21世紀の課題
社会調和を考える
日加社会政策シンポジウム

ISSUES FOR THE 21st CENTURY
THINK SOCIAL HARMONY
Canada-Japan Social Policy Symposium

ENJEUX POUR LE 21e SIÈCLE
PENSEZ HARMONIE SOCIALE
Symposium de recherche Canada - Japon sur la politique sociale

June 23-24 / *23-24 juin 2001*
2001年6月23～24日
Université
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Preface

As part of the *Think Canada Festival 2001,* the Canadian Embassy organized on June 23-24, the *Think Social Harmony : Canada-Japan Social Policy Symposium,* hosted by the Kwansei Gakuin University. The objective was to advance the cooperation between Canada and Japan in this new field by exploring issues of common interest and cultivating joint research and practical exchanges. The *Symposium* was organised in collaboration with the National Institute for Population and Social Security Research of Japan, the Asia Pacific Foundation of Canada, and the government of both countries. It brought together a select group of Canadian and Japanese experts, including the Honourable Rey D. Pagtakhan, then Canada`s Secretary of State for Asia-Pacific. The *Symposium* examined three domains : work and family; health; and aging.

This publication contains the papers of the six Japanese and Canadian presenters, and the opening remarks by Dr. Imada, president of KGU, the message from the Minister of Foreign Affairs of Japan and the keynote speech by Dr. Pagtakhan. The opinions expressed herein represent the views of the individual authors and not necessarily those of the Government of Canada or of the respective Canadian and Japanese institutions. We wish to express our sincere appreciation to the distinguished presenters, chairpersons and discussants for their forward-looking contributions, and to our partners in this undertaking for their invaluable assistance.

Rob Wright
Ambassador

Préface

Dans le cadre du *Festival Pensez Canada 2001,* l'Ambassade du Canada a organisé les 23-24 juin, *Pensez Harmonie Sociale : Symposium Canada-Japon de politique sociale*. L'Université Kwansei Gakuin en était l'hôte. Le but était de stimuler la coopération entre le Canada et le Japon dans ce nouveau domaine en explorant des questions d'intérêt commun et en semant des germes de recherches conjointes et d'échanges pratiques. Le *Symposium* a été organisé en collaboration avec le *National Institute for Population and Social Security Research* du Japon, la Fondation Asie Pacifique du Canada et les gouvernements des deux pays. Il a rassemblé un groupe d'éminents spécialistes canadiens et japonais, dont l'honorable Rey D. Pagtakhan, à l'époque Secrétaire d'État (Asie-Pacifique) du Canada. Le *Symposium* a porté sur trois domaines: travail et famille; santé; et vieillissement.

Cette publication réunit les rapports des six conférenciers japonais et canadiens, ainsi que l'allocution de M. Imada, président de l'UKG, le message du Ministre des Affaires étrangères du Japon, et le discours de M. Pagtakhan. Les opinions exprimées sont celles des auteurs et ne représentent pas nécessairement ni l'opinion du gouvernement canadien ni celle de leur propre institution ou organisation. Nous tenons à exprimer notre sincère gratitude aux éminents conférenciers, présidents et commentateurs pour leur contributions innovatrices, ainsi qu'à nos partenaires pour leur aide inestimable.

L'ambassadeur,
Rob Wright

序文

「見えてくる、カナダ２００１」の一環として、カナダ大使館の企画したシンポジウム「社会調和を考える：日加社会政策シンポジウム」が６月２３・２４日、関西学院大学により開催されました。当シンポジウムは、この新分野において日本とカナダの共通関心事項を探求し、共同研究や実務交流を深めることにより両国間の協力を推進することを目的とし、国立社会保障・人口問題研究所、カナダアジア太平洋基金、並びに両国政府の協力のもと企画されました。レイ・パクタカンアジア太平洋担当閣外相（当時）をはじめ日本とカナダの卓越した専門家が参加し、仕事と家族、医療、高齢化の３つの領域について考察しました。

この出版物は、６人の日本人とカナダ人による発表内容、今田寛関西学院大学学長による開会の辞、日本外務省のメッセージ、パクタカン閣外相による基調演説を収録しています。これらは個人の見解であり、必ずしもカナダ政府や日本・カナダの各所属機関の見解ではないことをお断りしておきます。素晴らしい発表者、司会者、討論者の方々の積極的な御貢献と、シンポジウムの企画・開催に携わった方々の貴重な御協力に心より感謝申し上げます。

ロブ・ライト
大使

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Think Social Harmony : Canada-Japan Social Policy Symposium Agenda

Kwansei Gakuin University
23-24 June 2001

MC: Dr. Martin Collick
Dean of International Programs
Kwansei Gakuin University

Day 1

0830-0900 Registration at University Library Hall Entrance (Lobby)

0900-0930 Opening Remarks at Library Hall
Dr.Hiroshi Imada President, Kwansei Gakuin University
Mackenzie Clugston Consul General of Canada in Osaka
Message from Minister of Foreign Affairs Makiko Tanaka

0930-1000 Keynote Speech
The Honourable Rey D. Pagtakhan
Secretary of State (Asia-Pacific)
Department of Foreign Affairs and International Trade, Canada
Topic *Social Policy in Globalizing Era* - in English with interpretation

1000-1030 Break at Clock Tower Hall (2nd Floor of Clock Tower)

1030-1245 **Work and Family Domain** (at Library Hall)
Chairperson **Yuen Pau Woo**
Vice-President,
Asia Pacific Foundation of Canada

Lead Presenter **Nobuko Nagase**
Ochanomizu University
Topic *Balancing Work and Family in Japan: Inertia and a Need for Change*

Lead Presenter **Linda Duxbury**
Carleton University
Topic *Work-Life Balance in Canada: Making the Case for Change*

Discussant **Ito Peng**
Kwansei Gakuin University

Discussant **Michael MacKinnon**
Policy Research Initiative, Canada

1245-1415 Lunch at Clock Tower Hall

1415-1615 **Health Domain** (at Library Hall)
Chairperson **Shuzo Nishimura**
Kyoto University

Lead Presenter **Robert G. Evans**
University of British Columbia
Topic *Health Care in Canada : Organization, Financing and Access*

Lead Presenter **Hiroya Ogata**
Kyushu University and National Institute for Population and Social Security Research (NIPSSR)

Topic *Japanese Health Care System in Transition*

Discussant **Ms. Carmen Connelly**
Canadian Institute for Health Information

Discussant **Nobuyuki Izumida**
NIPSSR

1700 Reception and Dinner at Kwansei Gakuin Hall "Kaze-no-Ma"

Day 2

0830 Meditation at Bates Chapel

In recognition of the University's Christian heritage, the Bates Chapel will be open for participants who wish to have a time of reflection before the day's proceedings.

0900-1100 **Aging Domain** (at Conference Room –1st Floor of Kwansei Gakuin Hall)

Chairperson **Koichi Hiraoka**
Ochanomizu University

Lead Presenter **Yoshihiro Kaneko**
NIPSSR

Topic *The effect of Employment and Pension Policies on the Retirement Process of Elderly Persons in Japan*

Lead Presenter **Neena Chappell**
University of Victoria

Topic *Canadian Social Policy and Ageing*

Discussant **Michiko Mukuno**
NIPSSR

Discussant **Sherri Torjman**
Caledon Institute of Social Policy

1100-1115 Break

1115-1245 **Cross-Cutting Themes and Issues for Further Collaborative Research**

Chairperson **Noriyuki Takayama,**
Hitotsubashi University

Lead discussant **Michelle Stanton-Jean,**
University of Montreal

Lead discussant **On-Kwok Lai,**
Kwansei Gakuin University

Opening Remarks

Dr.Hiroshi Imada
President of Kwansei Gakuin University

On behalf of Kwansei Gakuin University, I would like to express my heartfelt welcome to all of you who are here on our Uegahara campus for the Canada-Japan Social Policy Symposium. As the representative of a University that has had a special and strong tie with Canada for these 90 years, I feel it a great honor and privilege, as well as very significant for us, to host this Symposium. Our tie with Canada officially started in 1910, when the Methodist Church of Canada joined the management of Kwansei Gakuin, which had until then been under the management of the Methodist Epispocal Church, South, U.S.A., since its foundation in 1889. With its rich historical ties with Canada, Kwansei Gakuin University is now a Center of Canadian Studies in western Japan, and has a variety of academic and educational exchange programs with 5 Canadian universities.

I would like to take this opportunity to talk a little bit about our College Motto 'Mastery for Service.' This Motto was given to us by our 4th Chancellor, C. J. L. Bates, who came to Kwansei Gakuin in 1912 as a Methodist missionary from Canada. I introduce our College Motto partly because I would like you to know the nature of our educational institution, and partly because I think the idea behind our Motto has a strong relevance to the main theme of today's symposium, namely social policy.

