Power Shuffles and Policy Processes

1 The Establishment of Long-term Care Insurance

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WELFARE and health care services for the frail or disabled elderly have been increasingly important items on the social policy agendas of governments in the developed countries since the 1980s (Organization for Economic Cooperation and Development [OECD] 1996, 13). Two distinct models emerged in Europe. In Scandinavia, welfare services, including universal health care, are funded mainly from general tax revenues and provided mainly by the state, whereas Germany, after lengthy debate, enacted a social insurance law in 1994 to provide long-term care for the frail elderly (OECD 1996, 247–259, 261–277).

The aging of Japan's population began two decades later than in Europe and North America, but is now extremely rapid. In the 1990s, the percentage of the total population comprised of the elderly—those 65 and older—has been comparable to that of the West. According to projections, by 2010 the elderly ratio of Japan's population will be the highest in the world. Three reasons are cited: life expectancy, already the world's longest, continues to lengthen; the birthrate is expected to decline; and the so-called baby boom generation, people born immediately after World War II, will become elderly about that year.

The Japanese public is fearful of heavy burdens in the future. Caring for elderly family members is already a hardship for many, an obligation vividly described in the media as a "nursing hell."

Nursing and other care services for the frail elderly in Japan have been provided mainly by family members, particularly women, in traditionally structured three-generation households. In the late 1970s,

however, the prolonged recession caused by the oil crisis made welfare reform an important political issue. The government advocated a "Japanese-style welfare society" centered on families and local communities. The family was to retain major responsibility for the elderly.

By the mid-1980s, it was apparent that due to urbanization and other demographic shifts families would no longer be capable of providing care by themselves. Moreover, the large number of bedridden elderly who were in hospitals on a long-term basis, because no other institutions could provide adequate care, had driven up medical expenditures. How to achieve cost containment and provide additional facilities was the policy dilemma. In the early 1990s, the government responded with a new social service system to provide care for the elderly.

A long-term care insurance system for the elderly was first proposed by the eight-party Hosokawa Morihiro coalition government, which ended the Liberal Democratic Party's (LDP) monopoly on power in August 1993. The following coalition governments attempted to enact a bill: Hata Tsutomu's six-party coalition, and the Murayama Tomiichi and Hashimoto Ryūtarō governments, both composed of the LDP, the Social Democratic Party of Japan (SDPJ), and the New Party Sakigake (*sakigake* means "pioneer"). I shall describe the policy-making process in the health and welfare system during these three coalition regimes.

Policy making in the coalition governments is suitable for a case study. According to Japanese political scientists, health and welfare policy in the LDP era (1955–1993) was shaped in the ruling party by Diet members who specialized in this area, the *kōsei zoku*, or welfare experts (Inoguchi and Iwai 1987, 194–198; Nakano 1997, 81–85). This chapter compares the changes and continuities in health and welfare policy making during the coalition governments with previous LDP administrations. Among the questions addressed are: Were the coalition governments able to change long-established patterns and, if so, to what extent? Has the Japanese-style welfare trumpeted in the 1970s given way to a new model? The outlook for the new scheme enacted in 1997 will be discussed.

The analysis will examine the relevant political events at each stage of the policy process: agenda-setting, preparation of a draft bill, compromises in the proposal and consideration of the bill, and abandonment of the bill. Although I found no outstanding innovations in the

policy process under the coalition governments, there were significant changes in the types of actors and how they interacted. In addition, the social insurance system created a new perspective in Japan on welfare for the elderly.

Systematic social welfare services for the elderly were established in 1963 by the Welfare Law for the Aged, which initiated free annual health examinations and provided for accommodations at nursing homes and low-fee homes for elderly people who could not remain at home because of their socioeconomic circumstances or their physical or mental condition.

In 1973, a free medical care system for those 70 and above replaced the copayment arrangement where medical costs were shared by patients and the national and local governments. The program boosted governmental spending on medical care for the elderly, making it a major portion of total medical expenditures.

Free medical care, however, was besieged by macroeconomic and demographic developments. The first oil crisis in 1973 triggered a recession and a fall in government revenues. The elderly population began to increase quickly, raising the demand for welfare services. Bureaucrats at the Ministry of Health and Welfare began to question the efficacy of continuing the free system and finally decided to abandon it. They convinced the LDP, which in June 1980 won control of both the House of Councillors (Upper House) and the House of Representatives (Lower House), that the system had to be altered (Campbell 1992, 282–300).

In 1982, the LDP-controlled Diet enacted the Health Care for the Aged Law. The legislation had three major features (Etō 1995, 102–103). First, free medical care was abolished, replaced by a copayment system that required beneficiaries to bear a certain amount of the expenses of medical services and was expected to make the elderly more aware of the costs of medical attention.

Second, in order to reduce the funds taken from general revenues to subsidize medical care for the elderly, the act allocated the costs among Japan's three health insurance systems: Employee Health Insurance (EHI) for most private-sector workers, Mutual Assistance Associations for employees of central and local governments, and National Health Insurance (NHI) for self-employed workers, farmers, and retired employees. EHI programs are of two types: government-managed programs for employees of small and medium-sized companies, and

programs managed by private health insurance associations that cover employees of large companies. Through this redistribution pool the three systems pay 70 percent of the total medical expenditures for the elderly (the amount above the copayment), the central government subsidizes 20 percent, and prefectural and municipal governments pay the rest.

Third, the 1982 act created home health care services for the elderly, including visiting nurses, and called for health facilities to release elderly patients as soon as possible for continuing care at their own homes.

In late 1988, the Takeshita Noboru administration, claiming that additional revenue was needed for an aging society, passed a 3 percent consumption tax that went into effect on April 1, 1989. Angry voters turned against the LDP in the July Upper House election, and the Japan Socialist Party (the name of the SDPJ until 1991), which had fought the tax, substantially increased its seats.

To show the electorate how the money would be used and to justify the new tax, in December 1989 the LDP government announced a "Ten Year Strategy on Health and Welfare for the Elderly," known as the "Gold Plan," with an estimated total budget of ¥360 billion. Designed to improve the social infrastructure of welfare services for the elderly, the Gold Plan set specific goals to be attained by 1999. For example, it promised 100,000 home helpers and 240,000 beds in special nursing homes that would provide long-term care (Campbell 1992, 243–247).

