation. If a community spouse has limited income, an institutionalized spouse can transfer his or her income up to a certain threshold.[14] These procedural

rules lessen the stringent aspects of Medicaid's financial eligibility criteria (Stone, 2008, pp. 7–10).

The second way for the middle-class seniors to qualify for Medicaid is 'asset transfer'. Since federal law restricts Medicaid benefits for those who disposed their assets for less than fair market value within a certain time period, a state government conducts a review of the financial transactions of an applicant for Medicaid coverage for long-term care services. If the state government detects an unallowable asset transfer during a certain 'look-back period' – currently five years[15] – it disqualifies the applicant from Medicaid long-term care coverage for a certain penalty period. The length of penalty period varies according to the amount of transferred assets in question and the average private-pay cost of nursing home stay in the respective state (Government Accountability Office, 2005, pp. 11–12; Stone, 2008, p. 12).[16] Although federal and state regulations on asset transfer are much more complicated than the above description, and the implementation of these rules varies across states, applicants for Medicaid long-term care coverage can protect their financial assets by manoeuvring those assets advantageously, without violating these regulations.

As Grogan and Patashnik (2003) call it 'universalism within targeting', Medicaid, which was designed as health care assistance for the lower-income population, has been gradually transformed into de facto long-term care benefits for the broader population. Its income limitation is lenient for the medically needy such as nursing home residents. Although the asset limitation of Medicaid is quite stringent, the recipients of Medicaid long-term care coverage tend to deplete their resources quickly due to the high costs of nursing home care. Since about half of all elderly households had less than $50,000 of non-housing resources (Government Accountability Office, 2005, pp. 13–15), the asset limitation is less likely to cap the Medicaid expenditures for nursing homes. Furthermore, a spouse and family members of institutionalized Medicaid recipients do not necessarily need to deplete their resources, and there are many ways to protect the assets of Medicaid recipients. The mundane description of Medicaid, such as 'a means-tested program for the poor', misstates the reality.

Long-term care programs and inequality

Numerous kinds of inequality are rooted in long-term care policy in the United States. First, inequality across states is huge. Although Medicaid is an entitlement program and imposes mandates on state governments, its program structure, such as eligibility criteria and coverage of services, is

surprisingly different across states. Some states have much more meagre HCBS programs than other states. Since state governments are allowed to target the benefits on specific categories and geographic areas under Medicaid HCBS waiver programs, some inhabitants might not have any possibility to receive the benefits of Medicaid long-term care coverage. As a result, Medicaid expenditures for long-term care services are surprisingly varied across states. Whereas three states (New York, Connecticut, and Pennsylvania) and District of Columbia, spend more than $500 per inhabitant on Medicaid long-term care services, seven states (Florida, Texas, Colorado, Virginia, Utah, Nevada, and Arizona) spend less than $200 per inhabitant on those services (Burwell et al., 2006). Although we cannot arrive at any conclusion about program generosity from this data unless controlling the demands for care services, still we can see a large difference of expenditure level across states.

Second, inequality is also enormous at the individual level. As is obvious in the above description, the structure of public long-term care programs is too complicated to apprehend, and therefore whether those who need care services can take advantage of public funding totally depends on their knowledge and personal networks. They might not know that Medicare does not cover nursing home care resulting from chronic illness and disabilities, but it does cover a stay of up to 100 days in skilled nursing facilities right after hospitalization for acute illness. The most notorious example is 'Medicaid estate planning': while those who can consult an elder-law attorney on asset transfer take full advantage of Medicaid long-term care benefits, others have to spend down their resources first in order to be eligible for those benefits. The same needs of long-term care do not necessarily lead to the same amount of care services, even in the same state.

What characterizes the U.S. long-term care policy is, as already mentioned, 'universalism within targeting' (cf. Grogan and Patashnik, 2003). Since its inception, Medicaid has been a major funding source for nursing homes and gradually expanded its roles in home and community care services. Its eligibility requirements have been amended a number of times to address severe problems, such as the impoverishment of a community spouse. As a result, the program has been approaching de facto public long-term care benefits for the middle class. However, Medicaid is still a means-tested welfare program, and its program structure is rooted in this feature. It is unlikely that the federal and state governments would expand the coverage of Medicaid long-term care services to the entire aged population. The rest of this chapter depicts

how these characteristics of U.S. elderly care policy have been generated during the post-war period.

6.3 The legislative history of long-term care policy in the United States

The history of U.S. long-term care policy is largely a by-product of broader and more significant social legislation. Individual legislators have been less interested in universalizing elderly care programs and rarely succeeded in forming a coalition able to bring a universalistic long-term care bill to the floor. The president and party leaders have also failed to pass a comprehensive reform bill on long-term care in the Congress. The current long-term care policy resulted from the accumulation of incremental changes and historical contingencies.

Kerr–Mills Bill

Medical Assistant for the Aged – known as Kerr-Mills in 1960 – was the harbinger of the establishment of Medicaid. The program structure of Medicaid nursing home care coverage was already prepared in this law, and its enactment resulted from the triumph of incrementalism over a radical-reform approach.

As in most other countries, the various categories of indigent people, including the old-aged poor, were accommodated in poorhouses and almshouses managed by counties or municipalities until the early twentieth century. The advent of Social Security in 1935 created a federal program of grants-in-aid to the states for old age assistance (OAA), which is non-contributory, means-tested old-age pension adopted as part of the New Deal in 1935, and which lifted the well-being of those old-aged poor. However, OAA did not work towards the improvement of public institutions such as poorhouses and almshouses. Since the conditions of almshouses were notoriously terrible, the law prohibited states from paying OAA benefits to any inmate of a public institution. As a result, OAA beneficiaries who were too frail to support themselves at home turned to proprietary homes for the elderly. Public almshouses were then gradually replaced by private, for-profit institutions (Vladeck, 1980, pp. 33–39).

The defeat of the Truman health care proposal in 1949, which aimed to introduce the national health insurance left out of the part that was implemented in the New Deal, is the important background for Kerr–Mills. Under the nation's post-war weariness towards the New Deal and anti-communism sentiments, the national health insurance proposal was

not even reported out of committee. The American Medical Association (AMA), the doctor's trade association, successfully defended itself from 'socialized medicine'. By contrast, the Truman administration and the Social Security Administration succeeded in amending the Social Security Act. The amendments of 1950 removed the prohibition of OAA payment for a resident of public medical institutions, introduced a new category of recipients – the 'permanently and totally disabled' – and authorized state and local governments to use federal matching funds for direct payment to the suppliers of medical services for those eligible for public assistance. The last point of the amendments is called 'vendor payments' for medical care, and it opened the way for medical institutions, including nursing homes, to recover the costs of indigent patients from public assistance. The Social Security Amendments of 1950 passed both houses of Congress by a large margin in August 1950 (Smith and Moore, 2008, pp. 30–35; Vladeck, 1980, p. 40). Through experiencing the setback of Truman's universal health insurance proposal and the success of the Social Security Amendments, the proponents of national health insurance in the Truman administration and the Social Security Administration learned that incremental change through amending the Social Security Act is strategically superior to a comprehensive proposal. They aimed to expand health care coverage over limited social groups step by step and reach broader coverage in the end.[17] For these incremental tactics, the categorically poor and the aged were obvious primary choices.

The contrast between the defeat of an ambitious, comprehensive proposal and the passage of an incremental bill was repeated in 1960. In 1957, Representative Aime Forand (D, Rhode Island), a member of the House Ways and Means Committee, introduced a health insurance bill for Social Security beneficiaries. At first, the bill received hardly any attention on Capitol Hill, except from the powerful doctors' group, the American Medical Association (AMA). Then, Senator John F. Kennedy (D. Massachusetts), who was preparing a run for the presidency and looking for a campaign issue, picked up the bill. In 1959, the Senate established the new Subcommittee on Problems of Aged and Ageing, and Kennedy served as its highest ranking Democrat, with his close friend, Senator Pat McNamara (D, Michigan) as chairman. Shortly after he announced his candidacy, Kennedy reintroduced the Forand bill in Congress. However, the AMA remained adamantly in opposition to the bill, and the House Ways and Means Committee quickly killed it by 17–8 vote (Smith and Moore, 2008, pp. 36–37; Vladeck, 1980, p. 46).

The proponents of the Forand bill underestimated the power of committee chairpersons in the Congress. Wilbur Mills (D, Arkansas) – the

chairman of the House Ways and Means Committee – as a fiscal conservative did not support the Forand bill's scheme that expanded health care coverage by using the Social Security trust fund. Without this tactful and astute legislator's support, it was difficult for a bill to create a coalition strong enough to get out of committee and reach the floor. In fact, when the separate proposals supported by Kennedy and by Eisenhower, respectively, were killed in his committee, the Democratic leadership approached Mills to urge him to get a bill out of his committee. They wanted to promote public awareness regarding a health care issue and to articulate partisan differences for the coming presidential election – although they expected any Medicare-type bill would be vetoed by Eisenhower (Smith and Moore, 2008, p. 37). However, Mills saw that in his committee 'such a legislative measure did not have the necessary votes at that time' (Mills, 1985, p. 1). To the Democratic leadership's surprise, Mills reported out his own bill, which had been secretly prepared and was completely different from the health care insurance for the aged, and passed it by a large margin in the House (Smith and Moore, 2008, p. 37). In the Senate, Robert S. Kerr (D, Oklahoma), an influential leader of the Senate Finance Committee, played a similar role to that of Mills. Kerr was also opposing the financing of health insurance by expanding Social Security. Kerr proposed his bill to the Senate and it passed by a vote of 91–2. Although the conference committee changed a few passages of the passed bills, Kerr-Mills was enacted in 1960 (Smith and Moore, 2008, p. 38).

Although Kerr-Mills did not gain, from contemporary observers, the reputation that it contributed to the expansion of public health care programs,[18] it had, from a historical perspective, significant implications for long-term care. Kerr-Mills established a new matching program, known as Medical Assistance for the Aged (MAA). MAA allowed states, at their option, to receive federal matching funds to help them meet the medical expenses of the 'medically needy'. This new category included the elderly not indigent enough to be eligible for cash assistance, but who do not own enough assets and have the income to meet their medical expenses (Congressional Research Service, 1972, p. 36). While this provision hardly had an impact on the health care services for the aged, its implications were substantial for nursing homes. Kerr-Mills created 'spending-down effects': since nursing home residents tend to stay longer than acute-care patients, the former quickly depleted their assets and qualified for MAA regardless of their monthly incomes. Public assistance bore all the medical fees after they became eligible. Kerr-Mills established this open-ended feature of public assistance for

institutional care in the United States. Although its potential had not been full-fledged until the enactment of Medicaid,[19] Kerr-Mills became a template for Medicaid.

The enactment of Medicare and Medicaid

The individualistic character of the U.S. legislative process, which is underpinned by its personal-vote oriented electoral system, intensified the autonomy of the committee and its chairperson, and initially inhibited the Kennedy and Johnson administrations from enacting the Medicare bill. Kennedy ran for the presidency with his 'New Frontier' platform, which included hospital insurance programs for the aged, and shortly after his inauguration as president, he proposed the extension of social security benefits for those 65 and over to cover hospital and nursing home costs. Although Democrats had a majority in Congress, the bill introduced in the House by Representative Cecil King (D, California) and in the Senate by Senator Clinton Anderson (D, New Mexico) – the King-Anderson bill – was killed at the committee level, again because of the reluctance of Southern Democrats in the House Ways and Means Committee to involve themselves in this contentious issue under the AMA's immense anti-Medicare campaign (Marmor, 2000, pp. 30–41). In 1964, after the assassination of Kennedy, Senate Democrats attached the King-Anderson bill to the Social Security amendment bill, which the House already passed, and passed it in the Senate by a 49–44 vote, bypassing the House Ways and Means Committee. The Senate's extraordinary move made Mills, the chairman of Ways and Means, fear that his committee would lose its control over the contents of health care bills. Hence, Mill thwarted this effort in the conference committee by promising his pro-Medicare colleagues in his committee that Medicare would be the committee's first order business in 1965. In the end, the conference committee was deadlocked over the hospital insurance amendment, and Congress adjourned without final action on the amendment of the Social Security Act (Congressional Research Service, 1972, pp. 48–49; Marmor, 2000, p. 43). The anti-Medicare coalition between Republicans and Southern Democrats in the House Ways and Means Committee showed this coalition's last resistance.

However, the landslide victory of Lyndon B. Johnson finally cleared the legislative barriers to the enactment of Medicare and Medicaid. The outcome of the 1964 election gave the Johnson administration strong momentum to fulfil his campaign promises, the 'Great Society', including Medicare. President Johnson carried most states against Goldwater in his presidential election, and Democrats

occupied more than a two-to-one ratio in the House. Reflecting the Democratic composition of the House as a whole, the composition of the House Ways and Means Committee shifted from 15 Democrats and 10 Republicans to 17 Democrats and 8 Republicans. This meant pro-Medicare liberal Democrats secured their majority against the anti-Medicare coalition of Republicans and Southern Democrats (Marmor, 2000, p. 45).

The actual law-making process of the 89th Congress led to an unexpected turn for both pro-Medicare liberals and anti-Medicare coalition. Three proposals were submitted to the House Ways and Means Committee: the administration's proposal (H.R. 1), AMA's eldercare alternative (H.R. 3737), and the Byrnes bill (H.R. 4351). At first, the legislative strategists of the Department of Health, Education and Welfare (HEW) still believed the King–Anderson bill's modest proposal – limited hospitalization and nursing home insurance benefits without coverage for physician's fees – was enough to spearhead incremental Medicare expansion for the future, and courted their supporters on the liberal side. Rather, criticism pointing out the significant limitation and insufficiency of the administration's bill came from the long-standing opponents to 'socialized medicine'. The AMA denounced the administration's bill as an inadequate proposal that did not cover physician's services, surgical charges, prescription drugs, x-ray, or other laboratory services. The AMA proposed their 'Eldercare' bill as the alternative, which was essentially an expansion of Kerr-Mills, and had two House Ways and Means members – Representatives Thomas Curtis (R, Montana) and A. Sydney Herlong (D, Florida) – introduce the bill. Republicans also attacked the deficiencies of the administration's bill. Under popular mandates for a liberal agenda, as shown by the electoral results, Republicans changed their strategy. The Republican members of the committee did not want Democrats to take exclusive credit for the unavoidable passage of the health care bill. For this reason, Representative John W. Byrnes (R, Wisconsin) introduced his bill, the Byrnes bill, which was essentially a voluntary health insurance plan for the aged that covered the major risks, including physician's services and prescription drugs (Marmor, 2000, pp. 46–48).