To quote from what he wrote: "We do not desire to be weaklings. We aim to be strong, be masters----masters of knowledge, masters of opportunity, masters of ourselves, our desires, our ambitions, our appetites, our possessions. We will not be slaves whether to others, to circumstances, or to our own passions. But the purpose of our mastery must be not our own individual enrichment, but social service. We aim to become servants of humanity in a large sense."

He also wrote, "Our ideal of the scholar is not a kind of intellectual sponge that always takes in, but never gives out until it is squeezed; but it is a man who loves to acquire knowledge not for its own sake, much less for the sake of his own fame, but whose desire for knowledge is a desire to equip himself to render better service to humanity."

I hope for the very great success of the symposium today and tomorrow, and pray too that the spirit of Mastery for Service will prevail in every aspect of social policies both in Canada and in Japan. I strongly believe that this is the key to a truly effective approach to Social Harmony.

Thank you.

Message from Minister of Foreign Affairs Makiko Tanaka

The Honorable Dr Rey Pagtakhan, Secretary of State, Department of Foreign Affairs and International Trade, Canada
Dr Hiroshi Imada, President, Kwansei Gakuin Univeristy,
Ladies and gentlemen,

Permit me to offer a brief message at the opening of this 'Think Social Harmony: Canada-Japan Social Policy Symposium'.

The strengthening of cooperation between Japan and Canada in the field of social policy research was welcomed in the joint press statement released after the Canada-Japan summit meeting in 1999, and I am extremely pleased that, through opportunities such as this symposium, cooperation between our countries in this important field has been making progress. At present in Japan, the aging of the population and the decrease in the number of children are rapidly becoming more pronounced, and it is forecast that by the year 2025 there will be one elderly person for every two workers in Japan. With finances at the national and local levels mired in very severe conditions, it has also become necessary to examine methods for health and medical care from new perspective. In addition, measures should be enhanced throughout society for increasing the participation of women in society and supporting families raising children. These problems are not those only of our country alone, but are problem that many countries around the world are commonly facing.

Under these conditions, this joint symposium, which has as its main themes health and medical care, aging, and work and the family, is a very timely and meaningful opportunity. I hope and expect that his symposium will achieve very fruitful results through the active discussion of the participants and will see further progress in Canada-Japan cooperation in this field.

Lastly, I would like to extend my sincerest appreciation to the Canadian Embassy in Japan and Kwansei University, the joint sponsors for this symposium, and to the National Institute for Population and Social Security Research, the Asia Pacific Foundation, Canada, and other concerned organizations for their many contributions in preparing the symposium.

Keynote Speech

"Social Policy in a Globalizing Era"

The Honourable Dr. Rey D. Pagtakhan
Secretary of State (Asia-Pacific)

INTRODUCTION

Good morning, Ladies and Gentlemen. I would like to begin by thanking Kwansei Gakuin University, the National Institute of Population and Social Security Research and the Asia Pacific Foundation of Canada for the opportunity to speak to you today.

I am very pleased, as well, to have the honour to speak at Kwansei Gakuin University which has a close partnership with a number of Canadian universities, and whose 4th Chancellor, a Canadian missionary, Dr. Bates, established the university's motto, "Mastery for Service," encouraging students to not only master academic knowledge, but also to serve others. This is a very appropriate motto to guide us in this social policy symposium.

Canada places great importance on the very positive and multi-faceted relationship we enjoy with Japan. In recognition of the special importance of the Canada-Japan relationship, the Canadian Government launched in March of this year the *Think Canada* festival. *Think Canada* is the largest ever Canadian festival to be held in Japan. It will continue until July with some 200 events throughout Japan highlighting Canadian Arts and Culture, Business, Science & Technology, Politics and Society, Education and Lifestyles.

This Social Policy Symposium is an important element of the Think Canada Festival. Canada-Japan cooperation in social policy is an innovative new aspect of our relationship from which we can realize mutual benefits.

Most countries around the world are grappling with how best, in the 21st century to secure economic prosperity in an increasingly globalized society while at the same time ensuring that no member of society is left behind. Increasing our knowledge base regarding social policy is an important part of ensuring this goal; and this conference is an excellent mechanism to share ideas, knowledge and experience on these issues.

Today we will have the opportunity to learn about and discuss three social policy issues that are of great concern in both of our countries. I am pleased to see that you have focused on the three issues of Health, Ageing, and Work and Family. I believe that bilateral cooperation on social policy will enable Japan and Canada to acquire a better mutual understanding of social policy concerns and will allow us to learn and benefit from each other through a sharing of knowledge, ideas and experience.

Developing partnerships in the policy research community, as we see here today, is critical to our understanding and knowledge development of social policy. With proper knowledge, we will be better prepared to face the many challenges that both Japan and Canada face in this era of globalization.

As you are all well aware, social policy cannot be discussed in the abstract, nor can it be divorced from the issue of ethics and values.

In my remarks today, I would, therefore, first like to describe some of what I believe are the values underlying social policy.

Second, I will outline the basic structure and development of social policy in Canada.

Third, I would like to identify, from my perspective, what some of the challenges and opportunities are, in terms of social policy in a globalizing era.

Finally, I will discuss our efforts at envisioning social policy with a future perspective.

1.VALUES

My concern for social policy developed through my experience as a doctor, which demonstrates my desire to address the concerns and problems of people, not just their illness, but what I call societal illness. For this reason I am particularly concerned with social policy and its fundamental values.

I believe that the success a nation achieves is, in large part, attributed to an abiding commitment to strong values – caring and compassion, an insistence that there be an equitable sharing of the benefits of economic growth.

My Prime Minister calls this "The Canadian Way" – the values that Canadians share: freedom, equality, fairness, respect for individual dignity and the rule of law. Canadians are committed to solidarity and social fairness, believing in equal worth of all and in mutual responsibility.

In developing public policy in Canada, our values are reflected in the importance we place on our legal framework and history, our mixed economy, strong communities, bilingualism and diversity, social safety net and system of universal health care, and recognition of global interdependence.

I believe these values are a key to understanding why Canada has been ranked by the UNDP during the past seven years as the country with the highest quality of life.

2. STRUCTURES AND DEVELOPMENT OF SOCIAL POLICY

I would now like to turn to my second point, which is the structures and development of social policy, our experiences in developing social policy and the role that research can play in its development.

Building this knowledge base requires research that:

- We go deeper in understanding trends shaping the future;
- We build linkages across disciplines, jurisdictions and different sectors of society; and
- We recognize, for example, that good social policy is good economic policy and good economic policy is good social policy.

Access to data and research resources is essential for the policy research community. Policy researchers and decision-makers need easier access to policy data in today's faster moving policy context.

It is clear that we need a stronger knowledge base and capacity to make the most of emerging opportunities in a fast-changing and complex world.

In Canada, we have in conjunction with partners in over 30 federal departments and agencies, including my Department of Foreign Affairs and International Trade, as well as provincial governments, numerous think tanks such as the Asia-Pacific Foundation and many universities, a desire to promote horizontal linkages, working in partnership to identify social policy issues within the Canada.

The Policy Research Initiative is a catalyst in this effort, bringing policy researchers together, helping to build partnerships, synthesizing research results and sharing knowledge.

Over the course of the Japan-Canada social policy collaboration, some of you have attended the Policy Research Initiative (PRI) National Conference and interacted with researchers and policymakers. The purpose of the PRI is to help build a stronger knowledge base on the complex issues facing Canada with international collaboration in a globalizing context. To do this the PRI pursues three objectives:

1. To develop a stronger base of longer-term policy research on crosscutting issues;
2. To build policy research capacity; and
3. To strengthen a culture of partnership in the policy research community across Canada and abroad.

Building partnerships in the policy research community, as we see here today, is critical to our understanding and knowledge development of social policy. With proper knowledge, we will be better prepared to face the many challenges that both Japan and Canada face in our social systems.

3. OPPORTUNITIES AND CHALLENGES

I would now like to take this opportunity to reflect on and talk about some of the principal social policy challenges and opportunities that we face in terms of social policy in a globalizing era.

Social cohesion, and the related concepts of inclusion, exclusion, social capital and differentiation are central debates in public policy today. We must consider such pressing issues as access to work and education, poverty and social inequalities, social and cultural diversity and such emergent challenges as the digital divide.

Let us first take a look at Diversity and Multiculturalism

It is important to recognize that diversity makes society more resilient, more creative and more innovative. In an era of globalization, diversity strengthens our economic, social and cultural ties to the world.