The Health Ministry decided to delegate implementation of the Gold Plan to municipalities. The national government was responsible for all aspects of social welfare, from conception to implementation, until the 1980s, when responsibility was decentralized and municipalities were authorized to implement social welfare services. In order to achieve the Gold Plan's objectives, the ministry required each local authority to prepare a plan for health and social services for the elderly.

Despite the expansion of the programs for frail old people from the 1960s, there was widespread dissatisfaction with the system. Many elderly who fell sick or were disabled became bedridden because adequate care was unavailable, and the burden fell on their families. The welfare needs of the elderly had far outstripped the supply of services

and trained personnel. For example, there were long waiting lists for admission to nursing homes.

Japan was aging so rapidly that the provision of services could not keep pace. More significantly, eligibility for welfare services was based on a means test that was supposed to balance demand for services with available supply. Municipal authorities decided who received services according to specified criteria, such as ability to perform routine activities, individual or family income, and household composition. Low-income elderly persons living alone had priority. The elderly with income above a certain level who lived with their family, especially if there were female members, found it difficult to qualify for welfare services, even if they were seriously disabled. But the frail or disabled old are not found only in the low-income bracket; in fact, most are in the middle-income range (Miura 1990, 11).

The welfare system had a built-in incentive for municipal authorities to suppress demand for services artificially. Actual need was rising but supply was inadequate, so they used eligibility standards to set welfare levels almost arbitrarily (Yashiro 1997, 8–9). While municipal officials limited demand to the supply of welfare services, nonprofit welfare organizations, many affiliated with religious organizations, also provided services. In many cases, municipalities subsidized providers to make services available.

POWERFUL PARTNERS

The policy community in Japan for health and welfare issues consists of Health Ministry bureaucrats, expert Diet members, and pressure groups.[1] John C. Campbell focused on bureaucrats in his study of the political process and aging policy, calling them the most important policy sponsors in most health and welfare policy changes (1992, 383–390). By contrast, Nakano Minoru, who analyzed policy making in terms of influence relationships among the main participants, emphasized the role of the health and welfare *zoku* members (1997, 65, 82–83).

Social policy making can be divided into two patterns depending on the issue and participants, according to Nakano. He argues that medical and welfare policies differ from pension policy. Various pressure groups, such as the Japan Medical Association (JMA), the Health

Insurance Association Union, and the National Federation of Social Welfare Councils, are involved in the former. In the case of pension policy, there are no intermediate groups and the role of special interests is not so evident. This distinction is applicable to other policy areas (Nakano 1997, 14–15).

Focusing on the interaction between politicians and bureaucrats, Nakano categorizes initiatives by *zoku* members as "interest politics." Bureaucratic initiatives, from agenda-setting to decision making in the Diet, are "technocrat politics."

Because of the sharp clash of interests in health and welfare affairs, Diet members representing pressure groups exercise a compelling influence on the policy process, including making compromises. Powerful organizations like JMA speak for themselves, but Diet members usually take the lead (Nakano 1997, 14–15).

The long-term care insurance system proposed in recent years was a new policy, not merely a revision of existing programs, and brought a variety of pressure groups with complicated relationships into the policy-formulation process. This makes it an interesting example of how the initiatives by *zoku* members differed under the coalition governments from those in LDP administrations.

Generally, during the LDP era bureaucrats in the Health Ministry set the policy agenda, with a few notable exceptions, such as the free medical care system for the elderly mentioned above (Campbell 1992, 144–153). In the early decades of LDP rule, the bureaucratic cognitive mode that focuses on a specific problem usually concentrated on how to secure equity by reducing benefit differentials, a problem that resulted from the variety of social insurance systems. In the 1980s, however, bureaucrats turned their attention to ways of ensuring stable insurance funding despite budgetary deficits (Hayakawa 1991, 153).

The usual procedure was for officials of the relevant bureau to draft a bill which was then considered by the appropriate advisory council (*shingikai*) in each ministry. After approval by the council, the draft was sent to the LDP's Policy Research Council where Diet members of the Social Affairs Division, the *kōsei zoku*, attempted to balance the interests of pressure groups and ministries. Once the LDP had agreed on the text, Health Ministry officials checked it and prepared a bill that was submitted to the Diet upon approval by the cabinet (Iwai 1988, 57–64).

While the bill was in committee in the Diet, *zoku* members

negotiated with the opposition parties and pressure groups to forge compromises and secure prompt passage. They also took the lead in revising the bill, though the process changed over time. In the 1970s, Diet members representing special interests simply pushed the Health Ministry for certain changes; the ministry's initial draft was often substantially rewritten. In the 1980s, however, they tended to share the same outlook on issues as the bureaucrats and urged pressure groups to make concessions, so drafts were often enacted with a minimum of revisions.

Writing of the leading LDP *zoku* members in the 1980s, Ōtake Hideo says they came to share the same broad national perspective as the bureaucrats, were very knowledgeable about technical details, and attained great influence and power. Ōtake calls this phenomenon the "technocratization of *zoku* members" and observes that, rising above local pressures and popular stands, they accepted a "logic of governance" as members of the party responsible for the nation (1994, 159).

In early 1994, the Hosokawa administration proposed a social insurance plan that added the responsibility of society as a whole to that of the family for care of the frail elderly. The proposal was made at the agenda-setting stage of the policy-making cycle, a stage I will describe in the section "Policy Streams" with the aid of John W. Kingdon's "revised garbage-can model." According to this model, the national agenda gets set by three process streams—problems, policies, and politics—flowing through the system (Kingdon 1984, 92–94).

CARING FOR THE ELDERLY

As noted above, an important problem in welfare for the elderly was eligibility based on a means test. Welfare bureaucrats and scholars had addressed the issue in the early 1970s. For example, in January 1971 the National Social Welfare Council submitted a report to the Health and Welfare Ministry urging revision of the no-fee system at welfare facilities for the elderly. The council pointed out the inequity between recipients of social welfare services in facilities on the one hand and the frail elderly being cared for at home on the other. The former received complete services paid for by the government; the latter were eligible for only a few, such as home helpers for a limited time per week.