Although the King-Anderson bill and the Byrnes bill were presented as proposals competing with each other, Mills, the chairman of the House Ways and Means Committee, proposed to combine these two bills. Mills asked HEW's leader, Wilbur Cohen, whether it was possible to put into one bill the administration's Medicare hospital plan and a broader voluntary plan covering physician and other services. Cohen

immediately answered that it was possible, and the legislative staffs of HEW wrote up the new proposal virtually overnight (Cohen, 1985, p. 6).[20] Through the process combining the King-Anderson and the Byrnes bills in committee, the details of the committee's proposal were adjusted. As the financing method of the voluntary part of health insurance, the committee adopted individual uniform premium payments by elderly beneficiaries with subsidies from general revenues; this excluded payments for drugs used outside hospitals and nursing homes. This is how Medicare Part A (hospital insurance) and Part B (supplementary medical insurance) were created. The combined 'Mills bill', including the extension of Kerr-Mills for various categories of the poor (later known as Medicaid), was reported out of the Ways and Means Committee and passed the House by a 315–115 vote; the Senate basically approved the House bill. The conference committee hammered out the differences between the House and Senate bills, and both houses of Congress passed the amendments of the Social Security Act in July 1965.

Compared to Medicare, Medicaid attracted little attention from policy makers and interest groups. Even the nursing home industry lobbied legislators around Medicare issues. The controversial issue for nursing homes was how to restrict the qualification of nursing homes for health care insurance benefits. For instance, Senator Clinton Anderson's amendment to the Social Security Act[21] limited its nursing home care benefits to the skilled nursing facilities affiliated with, or under the control of, hospitals. While the American Hospital Association (AHA) supported this hospital-affiliation requirement for nursing homes, the American Nursing Home Association (ANHA), the trade association of proprietary nursing homes, strongly opposed any affiliation requirement. During the deliberation of Medicare in 1965, whereas the administration dropped the hospital-affiliation requirement for nursing homes, it proposed to limit Medicare benefits only to post-hospitalization extended care and required formal agreements between hospitals and care facilities. Whereas the AHA endorsed these requirements, the ANHA continued to oppose any reference to 'agreements', 'contracts', or 'compulsory associations' with hospitals. In the end, the final version of the Medicare bill authorized Medicare payments for up to 100 days of skilled nursing or rehabilitative stay in 'extended care facilities' after hospitalization (Congressional Research Service, 1972, pp. 40–51). However, the issues of Medicaid, including Medicaid long-term care coverage, were hardly contended in the Congress. Wilbur Cohen, a major architect of Medicare and Medicaid, recalls:

> Most people did not pay attention to that part of the bill ... Title XIX was not a secret, but neither the press nor the health policy community paid any attention to it because of the dazzling bewilderment of the adoption of Part B. The proponents of Medicare were delighted with their victory; the opponents were demoralized. Those of us concerned with the legislation became preoccupied with the Senate amendments and the Conference Committee compromises. The full awakening to the scope of the Medicaid legislation did not come until much later. The health policy community in 1965 was a small band of brothers and sisters concerned about the controversial elements in Medicare and unaware of the possibilities inherent in Medicaid. (Cohen, 1985, p. 10)

The political battle was fought around Medicare, and '[a]lmost no one foresaw the potential of Medicaid' (Smith and Moore, 2008, p. 48). The entitlement to long-term care was produced as a by-product of health care legislation.

Implementation of Medicaid

The Social Security Amendments of 1967, enacted to address practical problems in the implementation of Medicare and Medicaid, stepped into two seemingly opposite but intertwined policy orientations. The first orientation was to set up a legislative basis for federal standards regulating nursing homes receiving Medicaid vendor payments. The second was to introduce the 'intermediate care facility' (ICF) so that Medicaid could grant vendor payments to nursing homes using lower standards than those stipulated for 'skilled nursing homes'. Since many of the indigent aged were already residing in low-skill nursing homes that provided custodial care under Kerr-Mills, the legislation had no alternative but to expand federal regulations over nursing homes while easing federal requirements to be qualified for Medicaid vendor payments.

The subsequent Moss Amendments provided, for the first time, a statutory basis for federal regulation of nursing homes. Senator Frank E. Moss (D, Utah), chairman of the Subcommittee on Long-Term Care of the Senate Special Committee on Ageing, introduced his amendments with a companion amendment by Senator Edward Kennedy (D, Mass.). These amendments included standards for custodial and medical care, staff requirements for nursing services, licensing of nursing home administrators, and authorization for the HEW to withhold funds for institutions not in compliance. While these amendments went nowhere in

1966, they were included in the omnibus Social Security Amendments of 1967, and they passed in the Congress (Smith and Moore, 2008, pp. 79–80).

The Moss Amendments required the HEW to issue a new set of regulations for 'skilled nursing homes', which were supposed to provide nursing care under Medicaid by January 1969. However, the HEW faced a dilemma in establishing such regulations: If the standards of regulations were high enough to satisfy those legislators who advocated improving the quality of nursing homes, most nursing homes would be unqualified, and many residents of those homes would be thrown out onto the street. If the regulations imposed weaker requirements on nursing homes, the government would approve and keep paying for the maltreatment of the indigent aged. Obviously, the ANHA was fiercely opposed to any regulation. The final regulations were in line with the ANHA's claims: the final draft regulations were significantly relaxed, and, although Senator Moss reacted vehemently, further even weaker regulations were issued in April 1970 (Vladeck, 1980, pp. 59–62).[22]

Creating a new category, 'intermediate care facility' (ICF), was an attempt to adjust the Medicaid legislation to the reality of the nursing home industry. Since the Moss Amendments would possibly expel many smaller, older care facilities, the nursing home industry invented the idea of creating a new category as 'a nursing home with just enough nursing to justify public support as a health-care facility' (Vladeck, 1980, p. 63). The supporters of this idea sold it by arguing that many residents of skilled nursing homes did not require extensive care, and the low level of care services required by them could be supplied in more specialized facilities with limited staffs. Senator Jack Miller (R, Iowa), a senior member of the Senate Finance Committee, proposed his amendment, known as the 'Miller Amendment', to introduce ICF. The amendment defined ICF as being 'licensed by the States and would include institutions which provided services beyond ordinary room and board, but below the level of skilled nursing homes' (Congressional Research Service, 1972, p. 78). The Miller Amendment easily passed the Congress because the backers of the Moss Amendments supported this amendment in exchange for the support for their proposal. As the result of the Miller Amendment, many states reclassified patients and care facilities, and some of them just renamed their substandard care facilities as an 'intermediate care facility' (Vladeck, 1980, pp. 63–64).

Finally, Public Law 92–603, enacted in 1972, sorted out the categories of nursing homes. While the Title XIX of Social Security Act stipulated

'skilled nursing home services' as the recipients of vendor payments, it did not define what 'skilled nursing home services' meant. P.L. 92–603 consolidated Medicare's 'extended care facilities' and Medicaid's 'skilled nursing homes' into 'skilled nursing facilities' (SNFs), and ordered the HEW to develop a single set of standards (Vladeck, 1980, p. 68).

The law-making process of small adjustments to Medicaid, as shown above, suggests that under Kerr–Mills and Medicaid the nursing home industry was growing as an interest group and gaining political influence in social legislation. The ANHA weakened the actual effects of the Moss Amendments on the regulation standards for nursing homes in the implementation process. It also successfully lobbied legislators to introduce a new category of nursing homes that could be run under lower standards but still receive reimbursement from public funds. While doctor's interests severely constrained the state's capacity to create a universal health care insurance, the nursing home industry started to restrain the HEW's ability to regulate nursing homes.

The Omnibus Budget Reconciliation Act (OBRA) of 1981: Medicaid waiver programs

The Omnibus Budget Reconciliation Act of 1981 was a first attempt by the Reagan administration to turn back 'big government' in the United States. Throughout his campaign, Reagan committed to cutting the federal budget, and OBRA '81 was a law-form expression of his campaign platform. Although Reagan promised to protect the 'truly needy' through a 'social safety net', such as Social Security retirement benefits, Medicare, Supplemental Security Income (SSI), and school lunches for the poor, the reconciliation bill was composed of hundreds of changes in dozens of education, health and welfare programs. It intended to save $35.2 billion, and 70 per cent of those savings came from public programs earmarked for the poor and lower-middle income people (*Congressional Quarterly Almanac*, 1981, p. 461). The OBRA '81 was a major blow to those programs – including Medicaid – developed under the 'Great Society'.

Medicaid waiver programs for HCBS were added to the OBRA '81, not *in spite of*, but *because of* this political atmosphere of budget austerity. The Reagan administration's proposal was to cut about $1 billion from Medicaid by putting a 'cap' on federal spending for Medicaid. The cap was set at 5 per cent more than the 1981 expenditure level, even though health care costs were rising at annual rate of 15 per cent. The National Governor's Association and state

officials bitterly opposed the cap. They claimed the cap would just transfer millions of dollars of Medicaid costs to the states, which were already suffering from burdens swollen by health care inflation. The states' perspective prevailed in the House, which was dominated by Democrats. While the House rejected the cap, it agreed to reduce federal Medicaid spending by 3 per cent in Fiscal Year 1982, 2 per cent in Fiscal Year 1983, and 1 per cent in Fiscal Year 1984. Representative Henry A. Waxman (D, California), chairman of the House Energy and Commerce Subcommittee on Health, justified the House's approach by saying that a cap 'failed to deal with the underlying problem of a system that encouraged use of the most expensive services, *such as institutional care*, instead of those that were more cost-effective, *such as preventive programs*' (*Congressional Quarterly Almanac*, 1981, p. 479, italics by the author). Medicaid HCBS waiver programs were added to the OBRA '81 under this policy context.

The Medicaid HCBS waiver (section 1915[c]) was intended to provide community and/or home care services as an alternative to nursing home care. This policy idea goes back to an earlier initiative for extending and liberalizing home health care benefits of Medicare by Representative Claude Pepper (D, Florida) and the House Special Committee on Ageing in 1977; Henry Waxman also supported this idea and proposed in his bill to broaden the approach to include mental retardation and mental illness – the Medicaid Community Care Act – in 1980 (Smith and Moore, 2008, p. 338).[23] Since the rationale for Medicaid HCBS waiver programs in the OBRA '81 was the cost effectiveness of home and community care services, the framers of this waiver authority placed several cost-containing measures on state Medicaid administrators. First, it imposed 'budget neutrality' on the states that applied for HCBS waiver programs. That is, the average per capita costs of waiver programs and other Medicaid programs must be less than or equal to the average per capita costs of what the entire Medicaid program would have cost without waiver programs. Second, the eligibility of Medicaid benefits for home and community care services was to be limited to those who would require, without HCBS, the level of care provided in skilled nursing facilities, intermediate care facilities, or intermediate care facilities for the mentally retarded (Smith and Moore, 2008, p. 168). Due to these restrictions, although Medicaid HCBS waiver programs later contributed greatly to the 'normalization' of mentally retarded and developmentally disabled people, these programs have been less effective in ameliorating the institutional bias for the aged in Medicaid (see Section 6.2 in this chapter).

The Medicare Catastrophic Health Care Act of 1988

The biggest opportunity to open the door towards universalizing long-term care services in the United States came around the late 1980s. The Reagan administration's proposal to expand Medicare benefits over catastrophic illness directed the attention of policy makers and the public towards long-term care, and the proposal itself had potential to be incrementally expanded over nursing homes and home and community care services. However, the proposal's peculiar 'budget neutral' funding scheme and the lack of coverage over long-term care caused fierce a response from senior citizens to the new benefits and burdens, and seniors' furious opposition forced responsive legislators to repeal the Medicare Catastrophic Health Care Act (MCCA). In the end, the impetus to cover the risks of chronic illness and long-term care rapidly withered.

In spite of its ideological commitment to fiscal conservatism, it was the Reagan administration that set the issue of long-term care on a policy agenda on the national political stage. In 1982, Reagan appointed Otis R. Bowen, a physician and a former two-term Republican governor of Indiana, as chair of the Advisory Council on Social Security, in charge of examining the issues concerning Medicare (Thompson, 1990, p. 75). While this advisory council proposed to extend the hospital benefit coverage and cap out-of-pocket spending to provide protection against catastrophic illness, it also considered extending Medicare coverage to long-term care services. This is because catastrophic illness often entails long-term care (ibid, chapter 3). Although the recommendation of this council received little attention in the administration, the issue it brought up reappeared later.

In 1985, President Reagan nominated Bowen as Secretary of Health and Human Services (HHS). Three months after Bowen's appointment, catastrophic care appeared in the 1986 State of the Union Address. President Reagan said in his address:

> I am directing the Secretary of Health and Human Services, Dr. Otis Bowen, to report to me by year end with recommendations on how the private sector and government can work together to address the problems of affordable insurance for those whose life savings would otherwise be threatened when catastrophic illness strikes. (State of the Union Address, February 4, 1986)[24]

Acquiring Reagan's recognition of the issue, Bowen proposed to extend Medicare coverage to acute hospital and physician's costs in excess of

$2,000 yearly. The cost of this coverage expansion was to be financed by a flat $4.92 monthly premium levied on all Medicare recipients, and was to maintain fiscal neutrality (Himelfarb, 1995, p. 21). This proposal had no coverage for long-term care and the uninsured because the costs of both were projected to be prohibitively expensive (Thompson, 1990, p. 147).