In Canada, we are committed to fostering social inclusion and respect for ethnic, cultural and religious diversity, because they make our societies strong, our economies more flexible and promote exchange of ideas and knowledge. We celebrate the diversity of our nations. We encourage cultural diversity. Globalization, which is indeed about more contacts and more exchanges, should not lead to uniformity, but to the enrichment of people and the opening of cultures.

Canadians have learned that having two international languages is a comparative advantage and a source of continuing creativity and innovation. Through our immigration program, Canada accepts more newcomers per capita from more places than any other country in the world.

Canada's international voice draws on its distinct advantage as a multi-cultural society where people have roots in virtually every country in the world.

Canada is a country built on diversity. It is no coincidence that common principles are found in our *Canadian Charter of Rights and Freedoms*. We then took it one step further by passing the *Multiculturalism Act* in 1989, the first of its kind in the world

The issue of Safe communities is another important social policy issue.

I believe that a high quality of life requires safe communities where people wish to live and raise their families, where they can live without fear of crime or violence. Crime rates in Canada have been falling steadily since the 1990s. In 1997, Canada's police-reported crime rate decreased for the sixth year in a row, falling 5%. Canada is working to maintain this decline in crime rates, to ensure that its communities continue to be safe and that Canadians do not live in fear of crime.

In order to ensure safe communities, strong law enforcement and effective corrections is required but we must also focus our efforts on preventing crime before it happens.

Canada has been called a "public enterprise" society because of its traditions of social responsibility. We take pride in our reputation for mutual tolerance, mutual respect, and mutual responsibility. Our strong civic base is reflected in relatively low and decreasing rates of crime and violence, high rates of voluntarism and charitable giving, and a strong an active voluntary sector.

Another important development is the growth of the Voluntary Sector in many societies.

We cannot over emphasize the value of the voluntary sector in reaching out to those that government programs may too often miss.

In Canada, our Prime Minister has characterized the volunteer sector as one of the "strongest fibres in our social fabric". I could not agree more. By investing in our relationship with the voluntary sector we are investing in our communities and neighborhoods.

Ten years ago, the bulk of Canada's voluntary hours came from younger Canadians between the ages of 25 and 44. Today, those over 45 carry most of the load. Although more youth in Canada are volunteering, the number of hours they contribute is relatively small. The voluntary sector is vulnerable because it relies on a small core of supporters.

To face these challenges, our Government has developed the "Voluntary Sector Initiative" to strengthen the voluntary sector's capacity to meet the challenges of the future, and to enhance the relationship between the voluntary sector and the government, strengthening volunary organizations' ability to serve Canadians. The Government of Canada is investing $94.6 million over five years to developing its relationship with the voluntary sector.

One of the complexities of social policy in Canada is the structure of our government and the differing procedures and priorities of the Federal and Provincial governments. For example, health and education issues pose a unique challenge for Canada since jurisdictional issues between the Federal, Provincial and Territorial governments can complicate social policy discussions, developments and implications. The challenge is to find a balance between the perspectives of the various levels of government.

I am pleased to see that you will be discussing the issue of Health at today's presentations. This continues to be an extremely important social policy issue for both Japan and Canada.

Another important aspect that cannot be over emphasized is Education, which is key to a knowledge-based economy and society. Education is critical to equity, development and citizenship and is the key to social justice and economic dynamism. The Government of Canada stresses the importance of education by providing support in the form of grants, student aid programs, and in its efforts to help graduates manage debt. By expanding higher education, we are also creating a vibrant research base for new technologies.

Canada has the largest proportion of people with post-secondary education in the world, roughly 40%, but the demands of the knowledge economy are placing an increasing premium on quality, not just the number of degrees but also the quality of those degrees. The future will demand access to education of the highest quality, access to excellence.

Poverty and Marginalization continues to pose significant challenges.

Poverty is one of the central challenges in today's global economy and society. As unlikely as you might think, the eradication of poverty and marginalization also poses a great challenge to Canadians, especially in the area of child poverty. One in eight school-aged children lives in a family with very low average income - below $20,000 per year. I believe that governments have a key role to play in providing support to families and children.

A critical task for our government is to address the issues of poverty and underdevelopment in Canada and abroad. That is why we need efficient international co-operation that links together solutions to these problems.

Health/Ageing/Work and Family

I would now like to turn to the three topics that you will be discussing in today's symposium. These topics include health, ageing, and work and family, all of which are of great mutual concern in this era of globalization.

Canadians attach great value to and take great pride in our public health care system. Canada's system of universal health care (Medicare) guarantees access to essential health services regardless of income or place of residence. The Government of Canada has no

greater obligation than to work together with an uncompromising commitment to universal access to essential medical services of high quality.

Our two countries also face the challenge of adapting to an ageing population, to ensure that adequate health care is provided and to examine related issues such as maintaining public pension plans, home care and creating the conditions in which health and social services can adjust and respond to the evolving needs of the aging population.

The third topic of this symposium relates to work and family the difficult challenge of balancing these responsibilities. In Canada, government efforts to aid families in creating such a balance include, for example, a major new initiative to double parental leave from 26 weeks to a full year to enable working parents to choose to be with their young children.

In this globalizing era, it will be a challenge for us to not only make it easier for citizens to balance work and family but to also recognize our corporate social responsibility of ensuring that our citizens are not left out of the workforce.

4. ENVISIONING SOCIAL POLICY WITH A FUTURE PERSPECTIVE

Finally, I would like to discuss our ability to envision social policy with a future perspective, particularly in the context of the knowledge-based economy.

The world economy is becoming increasingly knowledge-based. This transition holds the prospect of improved performance, but introduces a new set of transition problems. In order to adapt, the challenge will be to upgrade the skills and education of its workforce and make the management of knowledge a priority for individuals, firms, governments and other institutions.

The knowledge-based economy also holds unique challenges for women. Women have much to offer the knowledge-based economy and society, given the evidence of the nature and scope of their participation in it. Our priority is to ensure that we are bringing women's perspectives to policymaking and related research.

Technological change and the information revolution are among the most important determinants of economic growth, human development and social cohesion. The promise and pressures of the information society will continue to be a challenging factor for us in this globalizing era. The government of Canada seeks to address this challenge by committing to have its services on-line by 2004 so that citizens will be able to access its services at a time and place of their choosing.

I believe it is important to see that social policy and economic policy work hand in hand, understanding the interdependency between the two. The society and the economy have to be seen as a reciprocating engine, where economic growth reinforces social cohesion and where social cohesion contributes to economic growth.

A strong economy is necessary for us to improve the quality of life of our citizens, preventing growing inequality and improving social cohesion.

Research is needed to help us understand the impact that the global economy is having and will continue to have on social policy.

We must support greater policy coherence at the international level, to address not only the economic, but also the social, environmental, health, and cultural consequences of globalization.

We will have to meet the challenge of building an international agenda that is coherent and governance structures that are more transparent and that engage civil society domestically and internationally.

CLOSING REMARKS

I would like to conclude my remarks by stressing the importance of Canada-Japan dialogue and collaboration, particularly on such critical issues as ageing, health, and work and family. I look forward to your deliberations since it is through sharing of knowledge, ideas and experience on issues of common concern that we will effectively learn and benefit from each other. I am honored to participate in this exchange between Canada and Japan, and I am committed to our partnership in social policy research.

Thank you.

Balancing Work and Family in Japan: Inertia and a Need for Change

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Please also read Nagase's "Standard and Non-standard Work Arrangements and Child-Bearing of Japanese Mothers" posted in the home page address
http://www.upjohninst.org/conference/nagase.pdf

Introduction

This paper will address changes in the work and family life of Japanese households which have been evident over the past decades. This paper will first address the changes seen in the field concerning women and labor in Japan. It will then look at changes in the family scene followed by its focus on policies and its impact, especially those concerning daycare and parental leave. The final purpose of this paper is to communicate between two countries, in order to exchange views and gain hints for options for measures on balancing family and work life.

Some changes Japan shares in common with many industrialized countries include the increase in female labor participation, increase in non-standard work arrangements and changing attitude of gender role towards work and family. However, there may exist what I would refer to as an "inertia" in the work and family choice pattern of average Japanese married women. Still as large as 70% of women are full-time mothers when one's first child has reached the age of 1. Even though more women participate in the labor market when their children grow older, their income is rather low, comprising only about 30% of family income on average according to the Household Survey. Yet, an increasing number of young women are delaying their marriage until their late twenties and early thirties.

Increased Labor Participation of Women

More women are in the labor force, a trend in line with Canada. In 1975, women comprised 37% of the work force, increasing to 41% in 1999. The labor participation rate of wives in the age group of 20 to 60 was as high as 69% in 1997 according to Basic Employment Survey. Despite a substantial difference in the tenure year between the sexes, as much as 4.9 years in 1998, the average tenure of female regular full-time workers increased from 6.1 years in 1980 to 8.2 years in 1998. The wage gap between the two sexes has also been narrowing for regular full-time workers, but the overall wage difference has not narrowed because of the increase in non-regular workers and their diminishing wage.