From the mid-1970s, the concept of a Japanese-style welfare society

emerged. Influenced by both neoconservatism and neoliberalism, it was posited on individual self-reliance and family and community solidarity, unlike the bureaucratic big-government programs of the West. The government reformed the social welfare system, requiring copayments by beneficiaries according to income. This was feasible because improved pension benefits had increased the elderly's ability to pay.

In 1980, there were several scandals involving for-profit welfare service providers, including the bankruptcy of a retirement home and the accidental death of a baby at a day-care center. For-profit facilities were not regulated under the 1951 Act for Social Welfare Institutions, and these incidents drew attention to shortcomings in the welfare system (Miura 1982, 14–15).

Ministry bureaucrats and some scholars also began to favor a universal and inclusive system that would cover both the poor and the middle class. They hoped the joint deliberations by the National Social Welfare Council, the Welfare Council for the Disabled, and the National Children's Welfare Council that began in January 1986 would result in revision of the eligibility criteria. Although the organizations studied the question for three years, the means test was maintained due to strong support by social welfare agencies and academic experts (Komuro 1989, 28–29). Why did these groups endorse the existing structure? They believed the system clearly prescribed the government's responsibility and the rights of beneficiaries, and that regulatory intervention could assure the quality of services (Furukawa 1997, 79–80).

Furthermore, welfare programs faced budgetary cutbacks. In December 1980, Prime Minister Suzuki Zenkō appointed the Second Provisional Commission on Administrative Reform (Second Rinchō), which called for financial restructuring without a tax increase, and the Ministry of Finance ordered each ministry to curtail spending. The Health and Welfare Ministry was obliged to submit a "minus ceiling" budget request in 1982 that cut outlays below the previous year. The ministry was hard pressed: Social programs included certain automatic increases and the aging of the population and higher personnel costs and prices overall were pushing up expenditures. The ministry skirted the immediate crisis by postponing the contribution to the national pension system and limiting medical expenditures. There was a limit to deferred payments and accounting gimmicks, however,

and the bureaucrats began to seek new revenue sources. From late 1985 through early 1986, for instance, they created a specific account for the social security budget to separate it from the General Account allocation and avoid interference by the Finance Ministry (Yoshimura 1986, 17).

Regardless of the budgetary crunch, medical costs for the elderly soared in the 1980s. The common experience of developed countries is that as the population ages the number of frail elderly rises, which usually translates into higher medical expenditures. However, if facilities for the elderly are divided by functions into acute care and long-term care, medical costs can be lowered. Patients with acute problems are treated in hospitals and those with chronic conditions are cared for in nursing homes or in their own homes. Scandinavian countries have successfully cut medical expenditure this way (OECD 1995, 9; 1996, 165–176), and Germany hopes to achieve similar savings with its new long-term care insurance system (Alber 1996, 261–278).

In Japan, because of the shortage of facilities providing long-term care, such as nursing homes and home-care services, elderly patients with chronic illnesses who do not require acute treatment remain in hospitals for long periods. Referred to as "social hospitalization," this amounts to a waste of medical expenditures. The Health Ministry position was that "elderly persons with chronic conditions should not be kept in hospitals" (Okamitsu 1987, 6).

Pressure to reduce costs also came from other corners. The EHI associations, forced to contribute a great amount toward the medical costs of the elderly under the cross-subsidization scheme established in 1982, wanted relief. Corporations, which pay half the contribution for their employees, lobbied for reform on the grounds that rising contributions were an untenable financial burden. The Federation of National Health Insurance Associations and major business organizations like Keidanren (Japan Federation of Economic Organizations) demanded a new system that would cover medical costs for the elderly from public funds (Shakai Keizai Kokumin Kaigi 1988; Nikkeiren, Rengō, and Kemporen 1990, 27).

The cross-subsidization solution had reduced national expenditures for the elderly; it was impossible to restore the pre-1982 system unless the Finance Ministry relaxed its policy of ordering ministries to slash requests each year, which was not to be expected. But lowering costs would ease criticism of the cross-subsidization system. Health

Ministry bureaucrats recognized that cost containment required less occupancy of hospital beds by the elderly, which in turn meant a substantial expansion of welfare services, including those by for-profit suppliers. A new system was needed.

POLICY STREAMS

Kingdon notes that "The separate streams of problems, policies, and politics come together at certain critical times. Solutions become joined to problems, and both of them are joined to favorable political forces. This coupling is most likely when a policy window—an opportunity to push pet proposals or one's conceptions of problems—is open" (1984, 204). This coupling occurred in the agenda-setting process for a long-term care insurance system in Japan. Although the problems were clear, there were many policy streams, and social insurance was chosen from among several possible solutions.

The Health Ministry bureaucracy and social policy experts were well aware of the eligibility system's inadequacies. There was no formal policy debate. Instead, various alternatives were informally considered, and in the mid-1980s welfare bureaucrats and scholars began research on the long-term care insurance system under study in Germany (Tochimoto 1995, 28). A number of young bureaucrats, protégés of top-level ministry officials, organized a policy study group that in 1988 made public its findings in "A Proposal for a New System of Health and Welfare Administration in the Reform Period." The report recommended comprehensive home care programs funded by social insurance and a new service delivery format based on freedom of choice to replace the eligibility system.

At the time, some Health Ministry bureaucrats supported the Scandinavian model of funding health services from general taxation.[2] However, they concluded that the Scandinavian pattern was not feasible because municipal authorities and nonprofit organizations would object and the public would resist a tax increase.

Following the recommendations on deregulation of the Second Rinchō, the Nakasone Yasuhiro administration privatized the Japanese National Railways, Nippon Telegraph and Telephone Public Corporation, and the Japan Tobacco and Salt Public Corporation. The Health Ministry followed by organizing the Promotion and Guidance Office on Private Services for the Elderly to encourage private firms to provide

such services as home care and housekeeping. In 1985, life insurance companies began to market new policies that covered the cost for care if a person became mentally disordered or bedridden (Hori 1994, 12–17). Pro-deregulation bureaucrats endorsed private insurance for nursing expenses as an alternative to the publicly funded eligibility system (Niki 1995, 16).