Although the Bowen proposal, later the MCCA, was essentially applauded by Democrats and senior lobbies, they started to criticize it once President Reagan endorsed it. Their criticism came from the failure of the proposal to include Medicare coverage for long-term care.[25] As the administration's plan was introduced, officials of the American Association of Retired Persons (AARP) were waging a campaign to educate the public and politicians on the long-term care issue (Himelfarb, 1995, pp. 24–25).[26]

Because of increasing pressure to expand benefits from grey lobbies such as the AARP, the catastrophic care bill became typical 'Christmas tree' legislation.[27] Through the committee deliberation process, the members of the Ways and Means and the Energy and Commerce committees added to the administration proposal respite care, mammography, and protection against spousal impoverishment caused by the illness of one partner (Himelfarb, 1995, pp. 28–29). Although the amended bill was still lacking coverage for long-term care outside a hospital, the scope of Bowen's proposal was notably expanded. Furthermore, despite the concerns of the administration, a prescription-drug benefit was attached to the bill. Among these attachments the Democratic leadership especially encouraged this prescription-drug coverage. House Speaker, Jim Wright (D, Texas), met with Democratic members of the Ways and Means, Energy and Commerce, and the Ageing committees in May 1987, and he emphasized that 'adding a drug benefit would help put a Democratic stamp on a catastrophic-care plan that first began as a Reagan administration initiative' (*Congressional Quarterly Almanac*, 1987, p. 495).

Although the Medicare Catastrophic Care bill with a number of amendments was near to being presented for full House debate, Representative Claude Pepper, a leading senior advocate in the House, complicated the passage of the bill.[28] In June 1987, Pepper, who was chair of the House Rules Committee, introduced his Home Care bill, which intended to expand Medicare to cover home care services for disabled people of all ages. The costs of Medicare expansion for these home care services were to be financed by a payroll tax hike. With his power endowed as a chairman of the Rules Committee, Pepper

threatened to block the MCCA in his committee unless the Speaker of the House promised to allow a floor vote on his bill (Quadagno, 2005, pp. 176–177). Speaker Wright, at a lunch meeting with Pepper and more than a dozen members of the Ways and Means and the Energy and Commerce committees, ensured Pepper that he could offer his proposal for a floor vote sometime before the end of the current Congress in exchange for dropping his Home Care bill at this time (*Congressional Quarterly Almanac*, 1987, p. 496). Although many members of the House complained that the bill lacked the provision addressing the leading cause of 'catastrophic costs' – long-term care costs – the MCCA passed the House by a large margin in July 1987.

In the Senate, the Finance Committee deliberated the MCCA bill, and reported out a similar bill to the House version in May 1987. Although the Reagan administration staff and Bowen attacked this reckless expansion of coverage with the threat of a presidential veto, the administration could not afford to engage in the legislation process because of the Iran–Contra scandal (Himelfarb, 1995, pp. 29–31). As a result, after several concessions from both advocates of the elderly and the administration, the Reagan administration gave the amended bill a last-minute endorsement, and the Senate passed the MCCA. The conference committee hammered out the differences between the House and Senate versions. Many congresspersons still expressed concerns that the MCCA did not address the major problems of catastrophic care costs. For instance, Ways and Means member Frenzel said: 'Here is a bill which promises catastrophic coverage, but it comes up with only marginal improvements in the No. 1 problem area' (*Congress Quarterly Almanac*, 1988, p. 292). However, both chambers approved the committee's report, and President Reagan then signed the bill on July 1, 1988.

One month before the MCCA was enacted into law, Claude Pepper's attempt to expand Medicare over home- and community-based care for all age groups was defeated in the House in June 1988. Pepper's Home Care bill faced two problems. First, major interest groups opposed his proposal. Although his bill won support from the AMA by granting doctors a gatekeeper's role in home care services, the Health Insurance Association of America, the Chamber of Commerce, and the National Federation of Independent Business strongly opposed his measure (Quadagno, 2005, pp. 176–177). While the health insurance industry considered Pepper's bill to be an intrusion into its private long-term care insurance market, business organizations loathed the payroll tax hike. Second, Pepper antagonized two chairmen with jurisdiction over long-term care: Dan Rostenkowski (D, Illinois), of the Ways and Means

Committee, and John D. Dingell (D, Michigan), of the Energy and Commerce Committee. Since Pepper tried to make his bill bypass these two committees, these two powerful chairmen lobbied their colleagues to vote against Pepper's bill and managed to divide the Democratic rank-and-file enough to block the bill. At the vote, while members of the House praised this oldest, devoted congressperson with thundering ovation, they rejected his motion by 169–243 (*Congress Quarterly Almanac*, 1988, p. 293–294).

The legislative story of the MCCA does not end in its passage and Claude Pepper's setback. Since the MCCA presupposed that the benefits of the bill were to be financed solely through beneficiaries (i.e., senior citizens), the unexpected expansion of its coverage during deliberation in the Congress led to the repeal of the act itself. It was not long before elderly people realized new burdens and waged an opposition campaign against the MCCA. While the act benefited the 20 per cent of all elders who had no private insurance policy for catastrophic care, it would only moderately improve benefits for most elders and would significantly increase surtaxes for the considerable number of upper-income seniors (Quadagno, 2005, p. 155). The National Committee to Preserve Social Security and Medicare[29] and other senior groups started a furious campaign to repeal the MCCA. Those grey lobbies stirred up not only upper-income elders, who would incur a new burden, but also middle- and lower-income elders, who might well enjoy the benefit.[30] Letters and phone calls from angry seniors flooded the offices of members of Congress, and legislators were surrounded by angry senior protesters calling for the repeal of the act during the summer recess of 1989. As a famous example, Representative Rostenkowski, chairman of the House Ways and Means Committee, was chased in his Chicago district by elderly people shouting 'liar!' and 'impeach!' (Tolchin, 1989). Even the AARP, which still supported the act, could not prevent the opposition campaign from forcing congresspersons to repeal the act (Quadagno, 2005, pp. 155–158). Since the new president, George H.W. Bush, was had no strong commitment to the MCCA though enjoying the fiscal surplus generated by the MCCA's surtax, the decision to repeal it was left to the will of the Congress. In the end, in November 1989, the MCCA was repealed in the House and Senate. Ironically, while most provisions concerning Medicare, which the MCCA was intended to improve, were dropped, the spousal-impoverishment protection for long-term nursing-home patients was left intact in this repeal process (Himelfarb, 1995, p. 75 fn.72). The MCCA resulted in improving the usability of Medicaid long-term care benefits in the end.

Although the MCCA did not include coverage expansion for long-term care for the frail elderly, this bill could have been the first step that make Medicare the primary source of long-term care. The characteristics of the U.S. polity hindered the expansion of Medicare in several ways. First, Bowen took the reaction of constituencies and interest groups into his calculation and proposed a *fiscally neutral* plan, which would have imposed new burdens on only Medicare recipients – seniors. He knew a large increase in the payroll tax would kill his bill in Congress due to the pressure of interest groups, and this calculation inhibited the inclusion of long-term care coverage in the bill. Since interest groups can easily block a policy proposal through congresspersons, the policy options of Bowen and the officials of HHS were severely constrained. Second, even minor senior lobbies such as the National Committee to Preserve Social Security and Medicare were able to mobilize senior constituents to force Congress to repeal the act. The individualistic policy-making process is penetrated by societal interests, and therefore it is remarkably responsive to the swings of constituency's opinions.

The Health Security Act of 1993

It was President Bill Clinton's health care reform that dominated Washington during 1993 and 1994. He had guaranteed health care for all Americans during his presidential campaign and, once elected, pursued comprehensive health care reform. His reform plan tried to ensure universal health care coverage for every citizen through 'managed competition'. Although the comprehensive health care reform plan received support from the public in the beginning, the Health Security Act faced fierce opposition from interest groups, including the health insurance industry, then lost the endorsement of the majority of citizens, and ended up in a miserable debacle (cf. Hacker, 1997; Skocpol, 1996; Steinmo and Watts, 1995).

Although the emphasis of the reform plan was definitely on health care coverage for tens of millions of uninsured and on the control of health care costs, long-term care was also one of the important issues in the reform. In his presidential campaign Clinton said: 'No Americans should have to impoverish themselves to qualify for long-term health care' (Pear, 1993), and Ira Magaziner, in charge of the entire health care reform, also claimed that 'a comprehensive health reform package without some provisions for addressing long-term care problems may be flawed economically, socially and politically' (Wiener, Estes, Goldenson, and Goldberg, 2001, p. 211).

Reflecting the commitment of top executives to long-term care, the National Task Force on Health Care Reform, which was established to design Clinton's reform plan, included a working group on long-term care as one of many such working groups. This long-term care working group was directed by Robyn Stone, a researcher at Project Hope, and it had as many as 35 to 40 members but the core membership was 10 to 15 individuals. Although members of the president's economic team opposed the costs of new long-term care programs, the first lady – Hillary Rodham Clinton – and Magaziner maintained that long-term care should be kept in the reform plans, and President Clinton eventually supported them (Wiener et al., 2001, pp. 212–215).

After deliberating from February through May 1993, the long-term care working group proposed the following reform plan:[31]

- A large, capped matching-grant program to the states to cover home- and community-based services for people with severe disabilities, regardless of age or income;
- Tax clarification of, and federal standards for, private long-term care insurance;
- Minor liberalization of Medicaid nursing home coverage; and
- A tax credit for personal assistance services. (Wiener et al., 2001, p. 249)

The main focus of this long-term care proposal was on a capped matching-grant program for home- and community-based services. In Clinton's Health Security Act, the cost of this program was projected to be $56.7 billion in five years, from FY 1996 until FY 2000 (ibid, 250). At the same time, it should not be overlooked that this reform plan contained a proposal for private long-term care insurance. The Health Security Act was to improve the accountability of private long-term care insurance policies with national standards for policies and to allow individuals to deduct payments for long-term care services and insurance premiums under the individual income tax medical expense deduction. And the act was to permit employers to deduct insurance premiums from taxable income and consider them a business expense. In addition, the Health Security Act embraced a non-refundable tax credit to the disabled for up to 50 per cent of their assistance expenses, up to the lesser of $15,000 or the individual's income. The tax credit was to be phased out for persons with incomes over $50,000 (ibid, 251). Although these proposals for long-term care reform did not see the light of day due to the defeat of Clinton's entire health care reform project, the

regulation and tax deduction of private long-term care insurance was carried over into the Health Insurance Portability and Accountability Act of 1996.

From public towards private approaches

After several proposals to extend the scope of long-term care coverage beyond the 'poor' through public programs had failed in the Congress, the presidents and legislators shifted their policy emphasis from expanding entitlement programs to instead encouraging and subsidizing private solutions to problems related to long-term care.

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 is one those laws that regulate and subsidize private long-term care insurance. This law was considered to be, though an incremental reform, 'the most significant federal health care reform in a generation' (Atchinson and Fox, 1997, p. 146) because the MCCA and the Health Security Act did not come to fruition. The act is also called the Kassebaum–Kennedy Act after its sponsors, and it creates national standards for the availability and portability of group and individual health insurance coverage. Importantly, it also provides tax incentives for individuals and employers to purchase private long-term care insurance.

This legislation originated in the Clinton's Health Security Act. Through the discussion about health care reform, administration officials and congresspersons heard many problems of availability and portability of health insurance. Since the Clinton administration's health care reform had collapsed, these problems were still left without a remedy. The HIPAA attempted to address those problems.

Senators Nancy L. Kassebaum (R, Kansas) and Edward Kennedy (D, Massachusetts) introduced their bill to the Senate in 1995. The bill was supported by House Democrats, the president, the AFL-CIO, the AARP, the Blue Cross and Blue Shield Association, the National Association of Insurance Commissioners, and so on. Even insurance industry lobbies such as the Group Health Association of America and the Health Insurance Association of America did not oppose the bill (Atchinson and Fox, 1997, p. 148). The bill passed the Senate committees, and it seemed about to be enacted easily. However, even though the bill also won broad support from senators, several conservative senators put 'hold' on it.[32] Since Senator Robert Dole (R, Kansas), the Senate majority leader, had no interest in this bill, it was shelved for about a year. Kassebaum publicly appealed to Dole to introduce her bill to the floor of the Senate early in 1996, and he promised to bring the bill to the floor. After vigorous debate in committees and on the floor of both houses,

the Kassebaum–Kennedy bill was finally enacted (see Atchinson and Fox, 1997, pp. 147–149; Smith, 2002, pp. 157–165).

The HIPAA amended the tax law to make premiums for long-term care insurance tax-deductible. The tax amendment treated long-term care insurance premiums as medical expenses and allowed those expenses to be included in a tax formula. However, the amount of this tax deduction was not large enough to encourage individuals to buy it. To examine the effect of the HIPAA on consumers' behaviour towards private long-term care insurance, Kaplan (2002, pp. 74–75) simulates one typical case, in which a seventy-year-old woman has $50,000 adjusted gross income[33] and pays $3,600 per year for long-term care insurance, $648 for Medicare Part B coverage, and $800 for Medigap insurance. Even this relatively wealthy woman can deduct only $688, and this tax deduction reduces her tax by $103 or $186, depending on her marital status. It is not enough of a deduction to persuade her to purchase a $3,600 long-term care insurance policy.[34]

This case shows the possibility and the limitations of long-term care policy reform in the United States. Since the Kassebaum–Kennedy Act negotiated the entire cumbersome law-making process in the Congress and, indeed, amended the tax code, it is possible to argue that the president and/or legislators can respond to growing care demands through tax exemptions for long-term care. However, the enactment of the Kassebaum–Kennedy Act is attributable to the fact that it was basically a regulatory law and not involved in sizable budget expansion nor revenue reduction.