More women are obtaining higher education. Percentage of enrollment to four-year degree at universities was approximately 35 for males in 1986 while the corresponding figure was nearly 15 percent for women when the Equal Employment Opportunity Law was implemented. The figures have now reached almost 45% for males and over 25% for females.

Still, there remains a marked difference between the sexes in the labor participation pattern. The age profile of labor participation for women still retains an M-shaped figure. The bottom of the age profile of labor participation comprises those in the age group of 30 to 34. Despite its increase from 51% in 1989 to 57% in 1999, the profile contrasts with that of males where the labor participation rates show a very high plateau of 95 to 98% in the age group of 30 to 59.

Table 1 Average Tenure of Male and Female Workers

	1980	1985	1990	1994	1998
Male	10.8	11.9	12.5	12.8	13.1
Female	6.1	6.8	7.3	7.6	8.2
Female Part-time workers	3.3	3.9	4.5	4.9	4.8

(Sorce) Ministry of Labor *Wage Census*

Figure 1 A Large Wage Gap Between Part-time and Regular Workers (Female)

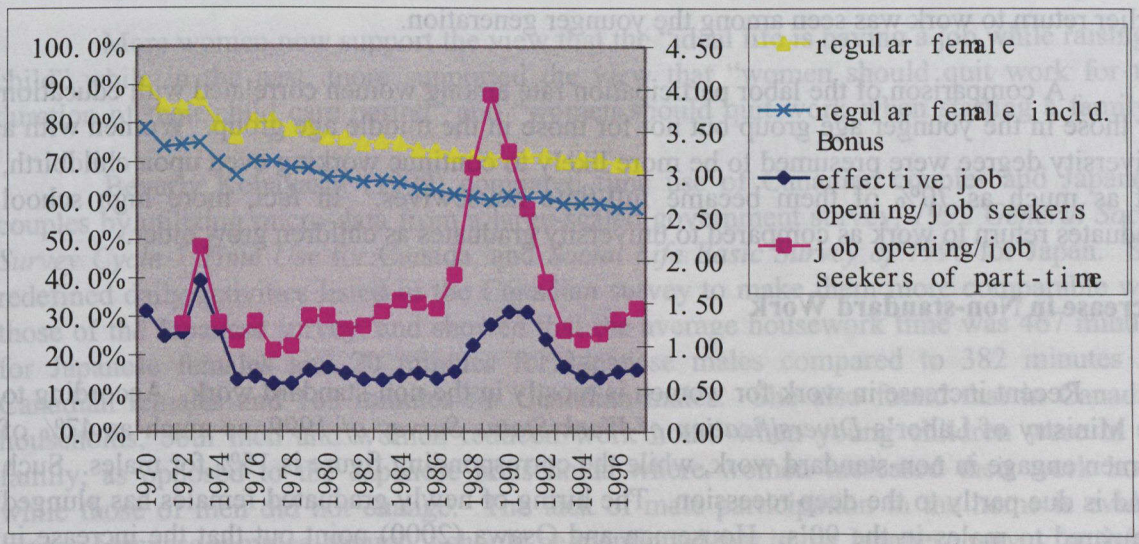


Table 2 Average Wage Difference between Sexes For Regular Workers

	wage difference				
	1980	1985	1990	1995	1998
Female/male	59%	60%	60%	62%	64%

Child Birth and Work Interruption

The *Eleventh Japanese National Fertility Survey* conducted in 1997 by the National Institute of Population and Social Security Research, which collects data on married women aged under 50 years, reveals married Japanese women's work and family patterns by retrospective questioning. It shows that 84% of females work in regular full-time employment after graduation from school. The remaining consists of part-time workers, the self-employed and non-labor participants. Those who work full-time with a standard work contract have high job security. The survey found that of the females with regular full-time employment status after school graduation, 46% of those born before 1962 became full-time housewives upon marriage. The younger generation showed a higher tendency to remain in the workforce, but the choice of becoming a housewife was still an option for the generation born after 1962, as 42% quit work upon marriage. For those who continued to work, another 40% resigned from their job to become a full-time mother upon their first childbirth. Therefore, the labor participation rate of women with a one-year-old child had only reached a mere 30% in Japan, with little change over the past three decades. On the whole, however, more mothers with young children stayed in the labor force in the early 1970's as opposed to a larger portion of women who were family workers working at home. As well, the portion of full-time mothers was larger in the cities than in local areas, higher in nuclear families than in extended families, and lower for women with less education.

Imada (1996), Nagase (1999), and Abe(2001), using different surveys, concluded that work participation of mothers with a child under three years did not rise in the past 20 years despite the fact that more women supported the view of maintaining a family while

working. However, more women returned to work when their children became older, and an earlier return to work was seen among the younger generation.

A comparison of the labor participation rate among women correlated with education for those in the younger age group but not for those in the middle age group. Women with a university degree were presumed to be more likely to continue working even upon childbirth, but as much as 70% of them became full-time housewives. In fact, more high school graduates return to work as compared to university graduates as children grow older.

Increase in Non-standard Work

Recent increase in work for women is mostly in the non-standard work. According to the Ministry of Labor's *Diversification of Work Status Survey of 1999*, as much as 47% of women engage in non-standard work, while the corresponding figure is 15% for males. Such trend is due partly to the deep recession. The hiring of newly graduated females has plunged compared to males in the 90's. Houseman and Osawa (2000) point out that the increase in non-standard work is demand-led.

The non-standard work is part-time work, contract work, dispatched work, temporary work and others. Among them, part-time work comprises 40% of 47% of non-standard work among females.

Compared to "standard work", hourly pay of non-standard work is low. The male and female wage gap for "standard work" is narrowing, but the wage gap between standard and non-standard work is widening. Compared with female standard workers, the hourly wage of part-time workers was roughly 80% of that of standard workers in 1970, and the gap diminished to approximately 60% in 1998, inclusive of yearly bonuses. Consequently, the overall male and female wage gap has been widening. Nevertheless, it should be noted that many married part-time workers are actually satisfied with their work despite their lower salary (Sato, 1998).

Table 3 Changes in Non-standard Job

	1994	1999
Percentage of non-standard jobs (Average of Both Male and Female)	22.8	27.5

Table 4 Constituency of Type of Employeed Workers(1999)

	Standard	contract	temporary	part-time	shukko	dispatched	other
Male	85.1	2.1	1.8	20.3	1.3	1.1	0.7
Female	53.0	2.6	2.0	39.6	0.4	1.8	0.6

(Sorce) Ministry of Labor *Shugyo Keitai no Tayouka ni Kanusuru Chosa* (Survey on the Diversification of Workers)

Changes at Home

More women now support the view that the "ideal life is having a job while raising a child" while in the past, more supported the view that "women should quit work for the duration of their child care period" and "women should quit work when starting a family".

Beverly Kobayashi (1999) compared time use of Canadian couples and Japanese couples by utilizing micro-data from a large-scaled government survey, *1992 General Social Survey Cycle 7 Time Use* for Canada, and *Social Life Basic Survey of 1996* for Japan. She redefined daily activities listed in the Canadian survey to make them more comparable with those of the Japanese survey, and showed that the average housework time was 467 minutes for Japanese females and 20 minutes for Japanese males compared to 382 minutes for Canadian females and 163 minutes for Canadian males. She also found that in Canadian households, both men and women reduced work hours when young children were in the family, as opposed to the Japanese households where women increased their work hours while those of men did not change. The lack of male participation in the home is evident among Japanese samples, though it should be mentioned that in the Japanese survey, activities with duration of less than 15 minutes were not recorded.

Policy concerning Support for Work and Family Balance

The Japanese government is promoting policies to support family and work. I will discuss the two large pillars of such policies. The first one deals with provision of daycare centers while the other deals with parental leave law.

Daycare Centers

Re-entry to the labor market after a period of absence often results in poor working conditions for the workers, especially in Japan where port of entry to regular and stable employment status becomes narrower with progression into middle age. Therefore, working while raising children is in part necessary to maintain a females' career. In the past, subsidized places of daycare for infants had been quite small and the governmental was reluctant up until 1994 when the Ministry of Health and Welfare proposed the "Angel Plan", which included details aimed at facilitating the coordination of work and family. In that year, the government proposed to increase places for children less than three years old from 400,000 to 600,000 within a year. Other issues addressed included plans to increase the hours of daycare centers and child consulting centers.