Yet social insurance brings funds to the Health Ministry's coffers, enlarging its role and importance in the government and society at large. Commercial insurance leaves the money in the private sector and does not aggrandize bureaucratic interests. Also, under a public system, social insurance funds are allocated to a specific account separate from General Account funds and are not subject to strict review by the Finance Ministry. In the late 1980s, the Health Ministry's preference for public insurance was further strengthened by academic experts who said private insurance would only be effective with a mixed infrastructure of service suppliers. Private care was a supplement to public services, not a substitute for them (Miyajima 1994, 13–14). Ministry bureaucrats concluded that the government should fund welfare services for the aged that private companies would deliver (Zenkoku Shakai Fukushi Kyōgikai and Shakai Fukushi Kenkyū Jōhō Sentā, eds. 1989, 21–160).

From about 1987, many scholars and bureaucrats published articles on long-term care insurance. Two young officials advocated nursing insurance in a journal affiliated with the Health Ministry (Nishikawa 1987; Sawamura 1988) and Yamazaki Yasuhiko (1988), a prominent academic authority and a member of a Health Ministry advisory council, called nursing insurance the new frontier of social insurance. Such writings focused attention on long-term care insurance as the best solution.

In 1992, key members of ministry sections concerned with the elderly formed an informal working group to draw up an insurance system (Nihon Ishikai Sōgō Seisaku Kenkyū Kikō 1997, 12–13). The group's report, unofficially published, outlined a new system and listed potential problems such as insurance management and service delivery. According to Okamitsu Nobuharu, then director of the Department of Health and Welfare for the Elderly, after the younger bureaucrats presented their ideas members joined in a free-wheeling discussion (Kōseishō Daijin Kambō Rōjin Hoken Fukushi-bu 1992). The young bureaucrats were members of the policy study group mentioned earlier.

TAX REFORM

The policy window for long-term care insurance was opened when political streams converged. In our case they were a series of tax measures, from the 1989 consumption tax to the national welfare tax broached in 1994 by the Hosokawa administration.

As we have seen, the consumption tax led to the Gold Plan, which obligated municipalities to prepare health and welfare plans for the elderly. Another spillover effect was that latent welfare demands surfaced. Municipal service goals exceeded Health Ministry estimates in the Gold Plan. It called for 100,000 home helpers, for instance, but the municipalities wanted 170,000. Such disparities reinforced the ministry's perception that welfare services would require enormous funding.

A lesson from the consumption tax experience was that new levies could be justified in the name of welfare. The LDP and the Finance Ministry realized that the public would swallow a tax hike if it was told the money was for welfare purposes.

The final tap that opened the window was Prime Minister Hosokawa's proposal for a national welfare tax on February 3, 1994. The idea was formulated secretly by Ozawa Ichirō, secretary-general of the Japan Renewal Party (JRP), Ichikawa Yūichi, secretary-general of the Kōmeitō (Clean Government Party), and a few Finance Ministry bureaucrats. They persuaded Hosokawa that the government needed additional revenues. The governing coalition—the cabinet came from eight political parties—was not consulted. Takemura Masayoshi, leader of the New Party Sakigake and cabinet spokesperson, was not even informed (Katō 1997, 272–274). The cabal's main objective was to raise the consumption tax from 3 percent to 7 percent. Hosokawa called the hike a "welfare tax" but gave no indication how the money would be used. Questioned on this point by a journalist, the prime minister glibly responded that the health minister would elaborate on the welfare aspects.[3]

Enter the Welfare Vision Discussion Group, a private advisory body that had just been appointed to help Health Minister Ōuchi Keigo (Nihon Keizai Shimbun-sha 1994, 93). Each new minister has a panel of experts whom he can call upon for assistance, a perquisite of office that shows a new man is at the helm. Suddenly the group had the important

task of justifying a 7 percent consumption tax rate. Hosokawa's press conference remark also gave Health Ministry bureaucrats a good opportunity to push the elderly up the policy agenda.

When other parties in the coalition government attacked Hosokawa's proposal on procedural grounds, it was immediately withdrawn. Nevertheless, the Welfare Vision Discussion Group, its mandate changed from rationalizing a tax increase to designing a grand plan for an aging society, went ahead with its work. The group's report, "A Welfare Vision for the Twenty-First Century," issued in March 1994, advocated socialized care for the elderly. In effect, the coalition government had in principle approved social insurance. Furthermore, "A Welfare Vision" confirmed the need to raise the consumption tax and called for a new Gold Plan to finance municipal health and welfare plans. Health Ministry bureaucrats had incorporated their ideas on welfare reform into the report.

THREE-PARTY COALITION GOVERNMENTS

The policy-making process examined below includes preparation of a draft bill for long-term care insurance, the struggles within the coalition over submission of the bill to the Diet, and abandonment of the bill. The process extended from the Murayama administration to the first Hashimoto cabinet under the three-party coalition formed by the LDP, the SDPJ, and Sakigake.

In April 1994, immediately after "A Welfare Vision" was made public, the Health Ministry organized a task force on elderly care measures, led by the vice-minister, that completed a long-term care insurance draft bill. In July 1994, the ministry appointed a Study Group on Care and Self-reliance for the Elderly that included experts on social policy and elderly care and directed it to make suggestions on socialized care. It should be noted that the ministry had already chosen social insurance. The scholars and experts were assembled to lend their authority and prestige to the bureaucrats' preferences. Not surprisingly, the group's report in December 1994 recommended what the ministry wanted.

A social insurance system for long-term care had already been proposed two months earlier in a report by the Committee for the Future of Social Security, a subgroup of the Social Security Systems Deliberation

Council. The council prepares reports for the prime minister and has substantial influence on decision making in the Health Ministry: the Health Ministry is not subordinate to the council, however. The two are usually in agreement on policy, and the council occasionally provides ideological support for the ministry. In this instance, too, the council endorsed the ministry's position.