The Clinton administration also embarked on providing tax benefits for those who take care of relatives in the needs of long-term care, and the George W. Bush administration also proposed to grant tax breaks to those who purchase private long-term care insurance. However, their proposals were unable to overcome the legislative hurdles in the Congress. First, in January 1999, President Clinton proposed a $250 billion tax relief package, including a $6.2 billion initiative to provide an up to $1,000 tax credit for families that give long-term care to the elderly or disabled (*Health Care Policy Report*, 1999a). However, since the tax relief plan ballooned into a total of $792 billion over ten years in the Republican-dominated Congress, President Clinton vetoed the entire tax relief package (*Health Care Policy Report*, 1999b). As a result, his tax credit for long-term care itself did not materialize. Second, in 2000, President Clinton again proposed a $250 billion tax relief proposal over 10 years. This time he tried to put in his budget a $3,000 tax credit for people with long-term care needs or their caregivers. The president's

long-term care initiative would have cost $28 billion over 10 years (*Health Care Policy Report*, 2000c). At the same time, a bipartisan group of senators submitted a bill that offered a tax credit to cover care expenses and a tax deduction for long-term care insurance policies (*Health Care Policy Report*, 2000a).[35] However, neither of them were enacted. Finally, President Bush also took an initiative to offer tax breaks to alleviate long-term care problems. During his presidential campaign, he suggested a 100 per cent tax deduction for individuals who purchase a private long-term care insurance policy (*Health Care Policy Report*, 2000b), and almost every year in his first term he proposed a tax credit providing incentives for long-term care insurance and long-term caregivers. Yet he could not get his proposals through the Congress.[36]

In contrast to tax breaks for long-term care, the approach to segment the population and permit a part of them to purchase private long-term care insurance at a discount rate was successful in the Congress. The Long-Term Care Security Act (H.R. 4040) passed both houses of Congress with bipartisan support by voice vote and was enacted in September 2000. This bill was introduced by Representative Joe Scarborough (R, Florida), chairman of the Government Reform Subcommittee on the Civil Service, and it intended to allow federal civil and military employees to buy a private long-term care insurance policy at a group discount rate for them and their close relatives. Although each federal employee has to pay the full cost of such a policy, the act authorizes the Office of Personnel Management to negotiate premiums and benefits for long-term care with insurers, and it aims to reduce the premiums for 13 million government workers and their relatives by 15 to 20 per cent compared to individual policies (Congressional Quarterly, 2000a). The supporters of this bill called it 'a model for private industry'. For instance, Scarborough, the sponsor of this bill, said 'companies are likely to follow the government's lead and offer their own employees this very important protection [for long-term care]' (Congressional Quarterly, 2000b). Since legislators were able to bring benefits to government employees without spending a dime of government outlays, this bill faced no opposition and easily passed the Congress.

6.4 Conclusion

Comprehensive policy reform for long-term care has rarely happened under the U.S. polity. Even when large-scale policy reform such as Medicare and Medicaid occurred, it is hard to claim that the policy makers expected Medicaid would in the future play such an enormous

role in covering long-term institutional and home care needs in society. Medicaid was essentially a 'fringe' to Medicare. Then there has been no comprehensive long-term care reform enacted since the establishment of Medicaid.

The reason why the policy-making process is biased to the status quo in the United States is, as Section 6.1 argued, that its policy process is highly embedded in societal interests due to its individualistic political competition. For example, Truman's universal health insurance proposal and Kennedy's Medicare proposal were unable to get out of the House Ways and Means Committee under the barrage of the AMA and other interest groups. The enactment of Medicare and Medicaid required a huge ideological shift in the Congress due to Kennedy's assassination and, not just the majority, but the super majority of liberal clouts in both houses. In addition, the legislative stories after the 'Great Society' tell us how influential those interest groups are. The proprietary nursing home industry influenced the implementation of federal regulation standards to be in line with their preferences, and the health insurance industry and business organizations successfully blocked Pepper's Home Care bill, which was the only serious attempt to universalize long-term care benefits this author can find other than Clinton's Health Security Act. Re-election oriented congresspersons were so sensitive to the opinion swing of their constituency that they repealed the MCCA when some grey lobbies mobilized confused senior citizens and made those angry 'senior mobs' surround congresspersons in their electoral districts. Political parties have not functioned to discipline and direct their rank-and-file members and insulate the policy-making process from societal interests.

However, these setbacks to large-scale policy reforms do not necessarily mean that the U.S. long-term care programs have not changed. In fact, the U.S. long-term care policy has evolved. Table 6.4 outlines the changes of Medicaid long-term care coverage since the initiation of Medicaid in 1965. Even this table is not comprehensive; it includes only significant changes in Medicaid eligibility, benefits, and financing policy over the past 35 years. As these numerous small revisions in the table suggest, the U.S. Congress has gradually adjusted Medicaid, in an incremental way, to diversifying and ballooning demands for long-term care under the policy-making process constrained by entrenched interest groups.

Since comprehensive reform to expand public programs for long-term care is extremely hard to achieve under the U.S. polity, since the late 1990s the emphasis of policy makers has shifted from public towards

Table 6.4 Legislative history of Medicaid long-term care coverage, 1965–2005

Year	Legislation	Topic
1965	Social Security Amendments of 1965	– Enacted Medicaid.
1967	Social Security Amendments of 1967	– Establishment of intermediate care facilities (ICFs) Moss Amendment (federal regulatory framework for nursing homes)
1971	Act of December 14, 1971	– Allowed states to cover services in ICF – Allowed states to cover services in facilities for the mentally retarded (ICFs/MR)
1972	Social Security Amendments of 1972	– Enacted Supplemental Security Income (SSI) program for elderly and disabled – Required states to extend Medicaid to SSI recipients or to elderly and disabled meeting state 1972 eligibility criteria ('209[b]' option)
1980	Omnibus Reconciliation Act of 1980 (OBRA 80)	– Enacted the Boren amendment requiring states to pay 'reasonable and adequate' rates for nursing home services instead of Medicare reimbursement rates
1981	Omnibus Reconciliation Act of 1981 (OBRA 81)	– Enacted reduction in federal matching percentages applicable from FY 1982–1984 – Enacted section 1915(c) home and community-based waiver
1982	Tax Equity and Fiscal Responsibility Act of 1982	– Allowed states to impose nominal cost-sharing on certain Medicaid beneficiaries and services
1987	Omnibus Reconciliation Act of 1987 (OBRA 87)	– Enacted nursing home reform provisions that phased out distinction between SNFs and ICFs, upgraded quality of care requirements, and revised monitoring and enforcement
1988	Medicare Catastrophic Coverage Act of 1988	– Required states to phase in coverage of Medicare premiums and cost-sharing for low-income Medicare beneficiaries (QMBs) with incomes below 100 per cent of poverty – Established minimum income and resource rules for nursing home residents whose spouses remain in the community to prevent 'spousal impoverishment'
1991	Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1991	– Restricted use of provider donations and taxes as state share of Medicaid spending

Continued

Table 6.4 Continued

Year	Legislation	Topic
1993	Omnibus Budget Reconciliation Act of 1993	– Tightened prohibitions against transfers of assets in order to qualify for Medicaid nursing home coverage – Required recovery of nursing home payments from beneficiary estates
2005	Deficit Reduction Act of 2005 (DRA)	– Tightened prohibitions against transfers of assets in order to qualify for Medicaid nursing home coverage (3 to 5 years) – Excluded coverage for individuals with home equity in excess of $500,000 (or up to $750,000 at state option) – Lifted the moratorium on states expanding Long-Term Care Partnership Programs to increase the role of private long-term care insurance – Authorized the secretary to grant competitive awards to states to increase the use of community versus institutional services – Created a new state option for states to provide all HCBS waiver services without needing to get a waiver to seniors and people with disabilities up to 150% of poverty

Sources: Schneider, Elias, Garfield, Rousseau, and Wachino (2002); Crowley (2006).

private solutions for those who need long-term care assistance. The HIPAA granted senior citizens the tax deduction for private long-term care insurance for the first time. Although the Clinton administration's proposals to give tax credits for care givers were not actualized because of the complication of budget reconciliation bills, the Long-Term Care Security Act awarded federal employees the option to include a private long-term care insurance policy in their fringe benefits. Although it is unlikely that private long-term care insurance replaces public programs because Medicaid continues working as a 'last resort' without insurance premiums for most people, these private approaches will diminish the chances that the United States will universalize the coverage of public long-term care programs. For instance, a policy proposal to expand public programs would not pass the Congress if it undermined the existing benefits of government employees' long-term care insurance policies.

The more developed are the private solutions, such as tax credits and private long-term care insurance, the less feasible the universal coverage of public programs for long-term care needs (cf. Hacker, 2002). The most plausible future trajectory of long-term care policy would be that private solutions supplement the Medicaid long-term care coverage.

7
Conclusion: Political Institutions, Voter–Politician Linkage, and Universalistic Social Policy

7.1 Overview

This book endeavours to answer why long-term care policy for the aged is varied across advanced industrialized countries despite common socio-demographic pressures. Obviously the ageing population, especially the increase of the oldest old-age population (i.e., over 80 years old), is the main driver of the expansion of elderly care services because this age group is more likely to suffer from severe disabilities and needs supports for daily living. While socio-demographic factors are the most important determinants of elderly care policy, each country's policy responses to this social transformation are still diverse even after taking these explanatory factors into consideration. Essentially, this study aims to figure out how these socio-demographic changes are translated into public policy and how political institutions structure this transmitting process between socio-demographic demands and public policy.

To answer the above questions, this book presents its analytical framework – historical rational-choice institutionalism – and a deductive model accounting for the variations of social protection programs across countries. This book argues that to what extent the state retains its relative autonomy from societal interests has important implications for the distribution of limited public resources. While clientelistic voter–politician linkage sinks the state into the web of special interests – and biases the composition of social protection programs towards particularistic benefits and occupational social insurance schemes – programmatic political competition allows the state to coordinate the burdens and expenses of social protection programs in an equitable way and

thereby promotes the development of universalistic welfare programs. Furthermore, this study claims that each country's voter–politician linkage – in other words the dominant mode of political competition – affects the degree of state autonomy through structuring the politicians' incentives in a distributive process of public resources. For the state to be able to assign equally the burdens and expenses of social protection programs to citizens, a centralized and catch-all political party needs to delegate its policy-making functions to the executive branch. This is because universalistic social policy requires the state to overcome collective action problems at intra- and inter-party levels.

Electoral rules and the party system affect the mode of intra- and inter-party competition in each country. At the dimension of intra-party competition, electoral rules determine the dominant type of party organizations. When electoral rules force party politicians to compete with each other within their same political party in the election, those rules promote particularistic political competition. Under those rules, politicians need to secure the personal vote through dispensing particularistic benefits rather than waging their electoral campaigns under the party platform. The necessities of the personal vote give each politician the incentive to differentiate herself from the party platform if necessary and claim credits for her own achievement through particularistic benefits. The electoral independence of the rank-and-file legislators under the personal-vote-oriented electoral rules undermines the party leadership and the party platform, creates a decentralized political party, and motivates party politicians to favour particularistic benefits for their clients. On the contrary, when electoral rules force party politicians to rely on party vote, the rank-and-file legislators prioritize party reputation over personal reputation, stick to the party platform, and support the party leadership because their re-election and career promotion totally hinge on their contribution to their affiliated party. In other words, the heavy weight of the party vote in an election creates a centralized political party with strong discipline. A centralized, disciplined party is a necessary condition for the development of universalistic social policy, because strong discipline allows the party to whip free riders on public resources and to delegate each legislator's policy-making functions to the executive branch.

On the dimension of inter-party competition, if a ruling coalition is fragmented along regional, lingual, ethnic, and religious cleavages, each coalition partner prefers to target social benefits for their own constituent groups. For, under this condition, coalition partners compete with each other in the next election and then need to cultivate their

constituencies with particularistic benefits and occupational social insurance schemes. These coalition parties prefer these social protection programs to citizenship-based, universalistic social policy, because each coalition partner has incentives to expand targeted benefits for its own constituency groups and charge their costs on the general public. Even if political parties are centralized and compete with each other through their party platform, universalistic social welfare programs are less likely to thrive under the fractionalized coalition government. By contrast, if a country has a cohesive party system, the welfare state can protect its citizens from social risks with universalistic social policy. Especially, when one catch-all party dominates its ruling coalition, public policy becomes universalistic unless the dominant party itself is decentralized. The dominant party represents broader constituencies and then is able to internalize the benefits and expenses of social protection programs. This type of ruling party allows the state to bring benefits and assign their costs to the general public in an equitable way. The development of universalistic social policy becomes possible under this condition. In sum, whereas a fragmented ruling coalition along various social cleavages skews the distribution of limited public resources towards particularistic benefits and occupational social insurance schemes, one-party dominance promotes the development of universalistic social policy unless the ruling party itself is decentralized.

This study maintains that public elderly care programs are more likely to thrive under the circumstances that are favourable for universalistic social policy. For public elderly care services are usually provided based on users' citizenship and needs and hardly geographically, occupationally, or socially stratified. Hence, this study hypothesized that one-party dominance by a centralized political party allows the state to coordinate the benefits and expenses of social protection programs in an equitable way and then facilitates the expansion of public elderly care services.

This book's quantitative and qualitative analyses shed light on quite different aspects of the politics of elderly care policy. Its quantitative analysis mainly revealed the structuring effects of electoral rules and party systems on the socio-demographic changes. Chapter 3 analysed the pooled time-series and cross-section data of 15 OECD countries from 1980 until 2001 with multivariate regression models. The results of the analysis demonstrated the consistent effects of socio-demographic factors: the percentage of the population aged 80 years and over is the main driver of public elderly care spending. However, as the theoretical argument suggested, electoral rules also indicated their

intervening effects between demographic changes and public elderly care expenditures. The results illustrated that personal-vote oriented electoral rules dampen the effects of demographic changes on public spending for public elderly care expenses while the party-vote oriented electoral rules promote these effects. In addition, this book's quantitative analysis consistently shows that a fragmented coalition government restrains the size of public elderly care expenditure. These results suggest that electoral rules and party systems structure the state's capacity to respond to socio-demographic transformation through public elderly care programs.