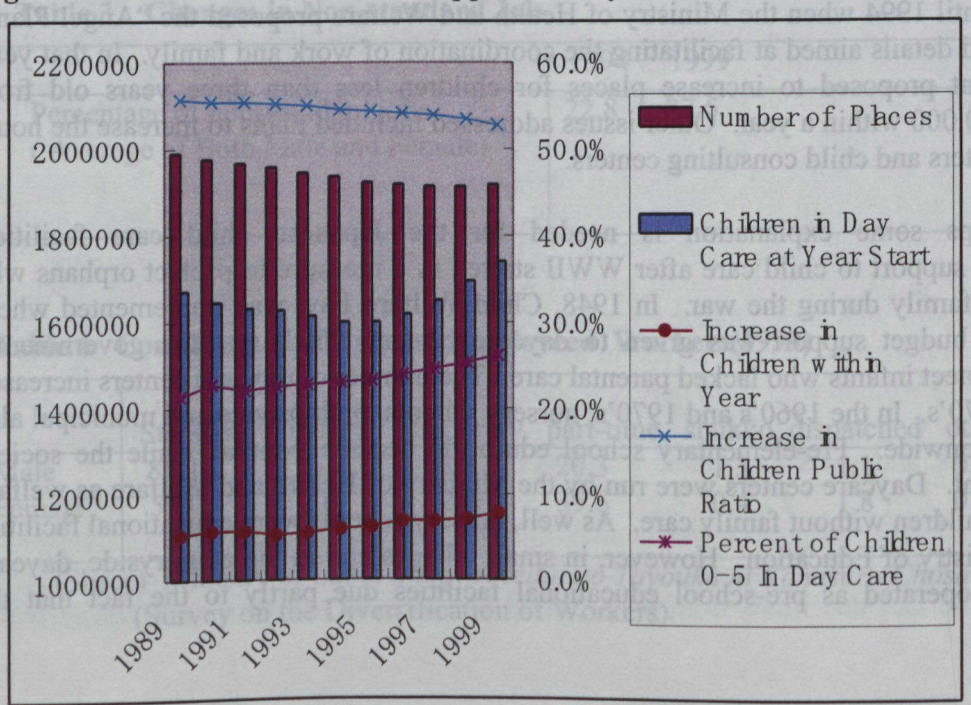
Perhaps some explanation is needed for the Japanese child care facilities. Governmental support to child care after WWII started as a measure to protect orphans who had lost their family during the war. In 1948, Child Welfare Law was implemented where governmental budget support was given to daycare centers which met the governmental standard to protect infants who lacked parental care. The number of daycare centers increased rapidly in the 70's. In the 1960's and 1970's, nursery schools, both private and municipal also increased nationwide. Pre-elementary school education became popular while the society became affluent. Daycare centers were run by the Ministry of Health and Welfare as welfare facilities for children without family care. As well, nursery schools were educational facilities under the Ministry of Education. However, in small villages and in the countryside, daycare centers often operated as pre-school educational facilities due partly to the fact that the

governmental subsidized more generously to daycare centers.

In the 1960's, the Council for Child Welfare proposed that services of daycare centers should be provided to children who lacked parental care, but advised that for children under 3 years with family care, home care was preferred for their well-being. As a result, only a small number of facilities providing infant care were available. Therefore, if mothers of newly born babies wished to work, they had to seek relatives' help, hire a baby-sitter, or use private (non-approved by the government) daycare centers until their children reached the age of 2 or perhaps 3. Because the government was reluctant in providing care for infants, the number of private centers where babies were cared for under lacking conditions increased. Particularly in urban areas where a grandmother's help within extended families was less likely to be found, women had to resort to such care centers. In 1980, infant care of private centers became a national issue when consecutive deaths of babies occurred in "baby hotels". The provision of baby care, however, remained insufficient until the implementation of the "Angel Plan" of Ministry of Health and Welfare in 1994.

Today, we have government-subsidized daycare centers and nursery schools for children aged 0 to 6 years and 3 to 6 years respectively and non-approved daycare centers. The 53% of government-approved daycare centers (the welfare facilities under Child Welfare Law) have been municipally owned since 1999. All the government-approved daycare centers receive subsidies from the national, local and municipal governments. The subsidies constitute roughly 50% in total of the operating cost – the remainder is covered by parents using their service. The fee is income-related and suggested by the government. However, the actual operating cost often exceeds the amount estimated and provided by the national government, and therefore the municipal government has been allocating more of their funds to pay for the cost. In the past in urban areas where the municipal government had abundant budget in the past, the municipal government made more additions to the regulations set out by the central government, including higher children-to-staff ratio. Because of such history, the process of increasing the number of facilities for infants has been slow despite the planning by the Ministry of Health and Welfare since doing so would lead to the municipal government facing budget deficit.

Figure 2 Increase in Children in Approved Day Care Centers



Still a large number of infants are on the waiting list and many have no choice but to use non-approved centers. Nagase (1997) found that there are less of these facilities in municipals where the percentage of public-to-private approved centers is high. In addition, she revealed that by two-stage least squares estimation, areas with higher percentage of public-to-private approved centers have higher labor participation of married women and vice versa. Further, metropolitan areas in Tokyo and Osaka are found to have high percentage of government-operated daycare centers, long waiting lists for entry, and lower ratio of daycare facilities to the number of newly born infants.

Figure 3 Shortage Yet of Governmentally Subsidized Day Care Centers as of 2001 April

	Number of Children in Non-Approved Day Care to Places in Approved Day Care	Number of Children on Waiting Lists to Places in Approved Day Care
Sapporo	26%	0.9%
Sendai	34%	6.8%
Chiba	14%	1.6%
Yokohama	27%	7.9%
Kawasaki	28%	11.4%
Nagoya	4%	1.8%
Kyoto	5%	2.3%
Osaka	7%	5.7%
Kobe	13%	8.9%
Hiroshima	7%	1.4%
Kitakyushu	8%	0.9%
Fukuoka	8%	2.2%

Parental Leave

The Child Care Leave Law, which allows for leave from work until one's infant reaches the age of 1, was implemented in 1992 to support the accommodation of family and work. Before the law took effect, one was able to obtain a maternity leave for only six weeks prior to childbirth and 8 weeks after childbirth. Also, 60% of one's salary is compensated through Health Insurance during the maternity leave.

The child care leave on the other hand started as unpaid leave. In 1995, however, the law was extended to workplaces with less than 30 employees, and the Employment Insurance began compensating 25% of the total salary during the period of leave. From 2001, the percentage has risen to 40%, 30% during the leave and 10% upon six months after returning from leave. The Ministry of Labor's statistics on *Basic Survey on Female Workers Labor Management* indicates that although some companies offer child care leave, the percentage of the total workplace with this provision increased rapidly after the implementation of the law. In 1981, 14% of the workplace with more than 30 employees had some form of child care leave provision while this figure rose to 22% in 1990. As well, 51% of the total workplace in 1993 had leave provision stated in the employee's work contract, which in 1999 increased to 77%. Therefore, in 1993, 48% of female workers used the provision and continued to work after childbirth. The figure increased to 44% in 1996 and 58% in 1999 at firms with more than 30 employees. Of those workers who took leave in 1999, females comprised 99% while

males comprised 0.5%. Therefore, more women workers now who continue to work enjoy longer leave period for childbearing.

A survey conducted in workplaces with more than 30 employees revealed other provisions offered to workers with family responsibilities as follows: 42% replied that their company had short work-hour provision; 10% replied that they had flexible work hours; 25% replied that they had varying work shifts; 31% replied that they had a provision to limit overtime work for workers with infants; 11% replied they had sickness leave for family care; 2% replied that they had use of an internal company child care center; and another 2% replied that they had child care allowance. Morita and Kaneko (1998) and Higuchi (1996) found that women who work at companies which provide child care leave have longer years of tenure.

What is puzzling is that despite the generous Child Care Leave Law, continuation of work by mothers with infants did not show a rise in 1990's as I have mentioned in the previous sections. According to the *Eleventh Japanese National Fertility Survey*, a little more than 6% of all childbirth after 1992 was cared through child care leave, and the figure was less than 8% for children born between 1995 to 1997. More mothers took advantage of the child care leave after the law took effect, but the portion of female workers who continued to work after childbirth stagnated. This could have been due to the deep recession in the 90's. Non-standard work which had increased most rapidly often did not give rights for child care leave. The *Eleventh Japanese National Fertility Survey* showed that women with higher education, higher salaries, and those working in the public sector were found to utilize the leave more often rather than returning directly to work after maternity leave. Opportunities for higher income, however, did not seem to give high impetus for continuation of work after childbirth (Nagase, 2000). Presence of grandmothers in households, wive's mothers' work history, family values, educational attainment and being publicly employed or not were evidently the factors that increased continuation of work after childbirth. Child care has changed in the past 20 years for women who continued to work. More relatives living in the same household helped in the 70's. Yet in the 90's, care from mothers, daycare services and child care leave were the main method for child care of working mothers.