In February 1995, the Health Ministry, having attained support for a social insurance system, opened discussions of a draft bill in the Council on Health and Welfare for the Elderly (hereafter the Elderly Health Council). The coalition government did not take up the issue, however. Conservative LDP members, admirers of the patriarchal family system—"a woman's place is in the home taking care of her family"—were not very interested in such insurance (Ikeda 1996, 63). The SDPJ, having backed a plan in 1990 for nursing care funded by tax revenues, hesitated to support social insurance. Yet no LDP politician opposed the objectives, which included containment of medical costs, a party goal. Nor were SDPJ politicians hostile to a plan that envisioned society sharing care for the elderly, a socialist tenet. During the LDP era, the ruling party never opposed Health Ministry proposals, largely because they were carefully crafted within the government's political capability. Ministry drafts were customarily revised during the LDP review.[4] The coalition government inherited this approach.[5]

When the Health Ministry conceives a new policy or revamps a current one, standard practice is to consult with the appropriate advisory council. Councils are organized by policy areas, and the draft bill fell under the purview of the Elderly Health Council. Its 26 members were drawn from groups involved in care and welfare services, as well as academicians and other experts in these fields. Among the groups represented were the Japan Medical Association, the Japan Dental Association, the Japan Association of City Mayors, the Federation of National Health Insurance Associations, business groups, and labor unions. Torii Yasuhiko, president of Keio University, was chairman.

The Health Ministry proposals laid before the council had seven key points (Kōseishō Kōreisha Kaigo Taisaku Hombu Jimukyoku 1996, 320–321): (1) financing to be half from social insurance contributions and half from national tax revenues; (2) municipal-level management; (3) premiums to be paid by everyone 20 years of age and older but beneficiaries limited to those 65 and older; (4) employers pay half of an employee's insurance premium; (5) no cash benefits to families caring

for frail or disabled members; (6) 10 percent copayments for service costs; and (7) implementation on April 1, 1997.

The ministry intended to complete a draft bill by the end of 1995 and submit it at the ordinary Diet session in 1996. JMA had an enormous stake in the outcome because the bill threatened a constituent interest—the income of small hospitals—and strongly objected to the haste (Nihon Ishikai Sōgō Seisaku Kenkyū Kikō 1997, 23). The ministry was forced to slow down the proceedings.

"Deliberations" in an advisory council are often formalistic; members docilely follow the ministry's scripted scenario. Draft bills are usually approved in seven to ten sessions; a favorable outcome is a foregone conclusion. However, the Elderly Health Council met more than 20 times and carefully considered the seven key features. The ministry still hoped the council would ultimately approve the proposal, albeit with a few members dissenting on some points. Given the April 1996 deadline, the council would have to finish its work no later than December 1995. In fact, disagreements in the council derailed the ministry's timetable.

CONFRONTATION

Four points were particularly contentious: management of the system, minimum ages of the insured and beneficiaries, employer contributions to premiums, and cash benefits to families (Kyōgoku 1997, 26–37, 85–100).

Confrontation was sharpest on who would bear responsibility for running the system. The Japan Association of City Mayors, the National Association of Towns and Villages, and the Federation of National Health Insurance Associations were against local management. Their concern was twofold. First, fear that inadequate funding —subsidies—might force municipalities to cover the shortfall, as had occurred with national health insurance. Contributions to NHI are far less than expenditures because the enrollees have high rates of illness. In most municipalities the program is in the red and local governments have to make up the deficit. The Health Ministry proposal included a certain amount of subsidies, as are provided for NHI. Yet the mayors were afraid the insurance system would turn into crippling local deficits (Kōteki Kaigo Hoken Seido Kenkyūkai 1996a, 32).

Second, the mayors doubted their jurisdictions, so short on service

infrastructure, could handle the anticipated wave of applications for various kinds of help. Enrollees were expected to demand services as a legal right as soon as the law took effect (Ikeda 1996, 64).

Ministry bureaucrats went through the motions of negotiating, suggesting management by the national government or a third party, but they insisted accessibility for citizens made local governments the logical entities to administer welfare. A separate program for the elderly would help to reduce the NHI deficits, the ministry said, and long-term care insurance should be seen as part of a series of reforms to improve health insurance finances.

The Elderly Health Council took up the issue of inequity between premium payers and beneficiaries in late 1995.[6] The Federation of National Health Insurance Associations and business groups, which wanted to reduce employer contributions, objected to premium payments from age 20 (Mizuno 1997, 8). Why should everybody be obligated to share costs for services they would not receive, the argument went, since not everyone would become bedridden or mentally incompetent (Ikeda 1996, 65).

The ministry refused to budge. The insurance scheme was designed to reduce medical expenditures for the elderly while also creating a new welfare system for an aging society. If only those 65 and older paid in, premium revenue would be wholly inadequate. Conversely, if frail people below 65 were entitled to benefits, the system would have been skewed completely away from the ministry's policy objective.

Related to eligibility was the question of employers paying part of employees' premiums. Management groups insisted that companies should not have to share the costs of caring for retired employees (Takanashi 1997, 10), and the Federation of National Health Insurance Associations agreed. Both had initially supported a long-term care insurance system because lower expenditures for the elderly would reduce their contributions,[7] but now the ministry plan entailed additional payments.

Rengō (Japanese Trade Union Confederation) took a neutral position on employer obligations.[8] Composed of companywide unions whose health insurance programs are based at each firm, the federation could not reach a consensus and just embraced the lofty principle that long-term care insurance should improve workers' lives.

Mayors opposed the Health Ministry's stricture against cash benefits for families providing care (Naruke 1997, 12), claiming it was

contradictory to pay an outsider but not a relative who performed the same acts. The JMA agreed, citing the German system that permits cash allowances to the family. The underlying reason they sided with the mayors was the expectation that family members would have to fill the gap in trained care workers.

Female members of the Elderly Health Council led by Higuchi Keiko argued against cash allowances, convinced that such payments would keep elderly care a family responsibility, with women still the primary caregivers, and impede improvement of professional services (Kōteki Kaigo Hoken Seido Kenkyūkai 1996b, 35). The Health Ministry also saw payments as a barrier to development of a service infrastructure.

These conflicts over the draft bill split the Elderly Health Council into three factions. Faction A, comprised of scholars, women, and labor union representatives, basically favored the ministry draft with amendments, though they disagreed among themselves on some issues. They wanted socialized care for the elderly established as soon as possible. It should be borne in mind that the academic experts on the council would not have been chosen if their views differed from those of the bureaucracy, particularly the Health Ministry (Kusano 1995, 195–217). The labor unions, notably Jichirō (All-Japan Prefectural and Municipal Workers' Union), were especially important in this faction.