This book's case studies have demonstrated an active and important role of state actors in the development of public elderly care policy. These cases examined the elderly care policy and politics in Sweden, Japan, and the United States. The case study of Sweden (Chapter 4) examined the early development of elderly care policy until the 1980s, Ädel reform in 1992, and maximum fee reform in 2002, and revealed that the Social Democratic one-party dominance, underpinned by the party-vote oriented electoral system, allowed the state to universalize the coverage of old-age homes in the 1940s and 1950s and promoted home help services after those services were turned out to be popular among the electorate in the 1960s and 1970s. The political process of the Ädel reform demonstrated that the centralized ruling party also facilitated the state's reforming of existing health and social care programs for the aged and adapting them into the ageing population.

The case study of Japan (Chapter 5) mainly tackled the following question: Why was Japan able to enact public long-term care insurance to expand elderly care services even under highly clientelistic political competition. Japan's chapter revealed that its peculiar electoral system – the SNTV-MMD system – had asymmetric effects between the ruling party – LDP – and non-LDP parties. Since the SNTV-MMD system forces only LDP politicians to compete with their colleagues under its one-party dominance, opposition parties engaged in programmatic competition while LDP politicians devoted themselves to the patronage-based competition. Hence, public elderly care programs were developed when LDP faced the crisis and demise of its one-party dominance and these non-LDP parties seized political influences due to the electoral results, set public elderly care programs on the governmental agenda, and opened the window of opportunity for the state – the central welfare bureaucracy in Japan's context – to push its policy idea. The public long-term care insurance was the attempt of the welfare bureaucrats to

rationalize and restructure existing health and social care programs for the aged.

The case of the United States (Chapter 6) demonstrated that extremely individualistic political competition underpinned by the personal-vote oriented electoral system has prevented universalistic elderly care programs from being enacted in the United States. The SMD system, with a primary election, forces congresspersons to compete with their colleagues and then prioritize particularistic benefits to their constituency over the public goods benefiting their affiliated party. As a result, Medicaid, which was established during the 'Great Society', has evolved to fulfil the societal demands for long-term institutional and community care services without changing its core as a means-tested health care assistance.

In conclusion, this study's quantitative and qualitative analyses complement each other: while the state plays a key role in elderly care politics as the qualitative case studies suggest, electoral rules and party systems structure the state's capacity to transmit socio-demographic changes into public elderly care policy by determining the predominant mode of political competition as the quantitative analysis suggests. The closed-list PR system generated a strong political party, and the one-party dominance by the Social Democratic party allowed the state to develop universalistic services of elderly care in Sweden. In the United States, its personal-vote-oriented electoral systems – the SMD with a primary election – prevents legislators from delegating their policy-making functions to the executive branch and motivates them to bring particularistic benefits to their constituents and obstruct any policy proposal that offends their own constituencies. Since societal interests penetrate the policy-making process through the influence of congresspersons, the state is hardly autonomous from these interest groups. In Japan, since its peculiar electoral system – the SNTV with MMD – generated LDP as a decentralized ruling party, the constellation of social protection programs was skewed to particularistic benefits and fragmented social insurance schemes, and therefore the development of public elderly care programs had to wait for the crisis and collapse of LDP's one-party dominance. Because the SNTV with MMD also created centralized opposition parties supported by urban constituents, these non-LDP parties opened the window of opportunity for the state to coordinate varied societal interests in line with the establishment of new social insurance system when these parties gained political influence on public policy. As the above discussion illuminates, while the qualitative research can enrich the interpretation of quantitative

analysis's empirical results, the quantitative research can augment the confidence of qualitative research's arguments.

7.2 Alternative explanations

This section examines several alternative explanations to this book's argument. It will explore the socio-demographic approach, senior interest-group approach, cultural approach, and path-dependency approach, and compare them with this study's institutionalist approach. While this section points out this study's advantages over other approaches, it also clarifies other approaches' values and this study's limitations.

Demography rules!

That social-demographic change is the main driver of public elderly care policy development is an undeniable fact. As this study's quantitative analysis demonstrated, among the explanatory variables the percentage of the old-age population is the most substantive and consistently significant explanatory factor of public elderly care spending. It accounts for a large part of cross-national and time-series variations of the dependent variable. In addition, this study's cases also show that the demography is an important explanatory factor of elderly care policy in these three countries. Sweden universalized and expanded its public elderly care services early because it faced a population ageing much earlier than other industrialized countries. In Sweden, the aged population (65 and over) already accounted for more than eight per cent of the total population around the turn of the twentieth century because many younger Swedes emigrated to the new continent then. Japan's extremely rapid pace of population ageing was an important trigger of the introduction of public long-term care insurance. During the 1980s, welfare bureaucrats generated policy ideas to address increasing care burdens expected in 10 to 20 years later. When we talk about the limited availability of public elderly care services in the United States, we also need to take its demography into consideration. While the female labour force participation rate is quite high and creates the demand for formal care services, its demography is younger than other advanced democracies because of immigrants: in 2005, while Japan's population aged 85 and over was 2.3 per cent, and Sweden had 2.5 per cent, the United States had only 1.7 per cent (Lafortune, Balestat, and the Disability Study Expert Group Members, 2007). This demographic advantage lessens the societal pressures for the expansion of public programs.

However, these socio-demographic factors do not explain how program pressures are translated into public policy. It is this point that this book has tried to clarify. In Sweden, the centralized political party and the strong state, both of which were shored up by its party-vote oriented electoral system, put institutional and home care services under their control and used them as a part of their welfare state benefiting broader constituencies. The direct control over institutional and home care service provision also facilitated it for the state, independent of societal interests, to adjust the boundary between health and social care for the aged and adapt those services to the ageing population. In Japan, its personal-vote oriented electoral system – the SNTV-MMD system – motivated LDP politicians to bring particularistic benefits to their constituents and protect their vested interests, and then LDP politicians showed less interest in developing universalistic social services. Although the state actor – central welfare bureaucrats – succeeded in providing universal benefits for frail older people through a new social insurance scheme, the bureaucrats achieved this policy by compromising with those vested interests. In the United States, its personal-vote-oriented electoral system – the SMD with primary – also gives congresspersons the incentive to cultivate their political machine through particularistic benefits, and it makes it extremely arduous to create a legislative coalition sufficient to pass a bill ensuring universalistic social care provision. That is the reason why the United States has fulfilled the care demands through Medicaid, which was 'accidentally' enacted during the 'Great Society'. All three countries have covered their social demands for elderly care through public programs – public funding and service provision in Sweden, a new social insurance scheme in Japan, and means-tested health care assistance in the United States – but their responses to the socio-demographic pressures are remarkably diverse because of political institution differences.

Does 'grey power' matter?

The population ageing, without doubt, creates an objective need for formal elderly care services. However, it is a different question whether the aged citizens press the welfare state to expand elderly care services by organizing themselves and exerting their political power as a growing voting bloc in aged societies. Is senior political power an important expansionary factor for public elderly care programs? On one hand, some scholars argue that population ageing biases the welfare state's efforts towards the aged because they enforce their power through democratic institutions. For instance, Pampel and Williamson's (1988,

1989) interest-group theory argues that senior citizens enforce their policy preferences upon the welfare state through varieties of political activities and democratic processes. Furthermore, some political economists (e.g., Sinn and Uebelmesser, 2003) theoretically suggest that since the median voter comes to belong to the aged generation in a certain time point, welfare reform against senior interests would become impossible after that. On the other hand, other social scientists empirically demonstrate that the intragenerational diversity of older people's political preferences is larger than intergenerational differences between younger and older generations (Busemeyer, Goerres, and Weschle, 2009; Goerres, 2007, 2009; Goerres and Tepe, 2010; Tepe and Vanhuysse, 2009). Senior constituents have been politically socialized through their life course, and then not just their generational but also cohort effects have important implications for their political behaviours. In addition, to what extent grey interests and senior voters impose their policy preferences on the entire society varies, contingent upon each country's political context.

This book's empirical analyses support the latter argument. Pampel and Williamson's (1988, 1989) regression analysis faces empirical problems in sorting out the political influences of senior interest groups and elderly voters from objective policy demands deriving from population ageing. Although this study's quantitative analysis is unable to distinguish the political influences of grey interests from the effects of demographic changes either, its qualitative analysis shows that grey lobbies have never been the main driver behind the development of public elderly care programs in the three cases. In Sweden, although the pensioners' organization enforced their political influences over the maximum fee reform, the development of public elderly care services was mainly an elite-driven process. In Japan senior interest groups were never a vocal advocacy group during the policy-making process of long-term care insurance. Although the United States has the AARP – the largest senior lobby in the world – in its political system (cf. Morris, 1996), it failed in the late 1980s and early 1990s to enact a universalistic elderly care policy despite its organizational efforts to enlighten political elites about the necessity for more generous long-term care programs. The variation of senior political power is incapable of accounting for the diversity of public elderly care programs across advanced democracies.

Does culture matter?

As some scholars ask (cf. Pfau-Effinger, 2005), is 'care culture' or 'care value' important in social care policy? The cultural approach suggests

that while some countries developed their generous elderly care programs because people considered those services natural, other countries did not because people thought them unnatural. Is this claim convincing? The cultural approach misconceives the causal relationship between people's attitudes and public policy as the other way around. In his seminal work on tax policy, Steinmo (1993, p. 193) argues:

> [M]ost political scientists believe that differences in tax burdens are explained by differences in spending desires. In short, the United States taxes its citizens less than Sweden because Americans do not like government spending as much as Swedes. I suggest that the causal arrow in fact points the other way. Both Swedes and Americans like public spending and hate taxes. The key difference in the size of the U.S. and Swedish welfare states has less to do with dissimilarities in public attitudes towards public spending and more to do with tax policy choices made for those citizens by political elites.

His argument can be directly applied to public elderly care policy. Public attitudes towards formal care services do not determine the outcomes of public policy. Rather, public policy forges people's attitudes towards those services through creating choices available to them.

The results of public opinion surveys are suggestive for this point. Table 7.1 indicates the results of *Eurobarometer 2007* (Papacostas, 2007), and shows people's expectations and preferences for formal and informal care in five European countries. Although the cross-national comparison of opinion survey should be extremely cautious because the same wording can have different meanings depending on each country's national context, the results illuminate that the forms of care people expect to receive almost exactly correspond to the forms of care they prefer to have in these countries. People rarely express their preferences beyond their currently available options. What people appear to want is no more than a construct created within the boundaries public policy provides.

The results of public opinion surveys carried out by the Japanese government also clarify my point. People's attitudes towards formal care services were gradually changed after public long-term care insurance was implemented and home care services became more accessible to frail older people. As Table 7.2. suggests, while 25 per cent of respondents preferred to be taken care of by only their family members in 1995, the percentage was halved (12.1 per cent) in 2003. The percentage of those who prefer to be cared by mainly formal care services and

Table 7.1 Public attitudes towards expected and preferred care forms in selected European countries in 2007

	In your own home by a relative (e.g. partner\ spouse, child living nearby, etc.)	In your own home by a professional care service	In your own home by a personal care hired by yourself or by your relatives for you	In the home of one of your close family members (e.g. a son or daughter)	In a long-term care institution (nursing home)	Don't Know
Denmark						
Expected	21.6	52.4	16.6	1.4	6.4	1.7
Preferred	19.2	47.0	20.1	2.3	7.9	3.6
France						
Expected	23.2	46.1	12.5	2.3	11.8	4.0
Preferred	22.8	43.5	14.7	3.2	9.8	6.0
Italy						
Expected	38.9	15.6	16.5	4.7	8.6	15.6
Preferred	45.8	19.3	15.0	4.0	7.6	8.4
Sweden						
Expected	30.6	32.2	11.3	1.5	21.4	3.1
Preferred	33.1	30.1	19.5	2.6	12.7	2.1
Germany (former *Länder* in West Germany)						
Expected	42.6	25.4	10.4	4.5	9.5	7.7
Preferred	44.9	23.7	15.0	5.6	7.8	3.1

Note: 'Expected' refers to the responses to QA20a: 'There are different ways of getting assistance if one becomes dependent and needs regular help and long-term care. If you needed such assistance, please tell me in which of the following ways you would be most likely to be looked after?'; 'Preferred' refer to the responses to QA20b: 'And in which way you would prefer to be looked after?'

Source: Papacostas (2007).

supplemented by family members increased from 21.5 per cent in 1995 to 31.5 per cent in 2003. In the opinion survey conducted in 2003, almost 80 per cent of respondents expressed their preferences for some form of formal care services. If a policy reform reflects the changes of value people hold, people's expressed attitudes should not be changed *after* the policy reform. But, in reality, the long-term care reform seemed to change their preferences for care in Japan to a considerable degree. These results of public polls in Japan suggest that people's preferences for social care – in other words 'care value' – are rather plastic and

Table 7.2 Desirable form of care at home in Japan, 1995 and 2003

	Only informal care	Informal care supplemented by formal care	Formal care supplemented by informal care	Only formal care	Others	Don't know
1995	25.0	42.6	21.5	3.4	0.9	6.7
2003	12.1	41.8	31.5	6.8	0.6	7.1

Note: Percentage of answers to the following question: 'Given that you became frail or had dementia and required care, if you are taken care of at home, which form of care would you want?'

Source: Naikaku Fu Daijin Kanbō Kōhō Shitsu (2003).

therefore hard to be used for explaining the cross-national and time-series variation of elderly care policy.