Need for Change in Employment Practice

We have overviewed the changes in women's average educational attainment, women's attitude and inertia in labor participation following childbirth; a significant point, however, is that the changes occurred notably in the form of an increase of the population who stay childless, rather than those who continue to work while maintaining a family.

Government policies aimed at supporting work and family have not yet effectively increased the portion of women with family and career. The available options for many females, particularly those who want to maintain a career, are still likely to be either heavy work commitment without having children, or having children with a low-paying job. Consequently, along with an increase in child care facilities, changes in employment practices are also necessary. *Nikkeiren*, an employer's organization, pointed out the need for a special type of employment status with similar work conditions of standard workers but with more freedom in terms of work hours. In addition, *Rengo*, a labor union's organization, discussed the need for improving wages and conditions of part-time workers. Thus, there is an increasing recognition for the need for change among various labor organizations and other parties.

Nonetheless, there are many issues which need to be resolved. Among the issues in relation to company rules, focus should be placed on the seniority and family wage, retirement pensions of standard workers versus market wage and short work term contract of non-standard workers. Examination into tax and social security system is also needed - work adjustment is prevalent among married part-time workers, who are eager to avoid tax and social security fee payment while enjoying the marriage benefit of being a dependent. As well, the marriage benefit is given generously to those with annual income of less than 100 million yen.

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Work-Life Balance In Canada: Making the Case for Change

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Introduction

As we enter the new millennium, Canadian governments, Canadian employers, Canadian employees and Canadian families face a common challenge - how to make it easier for Canadians to balance their work roles and their desire to have a meaningful life outside of work. A large number of studies over the last decade have revealed that many Canadians have difficulty in balancing work and family (Akyeampong, 1997; McBride-King, 1990; Lero et al., 1993; Duxbury et al., 1991; Higgins et al., 1992; Duxbury and Higgins, 1998, Johnson et al., 1997). Furthermore, recent work by the authors (Duxbury and Higgins, 2001) indicates that the percent of Canadians who suffer from high levels of work-life conflict has increased dramatically over the course of the past decade.

Why has work-life balance become more of a challenge? A number of trends (i.e. profound changes in Canada's economic situation, in the structure and functioning of Canadian families and in the role of governments) came together in the 1990s and appear to have overwhelmed employees' ability to cope. Fourteen years ago the Hudson Institute caught the attention of the business world with its publication of *Workforce 2000* (Johnston & Packer, 1987), a compelling description of anticipated changes in the work world and in the demographic profile of workers. It is now 2001 and many of the changes predicted in *Workforce 2000* have indeed materialized. As predicted, the workforce of the new millennium is quite different from the one organizations are used to managing (i.e. the male dominated workforce of the past). The new workforce is older, more ethnically diverse, and has a larger proportion of working women, working mothers, dual-income families, employees with responsibilities for the care of aging parents, fathers with dependent care responsibilities, and sandwich employees (i.e. those with both childcare and eldercare responsibilities). With the advent of the dual-income family, employees of both sexes are now coping with caregiving and household responsibilities that were once managed by a stay-at-home spouse. Such employees are not well served by traditional "one-size fits all" human resource policies which can impose rigid time and place constraints on employees or reward long work hours at the expense of personal time. Similarly, organizational cultures which focus on hours rather than output and dictate that work takes priority over family and life make it difficult for many of todays employees to achieve a balance.

The evidence suggests that both governments and employers have been slow to respond to these changing social and economic pressures on Canadian employees and their families (Scott, 2000). In the absence of supportive government policies and organizational practices families have struggled to accommodate job demands, often at the expense of their family role obligations and their own well being. The result has been an increase in work-life conflict and stress (Scott, 2000).

The fact that many organizations and governments tend to have a limited, somewhat biased, view of the topic of work-life balance (many still subscribe to what Kanter (1979) has been

termed "the myth of separate worlds") has also contributed to increases in work-life conflict. The myth of separate worlds paradigm assumes that work and family are two quite separate domains, that work demands take priority over non-work demands, and that employees both can and must manage their family demands so that they do not interfere with their ability to fulfill their responsibilities at work (Skrypnek and Fast, 1996). The utility of this paradigm as a management principal has been eroded in recent years as the number of Canadians in traditional (i.e. male breadwinner, woman homemaker) families have declined while the number of Canadians who are members of dual-income (i.e. both partners have paid employment outside the home) and single parent families has increased. The worlds of work and family are intricately connected (both positively and negatively) within these types of families and employees within these family structures find it difficult, if not impossible, to separate work and family demands and to always give work priority.

In addition to the above, organizations who ascribe to the myth of separate worlds often feel that helping employees balance competing work and non-work demands is not their responsibility. Instead, they argue that "it was the employee's choice to have a family, and as such, balancing competing demands is their problem not ours." Such organizations also argue that they "are in the business of increasing shareholder value and serving customers and not helping employees cope with stress!" To compound the problem, a backlash against "family friendly" which has occurred in some firms has made it harder for these organizations to address the issue. This backlash takes several forms but most commonly occurs when employees without dependent care responsibilities interpret "family friendly" as favoritism and complain that employees without children are being "unfairly" or inequitably treated. Such employees feel that their colleagues with childcare or eldercare responsibilities are "getting away with less work" and that the needs of childless employees are being ignored (Galinsky et al., 1991).

Our research (and the research of others in this area) does not support any of the above preconceptions. In fact, the empirical evidence would suggest the opposite - that the inability to balance work and family should be considered "every ones problem" as high work-family conflict has been shown to negatively impact the employer, the employee, the employees' colleagues and family, and Canadian society as a whole. Obviously more needs to be done to advance workplace and government strategies that assist Canadian workers and families (Scott, 2000). This paper is, hopefully, a step in this direction.

This paper is an attempt to synthesize Canadian research in the area of work-life balance so as to provide business and labour leaders, policy makers and academics with a more objective "big picture" view on what has happened in this area in Canada in the last decade. Specifically, this paper provides answers to the following questions:

- What is work-life conflict?
- Why is work-life conflict an issue in Canada at this point in time?
- How prevalent is high work-life conflict in Canada?
- How has the prevalence of high work-life conflict changed over the past decade?
- Who is at risk of high work-life conflict?
- Why should governments and employers care about work-life conflict?
- What can be done to help employees balance the demands of work and family?

The paper is organized into five parts. The first section of the paper provides the reader with relevant background material on the topic (i.e. definitions, measurement). Section two puts the data into context by outlining the demographic, social, economic, and governmental

changes that may have had an impact on work-life balance in Canada. Section three seeks to determine the extent to which work-life conflict is a problem within Canada today by: (1) looking at current (i.e. 2001) data on the prevalence of high work-life conflict in Canada, and (2) comparing employees' work-life balance experiences in 1991 to their experiences today (2001). Also included within this section is a discussion of who within the Canadian population is at risk of higher work-life. The data included in section four provides the business case for change as it looks at how high levels of work-life conflict effects individuals, families, organizations and society in general. Section five looks at what organizations and governments can do the decrease work-life conflict and offers a number of recommendations on how to best support working families in Canada in the 21st century.

1.0 What is Work[1]-Life Balance?

We all play many roles: employee, boss, subordinate, spouse, parent, child, sibling, friend, and community member. Each of these roles imposes demands on us which require time, energy and commitment to fulfill. Work-family or work-life conflict[2] occurs when the cumulative demands of these many work and non-work life are incompatible in some respect so that participation in one role is made more difficult by participation in the other role.

Research has been conducted in area of work-life balance for several decades. The research paradigm has, however, shifted over time from a preoccupation with the separate worlds of work and family (1970s) to research which focused on how experiences at work (both positive and negative) spill over into the family domain and vice versa (1980s) to research exploring the interaction and interconnectedness of the work, family and community domains (Scott, 2000).

At the present time work-life conflict is conceptualized to include role overload (having too much to do and too little time to do it in!) as well as role interference (when incompatible demands make it difficult, if not impossible, for an employee to perform all their roles well). Role interference, in its turn, can be divided into two factors: family interfers with work (FIW) and work interfers with family (WIF). In the first case, interference occurs when family-role responsibilities hinder performance at work (i.e., a child's illness prevents attendance at work; conflict at home makes concentration at work difficult). In the second case, interference arises when work demands make it harder for an employee to fulfill their family responsibilities (i.e., long hours in paid work prevent attendance at a child's sporting event, preoccupation with the work role prevents an active enjoyment of family life, work stresses spill over into the home environment and increases conflict with the family). In this sense, then, work-life conflict can be seen to have two major components: the practical aspects associated with time crunches and scheduling conflicts (i.e. an employee can not be in two different places at the same time), and the perceptual aspect of feeling overwhelmed, overloaded or stressed by the pressures of multiple roles.