Jichirō, a national federation of unions for municipal and prefectural government employees, initially opposed social insurance. Many local welfare officials and care workers believed the eligibility system funded by tax revenues effectively protected the rights of their clients, whereas a new scheme might shortchange the poor (Hori 1994, 16). Discussion in the Elderly Health Council was premised on support for a social insurance system; its fundamental suitability was not subject to debate. Nonetheless, in the arena of public opinion the social insurance model was challenged by the Scandinavian model.

Jichirō unions were also concerned that long-term care insurance might lead to municipal deficits as national health insurance had. Nevertheless, the federation approved a social insurance system at its general meeting in May 1995, an about-face primarily inspired by loyalty to the Murayama administration, which was sponsoring the bill.[9] Not only had Jichirō unions long supported the SDPJ, but Prime Minister Murayama, chairman of the party, was a former member of the federation's Ōita prefectural branch.[10]

Faction B consisted of the representatives of municipalities, health

insurance associations, and business groups. Not opposed to social insurance per se, they lobbied for a bill favorable to their constituencies.

Faction C, the nonprofit welfare organizations and the JMA, neither opposed nor supported the draft. What accounts for this behavior? The Elderly Health Council concentrated on insurance management and finance, matters of little interest to the nonprofit representatives.[11] The JMA was a covert activist that negotiated separately with the ministry. Having already secured its objectives, the JMA refrained from making demands at council meetings.

The JMA represented the interests of physicians who operated small and medium-sized private hospitals. Long-term care insurance was expected to change "social hospitalization"—shift elderly patients not requiring acute care to other facilities. Thus, some JMA members had a huge financial stake in the legislation. Yet the JMA president announced on April 9, 1996, that it "basically supported" long-term care insurance (Tsuboi 1996, 16). The explanation for this anomalous position is that JMA had changed its strategy in the 1980s "from acquisition to defense" (Takahashi 1986, 263), or, in the words of Ikegami and Campbell, "from enlarging the pie to securing vested interests" (1996, 61). Rather than rely on the *zoku* members to revise draft bills, the JMA sought concessions from the bureaucracy at the drafting stage.

In this case, the JMA held twice-weekly meetings with the Health Ministry parallel to the council meetings for a year (Nihon Ishikai Sōgō Seisaku Kenkyū Kikō 1997, 23). The JMA won the ministry's promise that long-term care hospitals used by bedridden elderly patients would be regarded as nursing homes and qualify for benefits under the new system (Ikeda 1996, 63).

Health Ministry plans to gain Diet approval in 1996 and implement the system in April 1997 were foiled when strong opposition to the draft bill prolonged the council meetings into 1996. The ministry had wanted the insurance system to start when the consumption tax rose from 3 percent to 5 percent on April 1, 1997 (Arioka 1995, 14). This was the understanding with the Finance Ministry, which saw long-term care insurance as the key to public acceptance of the tax increase, a lesson learned from the bitter experience with the initial levy in 1988 (Takiue 1995, 17). Social insurance funding was to be covered by premiums and governmental subsidies; the finance bureaucrats wanted to lay the groundwork for a higher consumption tax rate in the future. The Finance Ministry was positioning itself, and the Health Ministry

had no choice but to go along. The end of April was the deadline for the Elderly Health Council's report. To spur the council on, ministry bureaucrats issued a detailed analysis on March 15, 1996, of each provision in the draft the council had covered so far.

COALITION DECISION MAKING

The LDP-SDPJ-Sakigake government had a four-tier decision-making structure, with the three parties represented at each level. Controversial issues were first discussed by a project team set up for each ministry, and then taken up by the Policy Coordination Committee composed of two members from each party. Next, issues were referred to the Executive Committee made up of key party members. Final authority rested with the Liaison Committee between the cabinet and the governing parties, the highest decision-making organ, comprised of party leaders (Nakano 1996, 77). The Welfare Project Team corresponded to the LDP's Social Affairs Division in its Policy Research Council, the pivotal group on welfare policy during the party's long hold on power.

Under LDP administrations, Diet members were not supposed to be formally involved until the Health Ministry had finished a draft bill based on an advisory council's report. When the Elderly Health Council's deliberations dragged on, the Welfare Project Team entered the picture. In mid-March 1996, Niwa Yūya, an LDP Diet member long concerned with welfare policy and a former minister of health and welfare, drafted a set of "private" suggestions that the team used in an attempt to achieve a compromise within the council.

Niwa's plan made two key concessions to opponents of the draft bill. First, municipalities would manage the insurance system, but implementation would start with home-care services and institutional services would be phased in as facilities became available. This was to reassure municipal authorities they would not be overwhelmed by demands for nursing home admissions, for example. Second, the age of the insurees was raised to 40 and over, an adjustment favorable to health insurance associations and business. Why from age 40? People at that age, according to the reasoning given, start to face the problem of care for their parents and look ahead to their own senior years.

In early January 1996, Murayama resigned and was replaced by Hashimoto Ryūtarō. The LDP, so experienced in governance, now led the coalition. Called a "potentate" by *zoku* members, Hashimoto had been

involved with health and welfare policy since the 1970s, including a stint as minister of health and welfare. This shift in leadership paved the way for LDP initiatives.

Unable to reach a consensus, the Elderly Health Council submitted an inconclusive report, "Establishment of Long-Term Care Insurance for the Elderly: A Summary of Deliberations," to the Health Ministry on April 21, 1996, that merely identified points in dispute and enumerated different opinions. For an advisory body to end in such disarray was very rare.

The Health Ministry, still determined to get the bill through the Diet that session, offered a revised plan for an insurance system, based on Niwa's suggestions, to the Welfare Project Team on May 14. The major provisions were municipal management, insurees would be aged 40 and over, employers pay half of employee's premiums, initial provision of home-care services followed by gradual implementation of institutional services, and no cash payments to family members.