Time matters: Path-dependency and welfare regime theory

Bonoli (2007) argues that timing creates the divergent development of new social risk policies, such as child care, elderly care, and active labour market policy. As is well known, social policies in Scandinavian countries are better adapted to new social risks than are those in Continental and Southern European countries. He maintains that the timing of when a country entered post-industrialization causes these divergent trajectories of policy adaptation among advanced welfare states. That is, whereas Scandinavian countries expanded social services because they entered post-industrial societies relatively early and had little competition between old and new demands for social protection, Continental European countries have less generous new social risk policies because they developed into post-industrial societies after the maturation of industrial welfare states. The timing plays a critical role in policy adaptation to the changes of socioeconomic conditions. When we extend Bonoli's argument over the broader contexts of social policy development, it suggests that 'timing' generated the famous typology of welfare regimes. That is, Scandinavian countries and Continental European countries developed different welfare programs during the 'golden age of the welfare state', and the distinct configurations of social policy have been maintained since then and produced the social democratic regime – characterized with universalistic social services and income maintenance programs – and the conservative regime, marked by generous occupation-based social insurance programs (cf. Esping-Andersen, 1996).

These path-dependency arguments are worth serious consideration for their applicability to elderly care policy. Sweden experienced

population ageing much earlier than other industrialized countries and then developed its generous elderly care programs during the 1960s and 1970s. As Bonoli points out, Sweden was able to expand this 'new social risk' policy without competing with other, 'old social risk', policies over fiscal resources. And, in fact, when its economy stopped its rapid growth and the state faced fiscal stringency in the 1980s, Sweden ceased to expand the coverage of elderly care programs.

However, although it certainly fits with the regime typology, this type of path-dependent argument makes it difficult to explain why a path-breaking change sometimes occurs. In fact, such a change happens quite often. By contrast, this book's theoretical model and empirical evidence suggest that the seemingly path-dependent configuration of social protection programs requires continuous political support, and therefore the configuration can be transformed when the political arrangement is changed. The politics of public long-term care insurance in Japan is suggestive for this point: its particularistic social protection system was a product of the LDP's one-party dominance, and, when the influences of particularistic politicians temporarily retreated, a universalistic welfare program burst to the political surface. Since each country's voter–politician linkage – mediated by its electoral system and party system – underpins its welfare regime, the changes in its dominant mode of political competition can lead to path-breaking policy reforms. The path-dependent arguments need to look at the persistent political battles behind the calm surface of social policy.[1]

7.3 Implications

This study's theoretical argument and empirical results have broader implications for the current literature on welfare states. First, this study can be directly applied to the new research question developed by Lynch (2006). In her pioneering work, Lynch presents a puzzle: why do some countries spend their public resources on the non-aged and the aged in a balanced manner, while others skew their public outlays towards the aged? In other words, she asks about the age bias in the welfare state. Then Lynch answered her research question by arguing that programmatic party competition created citizenship-based, universalistic social policy whereas particularistic party competition developed occupation-based social insurance systems, and these divergent approaches led to different age biases across countries. This study agrees with and depends on her argument. However, the theoretical argument can go one step further with this study's theory and empirics. Although Lynch clarifies

that distinct voter–politician linkage leads to different forms of distributive politics, she does not explain the institutional foundations behind the diversified voter–politician linkage. This study can claim that the party-vote oriented electoral system with a cohesive party system promoted programmatic party competition and resulted in universalistic social policy, whereas the personal-vote-oriented electoral system or the party system fragmented along religious, ethnic, and linguistic lines induced clientelistic political competition and expanded particularistic benefits, such as occupation-based social insurance schemes, pork-barrel projects, special subsidies and regulations for a particular industry, and tax expenditures for specific groups. This study's stylized theoretical model compliments Lynch's arguments, accounting for each country's constellation of universalistic and particularistic social protection programs.

This study can also be connected to the debate around 'new social risk policies' (Armingeon and Bonoli, 2006; Bonoli, 2005, 2007; Esping-Andersen, 1999, 2002; Taylor-Gooby, 2004b). New social risks are defined as 'the risks that people now face in the course of their lives as a result of the economic and social changes associated with the transition to a post-industrial society' (Taylor-Gooby, 2004a, p. 3), and those risks include the inability to reconcile paid work in the labour market and care work in households, poverty among single parents, and precarious employment and/or long-term unemployment among low-skilled workers. Then, we can easily see that those 'new social risk policies', addressing newly emerging social risks under post-industrialization, tend to be universalistic social policy. For instance, child care policy addresses the reconciliation between paid work and care work; child benefits can alleviate poverty among single mothers; and active labour market policy helps lower-skilled workers to be integrated into the labour market. Elderly care policy is one of those new social risk policies. The scholars studying new social risk policies usually ask why those policies vary across advanced industrialized countries, and this study can obviously contribute to that debate.

Finally, this study points out the dilemma between liberal democracy and effective governing. It argues that public policy faces collective action problems because societal actors try to consume limited public resources through their representatives elected by democratic institutions, and that the state, relatively autonomous from societal interests, is necessary to solve these collective action problems. However, democratic institutions such as electoral rules were established to control the state as a potentially dangerous Leviathan, and legislators as an agency

of the electorate are supposed to be responsive to and accountable for their constituents. In other words, the state should not be autonomous from societal interests in order to protect the society against tyranny. In this respect, while the architects of the U.S. Constitution were brilliant because it effectively embeds the state into the society, the existence of an autonomous state in Sweden is problematic because the minority has no instruments to prevent the tyranny of the majority. On the contrary, the state tightly connected to societal actors is susceptible to collective action problems: electorally motivated and democratically responsive politicians are competing with each other to please their constituents and virtually drying up the scarce tax resources in Japan and the United States. There seems to be no easy way to overcome this liberal democratic dilemma.

Notes

1 Introduction

1. Several articles in Brady and Collier (2004) show the benefits of process tracing of qualitative case studies.
2. In the comparative political economy literature, a few exceptional works aim to pinpoint a causal relationship between political factors and social care systems for frail elderly people (Alber, 1995; A.L. Campbell and Morgan, 2005; Morel, 2006, 2007). However, these studies still need theoretical clarity. See the review of them in Hieda (2012).

2 Understanding the Politics of Universalistic Social Care Services: A Theoretical Framework

1. However, it should be noted that some scholars are critical about this harmonious view of political institutions within the rational-choice institutionalism school (cf. Knight, 1992; Moe, 2006).
2. Estévez-Abe (2008) brilliantly demonstrates that the single non-transferable vote system, which severely prioritizes the personal vote over the party vote, created Japan's peculiar social protection system – employment security through public work projects, heavily protected domestic industries through regulations, fragmented social insurances, and a small welfare state.

3 Political Institutional Conditions for the Development of Elderly Care Programs: Quantitative Evidence

1. These 15 countries are Australia, Austria, Belgium, Denmark, Finland, France, Germany, Italy, Japan, The Netherlands, Norway, Sweden, Switzerland, United Kingdom, and the United States. While Canada's data for public in-kind benefit expenditures for the aged is missing from OECD SOCX (2004), Ireland and New Zealand are not included in Estévez-Abe's (2008, p. 67) rank order of electoral systems (see below).
2. While Carey and Shugart's (1995) original index is based on ballot control, vote-pooling, types of votes, and district magnitude, Shugart (2001, p. 36) modified this index to take into account 'the locus of party nomination control'.
3. Since Cusack's (2003) dataset has missing values in the late 1990s and the early 2000s, some observations of 'Degree of Fractionalization of the Cabinet' and 'Minority Government Dummy' are filled in with the data from the *European Journal of Political Research* (various issues).
4. Generalized Least Square (GLS) random-effect models are also capable of estimating the effects of time-invariant explanatory variables on a dependent

variable. In general, however, GLS overestimates standard errors 1.5 times as much as OLS with panel-corrected standard errors, when the duration of time periods is relatively short (i.e., t < 50) (Beck and Katz, 1995).

5. As the R^2 gain between Models A1 and A2 suggests, putting into the regression models the interaction terms between the timely invariant political institutional variables and the demographic variable does not improve the explanatory power of the regression models. For instance, a X^2 test does not reject the joint hypothesis that both 'Degree of Personal Vote' × 'Percentage of the Aged 80 and Over' and 'Degree of Federalism' × 'Percentage of the Aged 80 and Over' have no effect in Model A2 (X^2 (2) = 2.88, p-value = 0.236). However, the constitutive terms – 'Degree of Personal Vote' and 'Degree of Federalism' – are almost timely invariant variables, so their significant coefficients in Model A1 just reflect cross-national variations of the dependent variable. It is misleading to conclude that the variables of political institutions have significant restraining effects on the public spending on in-kind benefits for the aged solely based on Model A1, because it is incapable of showing how these static political institutional variables influence the time-series as well as cross-national variations of the dependent variable with this model. Since this study hypothesizes that political institutions intervene between socio-economic changes and public elderly care spending, it is still required to test the effects of the interaction terms due to these reasons.
6. Model A2 can be shown in the following equation:

$$\widehat{\mathrm{Y}} = \widehat{\beta}_{p80} \cdot x_1 + \widehat{\beta}_{perv} \cdot x_2 + \widehat{\beta}_{fed} \cdot x_3 + \widehat{\beta}_{p80\times perv} \cdot x_1 \cdot x_2 + \widehat{\beta}_{p80\times fed} \cdot x_1 \cdot x_3 \cdots$$

where x_1, x_2, and x_3 indicate 'Percentage of Aged 80 and Over', 'Degree of Personal Vote', and 'Degree of Federalism', respectively. Hence, the marginal effects of 'Percentage of Aged 80 and Over' are expressed in the following derivative:

$$\partial \widehat{Y} / \partial x_1 = \widehat{\beta}_{p80} + \widehat{\beta}_{p80\times perv} \cdot x_2 + \widehat{\beta}_{p80\times fed} \cdot x_3$$

Then, the variance of these marginal effects can be calculated in the following:

$$\widehat{V\left(\frac{\partial \widehat{Y}}{\partial x_1}\right)} = \widehat{V\left(\widehat{\beta}_{p80} + \widehat{\beta}_{p80\times perv} \cdot x_2 + \widehat{\beta}_{p80\times fed} \cdot x_3\right)}$$

$$= \widehat{V\left(\widehat{\beta}_{p80}\right)} + 2x_2 \cdot \widehat{Cov(\widehat{\beta}_{p80}, \widehat{\beta}_{p80\times perv})} + 2x_3 \cdot \widehat{Cov(\widehat{\beta}_{p80}, \widehat{\beta}_{p80\times fed})}$$

$$+ 2x_2 \cdot x_3 \cdot \widehat{Cov(\widehat{\beta}_{p80\times perv}\, \widehat{\beta}_{p80\times fed})} + x_2^2 \cdot \widehat{V(\widehat{\beta}_{p80\times perv})} + x_3^2 \cdot \widehat{V(\widehat{\beta}_{p80\times fed})}$$

7. The data of both variables come from OECD (2004) SOCX.
8. Since OECD (2004) SOCX has the data of these two indicators on Canada, the number of countries analyzed adds up to 16 in the analyses below.

4 Sweden: The Manipulative State

1. However, Swedish cabinets were not legally subjected to the no confidence motion until 1971 (Hancock, 1972).

2. These two consecutive sessions need intervention by a general election (Hancock, 1972, p. 171).
3. The relative autonomy of the Swedish 'state' is frequently pointed out in the comparative welfare state literature (cf. Immergut, 1992a; Steinmo, 1993).
4. The party system and cleavage lines were almost identical between the Riksdag and the county councils (Särlvik, 2002, p. 249).
5. They came to office in 1976–1979, 1991–1994, 2006–2010, and 2010–current (2011). See Table 4.2.
6. Sweden's constitution is composed of the following four documents: the Instrument of Government (*Regeringsformen*), the Act of Parliament (*Riksdagsordningen*), the Law on the Freedom of Press (*Tryckfrihetsförordningen*), and the Act of Succession (*Successionsordningen*).
7. I thank Markus Gossas for informing me of the debate in the Swedish academic community.
8. In fact, the Social Democratic Party demanded this provision as a condition that it accept the constitutional reform (Hancock, 1972, pp. 103–104).
9. By United Nation's definition, the society with 7–14 per cent of 65 year olds and over population is called 'ageing society', and the society with more than 14 per cent of aged population is called 'aged society'.
10. Interview with Marta Szebehely, professor of social work, Stockholm University (April 7, 2009).
11. Home helper's salaries were intentionally set as a considerably low level. For instance, the Stockholm municipal council set the hourly wage as 2.25 SEK because a cleaner's wage was 2.50 SEK at that time. The councillors did not want to meddle with the regular labour market by home help service programs. Interview with Marta Szebehely.
12. According to Edebalk (1990, pp. 24–25), while the elderly care policy community exerting themselves to modernize old people's homes was antagonistic to Lo-Johansson then, Gustav Möller – a Social Democratic politician and an architect of the post-war welfare development in Sweden – had a personal connection with him and sympathy towards his cause. That partially explains the quick change of Möller's stance.
13. Interview with Gun-Britt Trydegård (January 27, 2009).
14. In 1992, the costs of public care services for the aged and disabled amounted to 51,000 million SEK, and a total number of 213,000 staff were engaged in those services (Inoue, 2003, 153–154; Socialstyrelsen, 1996, p. 41).
15. The Ädel reform came into force in January 1992.
16. For example, while the Conservative Party insisted that new programs should enhance freedom of choice over care services and strengthen the supports for informal care by relatives, the Centre Party defended the utility of old people's homes, which had been criticized as out-of-date (SOU 1987:21, pp. 187–194).
17. 'ÄDEL' is the acronym of '*äldredelegation*' (elderly commission) and it can also mean 'noble' (Yamanoi, 1993, p. 41).
18. Although the government proposition specified three members for the Ädel Committee, Bengt Lindqvist (Vice Minister), Lars Eric Ericsson (*Kommuneförbundet*), and Gunnar Hofring (*Landstingsförbundet*), the opposition parties stood against this decision because all of them were Social Democrats. Those opposition parties sent their members to the committee in the end (Yamanoi, 1993, p. 41).