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[1]Throughout this paper the term work refers to paid employment.

[2] In the 1970s through to the early 1990s researchers studied work-family conflict. In the later part of the 1990s the term was changed to "work-life" conflict in recognition of the fact that employees' non-work responsibilities can take many forms including volunteer pursuits and education, as well as the care of children or elderly dependents.

2.0 Why Is Work-Life Conflict An Issue In Canada At This Time?

The Canadian labour market throughout the 1990s could best be described as "tight". The dominant management strategy employed during this period was one of cost cutting rather than people development and as a nation Canadians were fixated on the economy and securing and keeping jobs rather than achieving balance. The decade was one of tremendous change as employees confronted:

- a reshaping of the workforce (more women, more cultural diversity, aging of the baby boomers),
- a recession (the early 1990's) followed by a "jobless recovery,"
- a diminished social safety net and greater government cutbacks,
- high unemployment rates,
- a greater need for both parents in a family to work to maintain a "decent" standard of living,
- a degradation in the quality of jobs and an increase in non-standard work,
- increased automation of work processes, and
- changing expectations around hours of work.

These dramatic demographic, social and economic changes have led to what has aptly been described as a work and lifestyle "revolution". While these changes demand that both employees and managers think and behave in new ways they also present opportunities for forward thinking employers and governments to do things differently.

Three set of forces have been identified as shaping the interplay between work and family: demographic/societal, economic, and the changing role of governments (Scott, 2000). The following section provides a brief overview of some of the key environmental influences within each of these categories that influenced work-life balance in the 1990's.

2.1 Demographic/Societal Forces

The face of the Canadian workforce has changed dramatically over the past several decades. A number of the key changes which have been found to be associated with increased work-life conflict are reviewed below.

More Women in The Canadian Labour Force

The story of work-life balance and stress cannot be told without mentioning the growing involvement of Canadian women in the paid labour force and the concomitant shift towards the dual-income family. Between 1977 and 1996, women's labour force participation rate increased from 43% to 57%. In 1998, 58% of women over the age of 25 worked for pay outside the home (Statistics Canada, January, 1999). During the same time period men's participation rate declined from 81% to 74%. In 1998 women comprised 45% of Canada's total labour

More Mothers in The Canadian Labour Force

For women with children (especially young children) the growth in labour force participation rates has been even more dramatic. Between 1976 and 1998 labour force participation rates for mothers with children under age 3 doubled from 32% to 64% (Vanier Institute, 2000). During the same time period the participation rate of women with a youngest child aged 6 to

15 increased from 50% to 72%. In 1998, two thirds of Canadian mothers of young children (i.e. at least one under 6) were in the paid labour force (Scott, 2000).

Women's Employment Patterns Have Become Like Men's

Recent data would suggest that in Canada, women's patterns of employment are becoming like those of men (Fast and de Pont, 1997). Traditionally Canadian women left the workforce once they started their families. In the 1990s this was no longer true as the majority of women (55%) returned to work within two years of giving birth (Scott, 2000).

Changing Family Patterns: More Dual-Income Families

At the beginning of the new millennium the dual-income family has replaced the traditional male breadwinner/homemaker wife as the prototypical Canadian family type and both husband and wife work for pay outside the home in seven out of ten Canadian families (up from 34% in 1967) (Statistics Canada, 1997d). Only 20% of Canadian families now fit into the male breadwinner, female homemaker model (Vanier Institute, 1997).

Changing Family Patterns: More Single Parent Families

A second family configuration, the lone parent household, also become more prevalence in the 1990s. The number of lone-parent families reached 1.1 million in 1996, up 19% from 1991 and 33% from 1986 (Statistics Canaada, 1997e). Although these figures include both male- and female-headed households, lone parenthood is largely the domain of women. In 1996, lone-parent families headed by women outnumbered those headed by men by more than four to one (Ibid.). Roughly half of female lone parents work for pay (Lero & Johnson, 1994).

Lone parents in the labour force face considerable challenges in terms of balancing their work and home lives. Like parents in dual-income families, they must cope with the combined demands of their paid work and their domestic responsibilities. Unlike parents in two-partner families, however, they often must do so without the assistance and emotional support of a spouse, and often under the additional burden of financial stress (Statistics Canaada, 1997e).

Canadian Fathers Spending More Time In "Family" Labour But ....

Although Statistics Canada only began to include unpaid labour in the 1996 census, that data which is available suggests that in the 80's and 90's men (particularly husbands and lone fathers) spent more time in unpaid work activities such as housework, child and elder care than was the case earlier in the decade (Vanier Institute, 2000). The movement of women into the Canadian workforce has not, however, resulting in sweeping changes in family roles. For many families, women's paid employment is still viewed as secondary to their unpaid caring work, particularly when the woman's earnings are less than those of her spouse (Scott, 2000). The research that is available (see Hochsfield, 1989) would suggest that women's paid employment has lead to the expansion of women's roles (i.e. the second shift) rather than lead to a redefinition of gender roles for both men and women. As the Vanier Institute (2000, pg. 144) notes,

> "... men have a long way to go before they catch up with their wives who still do by far the greatest share of housekeeping, even when they are also working in the paid labour force."

More Canadian Employees Have Elderly Dependents

Canada's population is aging, influenced largely by the baby boom of the 1950's and early 1960's and the baby bust of the late 1960's and early 1970's (Foot, 1996). A continuing low rate of fertility has resulted in an age distribution characterized by an over representation of people in their prime working years, and a diminishing pool of young adults aged 15-24 (Statistics Canada, 1997a). It has been estimated that by 2001, 20% of Canadians will be over the age of 65 (Scott, 2000).

This aging of the population has a number of implications for Canada, not the least of which is the fact that a greater proportion of Canadian employees will be responsible for the care of an elderly dependent. The 1996 census found that 15% of Canadians provided some care to seniors (Scott, 2000) and the Vanier Institute (1997) noted that 66% of seniors over the age of 75 relied on family members for help with housework, cooking and personal care. The fact that Canadians are living longer suggests that many adults at increasingly older ages may need to provide dependent care for their own parents (Scott, 2000).

The Percent of Canadians Who Are Part of The Sandwich Generation Has Increased

It has been predicted that work-life conflict will become more problematic over the next decade as "baby boom" and "baby bust" generations assume responsibility for both dependent children and aging parents (Scott, 2000). Employees with these dual demands have become known as the "sandwich generation" and typically experience extraordinary challenges balancing work and family demands (Vanier, 1994). It has been estimated that one in four Canadian are in the sandwich group at this point in time (Duxbury and Higgins, 1998). Furthermore, research by the Canadian Council for Social Development suggests that the number of employees who are in the sandwich generation will increase over the course of the next decade. They base this prediction of the fact that Canadians are delaying family formation and childbirth. For example, the average age of first marriage for women was 26.3 in 1995, four years higher than was reported in 1961 (CCSD, 1996).

Smaller Families Mean Each Family Member Has Heavier Demands

Declining fertility rates mean that Canadian families are smaller today than they were thirty years. The average family size in 1995 was 3.01, down from 3.67 in 1971 (CCSD, 1996). These data taken to their logical conclusion suggest that smaller families will be required to support larger numbers of family members. These families members can be expected to report higher levels of work-life conflict.

Caring From a Distance Increases Work-Life Conflict

The challenges associated with caring for ones parents has also increased in complexity due to the fact that over the past couple of decades Canadians have become more mobile and many now live miles away from other family members and friends. In 1995 approximately 44% of Canadians lived 100 km. or more from their parents (General Social Survey, quoted in Scott, 2000).

Family Incomes Have Declined

Between 1991 and 1996 real disposable income per head declined by 0.7% per year (CLMPC, 1997). Average family income also declined during the first half of the 90's. In 1990 the average family income in Canada was $57,300 (in 1995 dollars). In 1995 this had dropped to $54,600, a decline of 5% (Rashid, 1998). It is interesting to note that the costs of raising children increased during this same time period (Scott, 2000).

Women's Incomes Are Now More Important to The Financial Security of the Household

Women's incomes are more important than ever to the financial security of Canadian households. In nearly half of all Canadian families, women's earnings make up 25% to 49% of the families' income. In one in four families, women's incomes contributed half or more of the family income (Vanier Institute, 1997). Without these earnings the low income rate among dual-income families would have more than tripled in 1996 (Statistics Canada, October, 1998).