A joint meeting of the Welfare Project Team and the Policy Coordination Committee on June 11 failed to reach an agreement and referred the basic issues back to each party for consideration and decision. The Social Democratic Party (SDP) (formerly the SDPJ, which changed its name on January 19, 1996) and Sakigake agreed to submit the bill to the Diet. The Social Affairs Division of the LDP's Policy Research Council, however, could not reach a decision and delegated the matter to Yamasaki Taku, chairman of the council. On June 13, the council decided to consult with the coalition government's Policy Coordination Committee.

On the afternoon of June 14, the three party representatives in the Policy Coordination Committee—Yamasaki, Itō Shigeru (SDP), and Tokai Kisaburō (Sakigake)—met informally with leading members of the Japan Association of City Mayors and the National Association of Towns and Villages and appealed unsuccessfully for their support of the bill. That evening Yamasaki, Itō, and Tokai conferred with the Welfare Project Team. No consensus was possible, and the stalemate moved to the Executive Committee of the Ruling Parties, where the buck was supposed to stop in the coalition government. On the morning of June 17, the Executive Committee failed to resolve the conflicts. That evening the three parties abandoned efforts to bring the bill to the Diet immediately.

The coalition government was divided over presenting the bill to

the Diet, with the SDP and Sakigake in favor and the LDP unenthusiastic (Mochizuki 1997, 169–170). There was a pro-submission group in the LDP, junior Diet members on the Welfare Project Team and others who wanted to continue the three-party coalition, but they were unable to win over senior *zoku* members, and the most influential LDP politicians stayed aloof from the battle. LDP members who were antagonistic to the partnership with the SDP and Sakigake and wanted a coalition with the conservatives in the New Frontier Party (established in December 1994) strongly opposed submission because the other coalition members favored it.

The impending Diet dissolution and general election were also factors. In the new single-seat district system combined with proportional representation introduced in 1994, nearly all Lower House members' districts correspond to municipal jurisdictions. Desirous of mayoral support, many LDP politicians shied away from a bill that would alienate local leaders (Arai 1996, 12).

In contrast, the SDP and Sakigake persistently backed the bill in order to have a tangible accomplishment from participation in the coalition. The SDP was also pressed by Jichirō, which had collaborated with the Health Ministry in drafting the bill, while Sakigake was supporting a member, Kan Naoto, then minister of health and welfare.[12]

CONCLUSION

Did the emergence of coalition governments change the policy-making pattern on welfare? Nakano contends that the LDP pattern continued with some variations in form (1996, 89). It is true that the basic process —set an agenda, draft a bill, and reconcile differences—remained the same. Yet new actors joined the health and policy community and the balance of power shifted.

Before, a few pressure groups, including the JMA and the National Federation of Social Welfare Councils, were dominant. Now, municipal governments, the Health Insurance Association Union, Keidanren, and Jichirō vigorously promoted their agendas, with city mayors and heads of towns and villages especially forceful. Organized labor, a newcomer through Jichirō and Rengō, became deeply involved and supported the Health Ministry.

At the popular level, the Committee of 10,000 Citizens for a Public Care System was organized and encouraged public discussion of a

long-term care insurance system. Two influential figures represented the organization. They were Higuchi Keiko, a commentator and member of the Elderly Health Council, and Hotta Tsutomu, a former public prosecutor who had organized a group of welfare volunteers.

What induced these changes in the decision-making process? Marsh and Rhodes point out that policy communities are often a "major source of policy inertia, not innovation" and are "resistant to change." (1992, 261). By the same token, however, a new policy can destabilize a policy community. In Japan, the shift from eligibility criteria to long-term care insurance mobilized new participants.

Jichirō's strong ties with the SDPJ, especially the fact that the party chairman Murayama was prime minister, obligated the labor federation to endorse the legislation. Institutional linkages carried weight. That municipal governments and health insurance associations gained influence at the expense of LDP members was also important.

Furthermore, the Hosokawa administration championed transparency in government proceedings, opening the minutes and records of advisory council meetings to the public. Freedom of information forced ministries to transform the councils from superficial deliberations under bureaucratic control to forums for genuine discussion where interests clashed in full view. The Health Ministry had special cause to modify its behavior and image. Kan, minister of health and welfare in the first Hashimoto cabinet, had taken the lead in investigating and identifying officials who knowingly failed to stop the distribution of blood contaminated with the HIV virus. The emergence of such an unconventional minister curtailed bureaucratic secrecy and arrogance.

Did power shifts in the policy community affect the stages of policy formulation? No basic change was discernible in setting the agenda. Health Ministry bureaucrats perceived the problems in elderly care and seized an opportunity to open the policy window for a long-term care insurance system. According to Campbell, the mass media has played a significant role when the ministry altered policies (1990, 49–74; 1992, 140–144) and also influenced the agenda for a new system. It was not, however, because of human interest stories and television programs on the plight of family members trying to care for elderly relatives, the tales of hardship and sacrifice that put human faces in the issue. Rather, the bureaucrats, who saw spiraling medical expenses as more serious than the burden on families, used the media to advance

their policies. They released survey data selectively, for instance, to show public demand for service facilities, and gave journalists reports showing that Japan lagged behind other industrialized countries in care of the elderly. The bureaucracy also retained control of the second stage, preparation of a draft bill.

Substantial changes occurred at the next stage—the reconciliation of interests. The advisory council and the governing parties functioned quite differently from the past.

Advisory councils in the LDP era meekly reviewed ministry proposals; discussion was formalistic, with members deferring to the bureaucracy. Under the coalition governments, however, there were often violent arguments, disputes over crucial points in the draft bill were fully aired, and the confrontations persisted despite intervention by politicians. The final draft of the bill was modeled after Niwa's memorandum and bore little resemblance to the ministry version.

Why did the Elderly Health Council operate so independently? The most obvious factor was that social insurance was a new system that demanded a different working style.[13] This also happened in the legislative process leading to the 1982 Health Care for the Aged Law. Lacking a clear-cut policy, the ministry gave the Social Security Systems Deliberation Council carte blanche to draft the bill (Watanabe 1992, 1,175).