19. According to Bo Könberg, a former opposition councillor of Ädel Committee and a former minister of Health Care and Social Insurance (1991–1994), '[the committee] was a negotiating place trying to get agreement between different parties and different representatives of county councils and representatives of municipalities' (interview, April 23, 2009).
20. Interview with Bo Könberg.
21. Interview with Bengt Lindqvist, cited in Yamanoi (1993, pp. 82–84)
22. Interview with Kristina Jennbert, a former officer of Department of Social Affairs (April 22, 2009).
23. Interview with Gunnar Hofring, conducted by Yamanoi (1993, pp. 67–69).
24. The Liberal Party also took the top-down approach. Even though the majority of the Liberal Party county council group opposed the Ädel reform, the opposition councillor of county council in Ädel Committee, Bo Könberg, supported the reform and persuaded the party leader, Bengt Westerberg, to accept his recommendation. As a result, Bengt Westerberg and Bo Könberg secured the majority in the executive board of Liberal Party and determined its policy stance for the Ädel reform. Interestingly, when the author asked Bo Könberg how he persuaded the county council members of his party, he became perplexed by my question. He said: 'I didn't persuade so much. Of course, I managed the discussion. And in the end, accepted on the National Board of our party. If you have voted only among the group leaders of county councils, the big majority was against the reform' (interview with Bo Könberg). The practice that rank-and-file members follow the decision of party leadership is so obvious that nobody recognizes the necessity to compensate the minority in the Swedish political system.
25. Interview with Bo Könberg.
26. Interview with Bo Könberg.
27. In fact, when the author interviewed a former minister of Social Affairs (Bengt Westerberg) and a former minister of Health Care and Social Insurance (Bo Könberg) in the centre-right government, neither of them recognized that bourgeois parties initiated privatization. Bengt Westerberg said, 'I would say, in principle, this issue [privatization] was not so controversial in Swedish political debate. It's been accepted by both the Social Democratic and the non-socialist government. But very few local authorities, very few municipalities, wanted to contract-out before the 1990s' (interview with Bengt Westerberg, April 14, 2009).
28. Home help services were exempted from state regulation before the deregulation (Feltenius, 2008, p. 44, note 7).
29. Pensioners' Council (*Pensionärskommittén*), established by the Social Democratic government in 1991, is a forum for discussions between the government and pensioners' organizations (Feltenius, 2008, p. 34).
30. In Sweden, there are two large pensioners' organizations: the Swedish National Pensioners' Organization (*Pensionärernas Riksorganisation*: PRO) and the Swedish Association for Senior Citizens (*Sveriges Pensionärsförbund*: SPF). While the former mainly organizes working-class pensioners, the latter organizes middle- and upper-income pensioners. Since the fee hikes predominantly influenced relatively high-income pensioners, the SPF initiated the campaign for 're-regulation'. It sent a questionnaire on the fee structure to some 200 municipalities, brought the data collected from the

survey into the Pensioner's Council, and negotiated with the government (interview with Olof Björlin, a specialist of SPF, April 9, 2009).

5 Japan: 'MHW and the Japanese Miracle', in a Sense

1. In Japan, the hospitalization of senior citizens for non-medical reasons as a shortage of nursing care facilities is called 'social hospitalization' (*Syakai-teki Nyūin)*.
2. While there are Korean-Japanese and Chinese-Japanese and the native people of Hokkaido (*Ainu*) as ethnic minorities, none of them have not sent their own political party to the Diet.
3. These bodies are separated into three types: 'special nursing homes for the elderly' (*Tokubetsu Yōgo Rōjin Hōmu*), 'health facilities for the elderly' (*Kaigo Rōjin Hoken Shisetsu*), and 'convalescent wards in a general hospital' (*Kaigo Ryōyō-gata Iryō Shisetsu*). Each type of care institution needs, as specified by law, to be operated by an expert in the law.
4. I refer to the prime minister as 'him' because Japan has never had a female prime minister in its history. But a female politician ran for the Liberal Democratic Party's (LDP) presidential election for the first time in September 2008; the situation might be changed in the future.
5. Except if the Lower or Upper House decides to skip the deliberation of the committee.
6. However, Japan's interest coordination system during LDP's one-party dominance was different from West-European-style consensus democracy in one important respect: it lacked the strong presence of labour (T.J. Pempel and Tsunekawa, 1979). Although in the 1980s the LDP government started to incorporate trade unions in export-oriented sectors into its policy-making process (Tsujinaka, 1986), labour was the essential constituency of opposition parties.
7. The House of Councillors has 242 members, who have six-year terms. It holds elections every three years, and a half of its members are elected at one time. In an election, while 48 members are elected by proportional representation from a single nationwide electoral district, 73 are elected in 47 prefectural districts. Since the electoral system assigns at least two seats to each prefecture (i.e., at least one in each election), in the multi-member district part of the electoral system, the seats are apportioned in favour of rural prefectures. At the same time, as the mean of district magnitude suggests (see Table 4.1), the multi-member-district part approaches the single-member district (SMD) system. This amplifies the impact of swing voters, and in fact caused the triumph of opposition parties and the 'divided government' in 1989 and 2007 in the Upper House election.
8. For instance, the Committee on Health, Welfare and Labour in the Diet corresponds to the Health, Welfare and Labour Division of PARC, and the Committee on Education to the Education Division of PARC. And those committees in the Diet and the divisions in LDP are also in line with the central government ministries.
9. Those LDP politicians who have accumulated interests, expertise, and connections to bureaucrats within each division of PARC are called *Zoku-Giin* (see Inoguchi and Iwai, 1987).

10. Although the LDP politicians had delegated a major part of the policy-making process to the bureaucracy when conservative politicians founded LDP after World War II, they accumulated the policy expertise through the division of labour in the PARC and later started exercising substantial influences on a specific policy decision (see Satoh and Matsuzaki, 1986, pp. 78–104). However, Ramseyer and Rosenbluth (1993) claim that the emergence of *Zoku* (tribe) and LDP politicians' intervention in policy making in the 1980s reveal the discrepancy between the policy preferences of the party leaders and the rank and file. Rather, they argue, the perfect delegation of policy making to the bureaucracy denotes the harmonious principal–agent relationship between LDP politicians and the bureaucracy.
11. The 'administrative vice minister' is the top-rank position of career bureaucrats in a ministry.
12. 'Special nursing homes' (*Tokubetsu Yōgo Rōjin Hōmu*) is a type of public social welfare facility for elderly care. Although nursing homes used to be called 'asylums for the aged' (*Yōrō-In*) and accommodated only low-income citizens without relatives' help, in 1963 Elderly Welfare Law separated those homes into 'nursing homes for the elderly' (*Yōgo Rōjin Hōmu*) for low-income citizens and 'special nursing homes' (*Tokubetsu Yōgo Rōjin Hōmu*) for other older citizens. However, since the placement system put a priority on low-income elders and 'asylums for the aged' had been stigmatized among the middle class, most residents of special nursing homes have been low-income (Ikegami, 2006, pp. 141–144).
13. A 'social welfare corporation' is a type of non-profit organization that is established specifically to engage in social welfare services. While its corporate status is highly regulated by the Social Welfare Service Law, it can receive subsidies from governments for its social welfare services (Akimoto et al., 2003, p. 204). Although the social welfare corporation is a private body, it has worked as a government instrument to provide social welfare services on behalf of public administration in post-war Japan.
14. In 1993, 70,000 older people were accommodated in 'facilities of health care services for the elderly' (*Rōjin Hoken Shisetsu*). This type of facility was established in 1986 when the Law of Health and Medical Services for the Aged was revised. Although its function was very close to special nursing homes, the facility of health care services for the elderly was under the jurisdiction of medical care, and its costs were covered by health care insurance schemes (Akimoto et al., 2003).
15. There are three types of institutional care facilities covered by long-term care insurance: special nursing homes for the elderly (*Tokubetsu Yōgo Rōjin Hōmu*), health facilities for the elderly (*Kaigo Rōjin Hoken Shisetsu*), and convalescent wards in a general hospital (*Kaigo Ryōyō-gata Iryō Shisetsu*). The former is run by social welfare corporations, and the latter two are run by medical corporations. 'Group homes' and 'private nursing homes' are categorized as community care, and for-profit organizations can, therefore, manage these types of care facilities.
16. That is, Category I funds 19 per cent of the costs; Category II funds 31 per cent; the central government covers 25 per cent; prefectures 12.5 per cent; and local municipalities 12.5 per cent. Although the long-term care insurance is managed on the principle of social insurance, half of its expenditure is supported by the general tax revenue.

17. In 1990 the Japanese government reformed the medical fee scheme and established the 'inpatient management fee'– making medical treatments and tests inclusive instead of a fee-for-service basis, and pays higher reimbursement for the costs of nursing than before – and applied it to 'geriatric hospitals' (*Rōjin Byōin*). The government then introduced 'convalescent beds in hospitals' (*Ryōyou-Gata Byōsyou-Gun*), which set higher standards for living floor space (more than 6.4 square-meters) and residential environments (e.g., the dining hall) than the beds for general patients, and induced geriatric hospitals to convert their beds into convalescent beds. Although these reforms slightly improved the quality of care for the elderly institutionalized in medical hospitals, they further blurred the distinction between hospitals and nursing homes (Ikegami, 2006, pp. 146–147).
18. Although those convalescent beds are separated into '*Iryō-Gata Ryōyō Byōsyou*', medical-oriented convalescent beds covered by health care insurance and '*Kaigo-gata Ryōyō Byōsyou*', care-oriented convalescent beds covered by long-term care insurance, it is said that the elderly accommodated in either type of convalescent bed have few differences in medical conditions (Ebata, 2007, p. 91).
19. It was *Yokufūen*, which was established by the Ministry of Interior Affairs in 1925.
20. The Old Public Assistance Act was enacted in 1946, replaced by the New Public Assistance Act in 1950. Both assumed the role of giving financial relief to the needy, which the Poor Relief Act was undertaking before World War II.
21. Campbell (1992, p. 111) reports, based on his interviews, that the Ministry of Home Affairs opposed the idea because 'local governments…did not want to add members to the left-wing local government employees union'.
22. According to Seto, Ogawa seemed to be interested in nurturing old people's clubs as LDP's constituent organizations (Kōsei-syō Shakaikyoku Rōjin Fukushi Ka, 1974, pp. 15–16).
23. In Japan, unlike in the United States, salaried workers leave their occupational health insurance after their retirement and join National Health Insurance managed by local municipalities.
24. In 1973, in addition to free medical care, the LDP government, led by Prime Minister Kakuei Tanaka, expanded the coverage of health insurance for dependent family members from 50 to 70 per cent, raised the size of the employee's pension by two-and-a-half times, linked it to the consumer price index, and introduced child benefits (Miyamoto, 2008, pp. 86–88). Because of these institutional welfare expansions and the actual surge of social expenditures, this year was called 'the first year of welfare' (*Fukushi Gannen*).
25. However, LDP maintained its majority in the Lower House by adding conservative independents to its camp (Ohara Syakai Mondai Kenkyu-Jo, 1981).
26. Some LDP factions absented themselves from the vote of no-confidence and intentionally helped the opposition parties pass it in the Lower House.
27. See Campbell (1992), Kato (1991) , Nakano (1992, pp. 15–82), and Ohtake (1994, pp. 143–161).

28. In this period, it was reported, there were four powerful welfare-and-labour *Zoku* in the LDP: Tatsuo Ozawa, Ryūtarō Hashimoto, Kuniyoshi Saitō, and Masami Tanaka (Nihon Keizai Shimbunsya, 1983).
29. The JMA has for a long time wielded its power through its financial and electoral influences on LDP politicians, and as the union of doctors implementing MHW's health care policy on the ground. Its political power was at a peak under the reign of Taro Takemi as its chairman (1952–1982), and, in fact, it called an all-out strike of doctors ('Hoken-I Soujitai') several times. Since medical treatment fees are fixed in the official price system under Japan's health insurance system, the JMA always has conflicts of interest with the MHW. 'How to control the JMA' has been one of the biggest issues for the MHW in the post-war welfare administration. See Mizuno (2003) and Tahara (1986, pp. 292–303).
30. Japan's health insurance system has been notoriously fragmented. It is mainly classified into five types: government-managed health insurance; corporate health insurance society; seamen's insurance; mutual aid association; and National Health Insurance. Each category is further fragmented along occupational and geographical lines.
31. Minister of finance, minister of health and welfare, LDP secretary general, chairman of the LDP General Council, and chairman of the LDP Policy Affairs Research Council.
32. The Advisory Council on Social Security ('*Syakai Hosyō Seido Shingi Kai'*) is a deliberative committee under the jurisdiction of the General Administrative Agency of the Cabinet (*Sōri-Fu*). It is composed of academics and MPs and traditionally wrote a report by its members themselves. Until abolished during the process of reorganization of government ministries in 2001, it enjoyed more honour than the deliberative committees attached to the MHW (Akimoto et al., 2003; Sōri-Fu Syakai Hosyō Seido Shingi Kai Jimu Kyoku, 2000).
33. Although tax revenues had also funded 30 per cent of the free medical care for the aged in the previous system, the burdens of the national treasury would be decreased in the new system because the central and local governments had heavily subsidized National Health Insurance, thereby reducing its financial burdens, which would alleviate the cost of those subsidies.
34. Japan Federation of Economic Organizations (*Keidanren*), Japan Economic Federation (*Nikkeiren*), Japan Association of Corporate Executives (*Keizai Dōyūkai*), and Japan Chamber of Commerce and Industry (*Nihon Syōkō Kaigisyo*).
35. The 'inclusive payment' meant that the health insurance reimbursed lump sum costs regardless of the amount of vaccinations, medicines, medical tests, and so forth.
36. The special nursing homes (*Tokubetsu Yōgo Rōjin Hōmu*) are owned and managed by social welfare corporations, which are non-profit organizations regulated by Social Welfare Service Law; 75 per cent of their construction costs are subsidized and 100 per cent of running costs are covered by public expenditures (Kōsei Syō Kenkou Seisaku Kyoku, 1985, p. 66).
37. John C. Campbell (1992, p. 308), an expert in Japan's social welfare politics, calls it 'medicalization of long-term care'.

38. While the facilities of health care services for the elderly offer 8.0 square-meters per patient, geriatric hospitals provide just 4.3 square-meters per patient (Kōsei-Syō Kōreisya Kaigo Taisaku Honbu Jimukyoku, 1995, p. 98).
39. However, their attempt was not necessarily successful, since the facilities of health care services for the elderly presuppose their patients returning to their homes after a specific period and, therefore, cannot accommodate them as their 'last place'.
40. It is often pointed out that in Japan, tax offices take 90 per cent of a salaried workers' income, 60 per cent of the income of small business owners and self-employed workers, and 40 per cent of farmers' income. The Nakasone cabinet proposed a 'sales tax' (*Uriage Zei*), as it would amend the inequality of taxable income across occupations. However, the proposal was defeated because he had promised not to introduce an indirect tax during the campaign of general election and, therefore, not just opposition parties, but also rank-and-file LDP politicians, rebelled against him (Kato, 1994, chapter 5).
41. The Clean Government Party demanded cash benefits for elderly care during the negotiations over the consumption tax. Although the government did not institutionalize cash benefit programs for elderly care, this party played an important role in establishing long-term care for the aged as a policy agenda. Interview with a former vice administrative minister of MHW (October 22, 2008).
42. This is called *Rikurūto Jiken*. A newly emerging personnel company, Rikurūto, gifted their affiliated company's unlisted shares to many politicians and career bureaucrats, and then they were accused of receiving unjustifiable profits by selling those shares. Many members of the Takeshita cabinet resigned due to this scandal. See Kitaoka (1995, pp. 262–265).
43. The LDP obtained 15 seats in the PR part, 21 seats in the multi-member district part, and a total of 36 seats out of 126 seats. It was beaten especially in the single-member districts, where it won only three out of 26 seats.
44. It seems that the scale of program expansion required was unbelievable even for welfare officials themselves. When, during the inside-planning process of the 'Gold Plan', one welfare official turned in a rehabilitation plan that reduces the number of bedridden elders by only half of their current numbers, Tada Hiroshi, the director of Health Care for the Aged Department, ordered him to write 'zero' instead of 'half'. In another case, when one assistant division chief wrote a plan increasing home helpers to 50,000 and submitted it to Kenji Yoshihara, the administrative vice minister, he requested the assistant division chief change the plan to '100,000' since '50,000' had no punch (Ohkuma, 2010b, Episode 10).
45. Many of the young welfare officials who actually worked out the LTCI bill have been sent to local governments on loan and experienced many limitations of the placement system in offering care services for citizens. For instance, they had no choice but to limit the home help services to low-income households, since the volume of home helpers was constrained by the scant budgets of local governments; they were unable to send home helpers to frail elders on weekends and holidays since many of the home helpers were temporary employees of local municipalities. These flaws in the existing system decided the young welfare bureaucrats on reforming the placement system (cf. Ohkuma, 2010b, Episode 22; Wada, 2007, p. 36).

46. In fact, when Prime Minister Hosokawa proposed the new tax, Welfare Minister Ōuchi expressed his discomfort by saying 'the MHW should have been consulted in advance' (Syūkan Syakai Hosyō, February 14, 1994, pp. 40–41).
47. In addition to full-time members, more than ten officials were doubled as members of the headquarters as well as of their original bureaus. The number of full-time members grew to more than ten in 1996, when the government submitted the LTCI bill to the Diet (Masuda, 2003, pp. 33–34).
48. The report of the Advisory Council on Social Security was detached from the deliberation process in the MHW. While the members of the Long-Term Care for the Aged Headquarters were worried that the report would constrain the details of the policy proposal deliberated in the headquarters, they felt relieved when it turned out that the report was quite abstract rather than concrete. Interview with Prof. Masanobu Masuda, a former member of the Long-Term Care for the Aged Headquarters, Ministry of Health and Welfare (July 25, 2008).
49. *Jichirō* envisaged that in the future long-term care insurance would expand the infrastructure of elderly care services and shift towards the general tax revenue based scheme. In addition, the following condition allowed *Jichirō* to drop adherence to the placement system in elderly care: whereas the majority of child care facilities were public and their staffs were organized in *Jichirō*, most nursing homes were owned by social welfare corporations, and there were few social workers in local governments. Interview with Shingō Fukuyama, a former chief of health and welfare bureau of *Jichirō* (July 25, 2008).
50. Interview with Prof. Masanobu Masuda (July 25, 2008). See also Hieda (2005).
51. While some scholars espousing German-style social insurance and patriarchic journalism (e.g., *Sankei Shinbun*) supported care allowance to reward informal (mainly, female) care givers, feminist and caregiver organizations (e.g., 'Women's Association for the Better Aged Society' headed by Keiko Higuchi) opposed it. However, in the early stages of the policy-making process, the MHW had already discarded the idea to add cash benefits to the long-term care insurance system because the MOF was worried that the benefits would be abused (Ohkuma, 2010a, Episode 47; Wada, 2007, p. 71).

6 The United States of America: Evolution without Revolution

1. The average congressperson devotes enormous time and resources to the casework, which includes talking to constituents, supplying them with minor services, helping them to receive favourable treatment from bureaucrats, and so forth (Lowi et al., 2008, p. 187). See also Fenno (1978).
2. However, the U.S. Constitution does not stipulate the committee system. The Congress started as a relatively unspecialized assembly in the end of the eighteenth century. the two houses of the legislative branch transformed their organization between 1810 and 1825 and established the system of standing committees. See Gamm and Shepsle (1989).
3. This committee is responsible for government spending, and therefore has influences on pork-barrel projects.

4. This committee can amend tax codes.
5. Cox and McCubbins (2005, 2007) present the revisionist view that political parties – especially the majority party – as a 'legislative cartel' are controlling the entire legislative process, including the committee system, by using agenda-setting power and procedural rules. Although they argue that political parties have played more important roles than *existing views suggest*, it seems that they do not necessarily claim that political parties in the United States are as dominant as those in Europe in the legislative process. In comparative perspective, the autonomy of congressional committees is still conspicuous.
6. Krehbiel (1998) proposes a simple model to explain when the U.S. polity faces gridlock and why legislation regularly requires a super-majority coalition.
7. The federal matching rate – the percentage of Medicaid program spending paid for by the federal government – is generated for each state by using a formula that compares the state average per capita income with the national average. In general, poor states get a higher percentage while rich states get a lower. By law, however, the matching rate cannot be lower than 50 per cent or greater than 83 per cent (Health Care Financing Administration, 2000, p. 27).
8. See the list of services that can be covered under the Medicaid HCBC waiver program, in O'Shaughnessy et al. (2007, p. 51).
9. See Office of the Chief Actuary, 'Social Security Online'. from http://www.ssa.gov/OACT/COLA/SSI.html (accessed on October 11, 2009).
10. Currently, the following 33 states and the District of Columbia and Puerto Rico have medically needy programs: Arkansas, California, Connecticut, Florida, Georgia, Hawaii, Illinois, Iowa, Kansas, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Montana, Nebraska, New Hampshire, New Jersey, New York, North Carolina, North Dakota, Pennsylvania, Rhode Island, Tennessee, Texas, Utah, Vermont, Virginia, Washington, West Virginia, and Wisconsin. However, Texas covers only the mandatory 'medically needy' groups, which do not include the aged, blind, and disabled. See Centers for Medicare and Medicaid Services (2005, p. 2).
11. See Stone (2008, p. 2).
12. These conditions are stipulated in Supplemental Security Income (SSI) rules. Although states generally follow SSI program rules to determine Medicaid eligibility, state practices for counting assets vary significantly (Stone, 2008, p. 7).
13. The Deficit Reduction Act of 2005 introduced a new restriction on Medicaid eligibility criteria for income and assets. It prohibits states from providing Medicaid for a certain applicant if the equity interest in his or her home is greater than $500,000. A state is allowed to elevate the threshold to an amount that exceeds $500,000 but does not exceed $750,000 (Stone, 2008, p. 8).
14. Federal law in 2008 provided that this limit may be no greater than $2,610 per month, and no less than $1,712 per month (Stone, 2008, p. 10).
15. While the 'look-back period' used to be three years, the Deficit Reduction Act of 2005 tightened the regulation and made it five years.

16. For instance, if the disqualified applicant transferred $30,000 during the look-back period and the average private-pay rate of a nursing home is $5,000, the penalty period would be six months (=$30,000 / $5,000).
17. Wilbur Cohen, who served as Assistant Secretary, Under Secretary, Secretary of the Department of Health, Education, and Welfare, and was the principal architect of social legislation during the 1950s and 1960s, was highly aware of the advantages of an incremental approach in the U.S. policy-making process. See Cohen (1985, pp. 3–4).
18. For instance, Aime Forand said, '[Kerr-Mills is] a mirage that we are holding up to the old folks to look at and think that they are getting something' (cited in Smith and Moore, 2008, p. 38).
19. Only 40 states implemented Kerr-Mills, and only three states – New York, California, and Massachusetts – accounted for 45 per cent of those recipients in 1965. See Smith and Moore (2008, p. 40).
20. Why Wilbur Mills, who had been opposed to health care insurance for the aged through social security budgets, suddenly took an expansionary approach has been a mystery. According to his own account, 'With the resounding victory of President Lyndon B. Johnson in the 1964 campaign, it was inevitable that some Medicare program would be adopted in 1965. I proceeded promptly to try to develop a legislative package that could be passed' (Mills, 1985). However, the momentum of a new administration does not explain why he added Medicare Part B and Medicaid to the administration's bill. A recent archival research reveals that in June 1964 – about one year before Medicare and Medicaid passed the Congress – Mills floated to President Johnson the idea to combine the administration's hospital benefit with a voluntary physician's fee insurance and Kerr-Mills in order to cover Mills's and his colleagues' potential 'flip-flop' from opposition to support for old-age health insurance. President Johnson approved Mills's proposal and allowed him to take all the credit for the enactment of Medicare and Medicaid to court him (Blumenthal and Morone, 2009, chapter 5). This episode signifies the autonomy and influence of a congressional committee and its chairperson in the U.S. legislative process.
21. As mentioned above, Senate Democrats tried to bypass the House Ways and Means Committee by attaching the administration's health insurance bill to the Social Security amendment bill.
22. The ANHA cut deeply into the HEW. One of those employed by the HEW to draft the regulations turned out to be a paid consultant to the ANHA. In addition, the ANHA was gaining political influence over legislators as a major for-profit interest in the health care sector. It was said that several state officials and senators from the 'Sunbelt' had close political and financial ties to the nursing home industry and influenced the regulations issued by the Republican administration, which wanted to court conservative Southern Democrats (Vladeck, 1980, p. 62).
23. However, the bill was just referred to the House Committee on Interstate and Foreign Commerce, and no further major actions were taken.
24. Ronald Reagan Presidential Library Archives. Retrieved on October 17, 2009 from http://www.reagan.utexas.edu/archives/speeches/1986/20486a.htm
25. The health care insurance industry did not wage a campaign against the MCCA bill. According to Quadagno (2005, p. 152), 'the [insurance]

executives expressed no opposition to Bowen's proposal for the simple reason that insurers had no desire to pay for lengthy hospital stays beyond the Medicare limit. The Medigap market was saturated and never had been that profitable to begin with. Expanding Medicare to cover catastrophic illness might also slow the trend towards the self-insurance among large corporations.'

26. By this period, the AARP was organizing 28 million senior citizens and exercising enormous influence upon the policy-making process in Washington.
27. 'Christmas tree' legislation refers to a bill 'that attracts many, often unrelated, floor amendments. The amendments which adorn the bill may provide special benefits to various groups or interests' (U.S. Senate, n.d.).
28. Claude Pepper served as a U.S. Senator from Florida during the New Deal era, and after he lost his senate seat in 1950, he was elected to the U.S. House of Representatives in 1962, accumulated seniority and promoted himself to the powerful chairman of Rules Committee in the House. Undoubtedly his liberal ideology as the last New Dealer made Pepper fight for senior citizens. At the same time, however, it cannot be overlooked that his position as a vanguard of seniors served his own electoral interests because his South Miami district contains a large number of elderly constituents (cf. Lowi et al., 2008, p. 537).
29. This association was called 'the Roosevelt group' because it was led by Franklin D. Roosevelt's eldest son. This group was so infamous for confusing senior citizens and making them lobby their congresspersons that it was ranked as the 'worst interest group' by *Washington Monthly* (McWilliams, 1988).
30. The officials of the National Committee to Preserve Social Security and Medicare later conceded that 'they could have misled members into believing that all beneficiaries would have to pay the $800 maximum [surtax]' (*Congress Quarterly Almanac*, 1989, p. 150).
31. See also White House Domestic Policy Council (1993, pp. 170–188)
32. 'Holds' are used by senators to delay or postpone floor actions or nominations. See Smith (2002, chapter 5 n.55).
33. 'Adjusted gross income' refers to a person's total income minus the tax deductions listed in the Tax Code (Kaplan, 2002, note 255).
34. Kaplan (2002, 74) describes this tax deduction as 'illusory and thus incapable of motivating would-be insurance buyers'.
35. A bill to amend the Internal Revenue Code of 1986 to allow individuals a deduction for qualified long-term care insurance premiums, use of such insurance under cafeteria plans and flexible spending arrangements, and a credit for individuals with long-term care needs (S. 2225 in the 106th Congress).
36. E-mail communication with Cynthia Shirk (October 14, 2009).

7 Conclusion: Political Institutions, Voter–Politician Linkage, and Universalistic Social Policy

1. Recent historical institutionalists are working on this issue (cf. Mahoney and Thelen, 2010; Streeck and Thelen, 2005).

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Index