The political inexperience of bureaucrats in the ministry's Headquarters for Elderly Care Measures suffers by comparison with the savvy of officials in the 1980s. At that time, Insurance Bureau Chief Yoshimura Hitoshi and Pension Bureau Chief Yamaguchi Shin'ichirō, both skilled political operators, successfully promoted reform of health insurance in 1984 and the public pension system in 1985, respectively. During the coalition government period under review, the bureaucrats in charge were in their late 30s to early 40s and lacked both knowledge and experience.[14] In effect, they lost control of the Elderly Health Council.

How did the coalition governments affect the advisory council? First, the very fact of a new regime changed its makeup and work style.[15] The presence of former opposition parties and a new party in the government brought new blood into the council. This point is contested by a Health Ministry bureaucrat who denies that the advent of a coalition government affected council appointments. Prior to convening the council, he says, the ministry had contacted the Rengō and Jichirō

unions to sound out municipal officers and workers, because the proposed new system involved was such sweeping innovation.[16] Nevertheless, since these unions were long-time supporters of the SDP, how could they have been kept off the council?

The three-party coalition lessened the influence of the LDP *zoku* members in the health field. Their main role had been as intermediaries, mediating between policy-making bodies and pressure groups (Nakano 1997, 81–85). With the LDP reduced to a coalition partner, their influence declined and they had to accommodate others. The Health Ministry gained power over welfare policy at the expense of LDP members. The venue for horse trading and deals among the policy players shifted from the LDP Social Affairs Division to the Elderly Health Council.

Politicians became more involved in policy formulation, for instance, regarding the eligibility of persons under 65. The Welfare Project Team worked on the draft bill at the same time as the Elderly Health Council and had a hand in revising it. According to Arai Satoshi (Sakigake), a member of the Welfare Project Team, the coalition government itself decided on the skeleton of a bill (Arai 1996, 12). Gotō Masanori (SDP) and Kan corroborated Arai's description.[17] All three stressed that politicians were actively involved in the drafting process, a stage bureaucrats once initiated and controlled.

One case is insufficient to generalize about policy making in the coalition governments. However, the experience with social insurance shows that it was far more chaotic than the orderly process in the 1980s, which many observers consider the norm of governance. Confrontations in the Elderly Health Council were the functional equivalent of the compromise-making by *zoku* members in the LDP era. The only difference was at what stage the politicians undertook to revise the bureaucrats' draft bill.

The fact-finding function in the coalition governments was closer to the LDP style of the 1970s than the 1980s. Did LDP *zoku* politicians abandon their governance responsibility because they were in a coalition with other parties? Why did the smooth policy making of the 1980s break down?

Uncertainty and disorder in the coalitions stimulated public discussion through the mass media and forums established by the Health Ministry. Experts wrote extensively about the pros and cons of social insurance, and people who represented a variety of opinions

participated in Health Ministry groups. As noted, the Committee of 10,000 Citizens promoted social insurance, activism on a welfare issue unprecedented in Japan.

Nevertheless, coalition government itself was clearly not the crucial factor in establishing long-term care insurance. That honor goes to the issue of a tax increase, specifically raising the consumption tax, which was the decisive factor in setting the agenda. A new insurance system could have been proposed if the LDP had continued in power and needed to justify a tax hike.

The Long-Term Care Insurance Bill was introduced to the Diet with slight amendments in the autumn of 1996, approved by the Lower House in the spring of 1997 and by the Upper House in that autumn. It was enacted on December 9, 1997, and goes into effect April 1, 2000.

Will the new system improve care of the elderly? When "A Welfare Vision for the Twenty-First Century" was released, many people had high expectations. This optimism gradually withered away as the content of the new scheme became clearer.

The first point that betrayed public expectations was that few additional welfare services will be provided under the insurance system. At present welfare is funded from tax revenues; under the new system individuals will pay monthly premiums. The consumption tax went up 2 percent in April 1997, and there will be other outlays. The manager of a private nursing home calls the new plan essentially a "second consumption tax" (Takiue and Yokouchi 1995, 18). Whether the supply of services will be sufficient is unclear.

Yet many people also strongly hope—even expect—that long-term care insurance will solve some problems in the present welfare system. Okamoto Yūzō, a physician whose hospital has had a high percentage of bed occupancy by the frail elderly, contends that the obligation to provide some benefits protects the rights of the insured (Okamoto 1996, 151).

The new system is expected to facilitate deregulation, enlarge services, and increase the number of providers. The more the insured exercise their rights, the more services will be available. If business opportunities increase in the long-term care market, additional suppliers will enter the field. At present, recipients can receive services only from suppliers approved by the municipal authorities. The new insurance will offer many options, from public facilities and nonprofit welfare organizations to for-profit companies and other nonprofit

groups. Freedom of choice should stimulate competition among suppliers.

Although it is too early to predict outcomes, as insurees Japanese have acquired additional channels to articulate their interests. This may prove to be the most significant aspect of all.

NOTES

1. See Marsh and Rhodes (1992, 1–26) for a discussion of "policy community" and "policy networks."

2. Interviews with Satō Nobuto, a Health Ministry official, in Tokyo on October 17, 1997, and with Asakawa Tomoaki, also a Health Ministry official, in Tokyo on November 7, 1997.

3. Interview with Yakushiji Katsuyuki, of the *Asahi Shimbun*, in Osaka on February 28, 1997.

4. Interview with Miyashita Tadayasu, a former official of the Legislative Bureau, House of Councillors, in Tokyo on July 19, 1997.

5. Interview with Asakawa.

6. Interview with Asakawa.

7. Interview with Ikeda Shōzō, a representative of Jichirō (All-Japan Prefectural and Municipal Workers' Union) on the Elderly Health Council, in Tokyo on April 11, 1997.

8. Interview with Ikeda.

9. Interview with Ikeda.

10. Interview with Ikeda in Tokyo on May 15, 1997.

11. Interview with Asakawa.

12. Interview with Gotō Masanori, Lower House member and former SDPJ/SDP member of the Welfare Project Team, in Tokyo on June 19, 1997.

13. Interview with Kan Naoto, former minister of health and welfare in the Hashimoto administration, in Tokyo on July 11, 1997, and interviews with Satō and Asakawa.

14. Interview with Ikeda, April 11, 1997.

15. Interview with Miyashita.

16. Interview with Asakawa.

17. Interviews with Gotō and Kan.

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