2.2 Economic Forces

Concomitant to these social and demographic trends has been an unprecedented rate of environmental change for organizations. Betcherman et al. (1996) identified three environmental forces which drove the strategic response of Canadian organizations throughout the '90s. First was a competitive pressure resulting from a change both in the degree of competition (increasing domestically and internationally), and in the nature of competition (a shift from high-volume, standardized output to specialized "niche" products and services). Second was the rapid proliferation of computer-based technologies, and the upward pressure this growth placed on employee skills and training needs. Third was the increasing complexity of the regulatory framework governing HR issues, including more stringent standards related to human rights, harassment, gender-neutral workplaces, equity, employment insurance, and health and safety. Combined, these forces have forced Canadian businesses to rethink how they position themselves in the marketplace, how they do business, and how they manage their people.

The following dimensions of this issue are relevant to the issue of work-life balance and as such are covered in more detail below: downsizing and restructuring, growth in non-standard forms of work job insecurity, technological change, time in work, the polarization of work hours and corporate inertia.

Downsizing and Restructuring

At the outset of the 1990s the Canadian business climate was battered by a combination of factors that produced record high level of bankruptcies, declining employment and rising unemployment. Factors that had a negative effect on the economy included (among other things) high interest rates, a high exchange rate for the Canadian dollar vis-a-vis the U.S. dollar, the introduction of the Canada-U.S. Free Trade Agreement and the slowdown in the U.S. economy (Stone and Meltz, 1993).

These changes in the Canadian economy and the need to complete globally led many Canadian organizations (public, private and not-for profit) to down and right size aggressively throughout the late 80s and the 90s. During this same time period layoffs burgeoned and the

use of non standard forms of labour (i.e. contract and temporary workers, part-time employees) increased. Other companies (notably those in the high technology sector) engaged in "boom" and "bust" cycles (i.e. periods of growth alternating with periods of considerable restructuring and downsizing) as products and competition changed.

This downsizing and restructuring had a major impact on human resource practices (i.e. compensation, recruiting, retraining, benefits) with a concomitant decline in employee morale, job security and job satisfaction and increased levels of employee stress. As Scott (2000) notes:

> "organizational flexibility has been pursued at the expense of worker flexibility, resulting in heightened work-family conflict."

Research in the area would suggest that in the midst of downsizing and restructuring, an emphasis on work-life balance becomes vitally important for the "survivors."

High Unemployment

Until 1997, the 1990's were characterized by slow economic growth. The unemployment rate was high during most of the decade and only recently has it dropped to pre 1989 levels (Scott, 2000). Lowe (2000) notes that for most of the decade the unemployment rate hovered around 9%, approximately twice the level that economists used to consider full employment. The Vanier Institute (1997) reports that in 1994 alone, one in four Canadian families experienced a period of unemployment for at least one family member.

Growth in Non-Standard Forms of Work

Concomitant with the restructuring and downsizing that occurred in Canada in the '80s and '90s was a growth in the use of non-standard forms of work (Scott, 2000). More employees worked in part time, temporary or contract positions at the end of the millennium than in 1989 (CLMPC, 1997; Statistics Canada, 1998). The following data, taken from Statistics Canada's Labour Force Survey and Statistics Canada's Survey of Work Arrangements (quoted in Lowe and Schellenberg, 1999) illustrate this point:

- in 1997, 11% of Canadian employees were employed in temporary jobs. About half of these workers were in contract or term positions while approximately one third held casual jobs
- the number of people employed part-time rose from 12.5% of the workforce in 1976 to 19.0% in 1997,
- the percent of jobs lasting six months or less has increased significantly in recent years, and
- between 1976 and 1997, the share of part-time workers who took their job because they could not find a full-time position increased from 11% to 32%.

More recent work by Lowe (2000) points out that those in low paid and low skilled jobs are most likely to be affected by these trends and that many in this group are being excluded from the good jobs that are now being created by virtue of their education and skills.

What has this got to do with work-life conflict? A number of researchers express concern about the quality of many of these non-standard jobs (Scott, 2000; Lowe and Schellenberg, 1999). The fact that only 20% of employees in such positions are covered by employer sponsored pension, health or dental plans (versus 60% of those in full-time or permanent

positions) supports the perception that these jobs of are lower quality (Akyeampong, 1997). Employees who are engaged in low quality, inflexible work are more likely to experience high levels of work stress which "spills over" into their family domain. They are also more likely to express concerns with respect to job security.

Declines in Perceived Job Security

Lowe and Schellenberg (1999) contend that in Canada in the 1980s and 1990s there was a substantial decline in secure, life long career employment and perceived job security to the extent that in 1998 one in five Canadians said they were worried about losing their job. Job insecurity has relevance to work-life conflict in that for many employees, work-life balance takes second place to securing permanent full-time employment. In addition, employees who are worried about finding and keeping a job (i.e. those in low paid and low skilled jobs, those without the education and skills to compete in the "new economy", those whose family situation makes it difficult to relocate, those whose families are highly dependent on their incomes) may be more likely to accept non-supportive and abusive working conditions - conditions which can, in turn, increase work-life conflict and stress.

Technological Change

Technological advances have fundamentally changed the nature of work in Canada. They have altered when and where Canadians work, blurred the boundaries between work and non-work, increased the pace of work, and changed service delivery. Technological change in Canada is creating and destroying new jobs at an astonishing rate and can be linked to the issue of work-life balance in three ways. It has: (1) led to a decrease in job security and/or an increase in unemployment/ underemployment for those without the skills to compete in todays labour market (discussed above), (2) led to a blurring of the boundaries between work and life as it becomes increasingly easy to work any time and any where, and (3) contributed to increased workloads and greater job stress.

Many Canadians Are Spending More Time in Paid Employment

At a time when technology was supposed to be reducing the work week and freeing up leisure time a large segment of employees are instead working *longer* hours. Canadian labour force survey data indicate that between 1976 and 1995, the proportion of workers putting in a regular 35-40 hour week fell from 65% to 54% while the proportion usually working 41 hours or more climbed to 22% from 19% (Statistics Canada, 1997f). After adding overtime, travel, and work brought home to complete the majority of Canadians are now devoting 45 hours or more per week to paid employment. When time in employment and time in family work are totaled, many families with both parents working are devoting 120 hours or more per week to work and family activities - the equivalent of three 40 hour weeks (Vanier, 2000). Data on overtime work reflect a similar trend. In the first quarter of 1997, one fifth of the Canadian workforce— roughly 2 million employees— reported overtime hours. These employees spent, on average, 9 extra hours a week in overtime. Six out of ten of these employees received no pay for these extra hours (Statistics Canada, 1997f). Since time is a finite resource, it stands to reason that employees who devote more time to work have, by definition, fewer hours to spend in non-work roles and activities. As such, they can be expected to have greater difficulties balancing work and family.

There Has Been A Polarization in Hours of Paid Employment

While approximately one in five employees spend more time than they want in work, other data indicates that many employees do not spend as much time as they would like in paid employment. Both Lowe (2000), Scott (2000), and Donner (Atkinson Letter, 1999) observed that work distribution has became more polarized in Canada over the past decade with part-time employees working shorter hours and many full time employees working longer hours. Donner notes that people at both ends of the continuum are equally likely to be unhappy. One group is having difficulty getting by because they are excluded from paid work or forced into marginal situations of underemployment (as Scott (2000) notes, polarization of working hours means the polarization of incomes). At the other end of the continuum are those with unsupportable workloads who are forced to work long hours and are too busy. As Donner notes, both underwork and overwork are destructive conditions.

Corporate inertia

Research suggests that Canadian organizations have for some time been aware of the growing level of stress and work-family conflict among employees. A study conducted 10 years ago by the Conference Board of Canada indicated that 50% of surveyed employers believed that work-family conflict was generating stress for their workers, and a nearly equal proportion of respondents reported morale and recruitment problems (Paris, 1989). Research done by Duxbury and Higgins in 1991 and 1992 (Duxbury et al., 1991, Higgins et al., 1992) found that 40% of Canadian employees reported high role overload and one in three found that their work responsibilities interfered with their ability to meet family role demands. More recent research by the authors (Duxbury and Higgins, 1998; Duxbury and Higgins, 2001) found that the percent of employees with high work-life conflict had increased to approximately 50% in 1998 and 58% by 2001.

These data would suggest that while the rhetoric of management throughout the 1990s was one of "putting people first", "human capital" and "competitive advantage through people," management's practices throughout the past decade tended to move in the opposite direction (i.e. massive downsizing, restructuring, delayering, re-engineering, redeploying and reskilling of employees). As Lowe (2000, pg. 124) notes:

> "Despite several generations of management and organization theories that emphasize the importance of human resources, the idea that workers are the key to achieving all business goals remains a very hard sell."

Employers also "compacted" work - doing more with less and demanding more from the fewer employees that have "survived" these initiatives. Working longer and harder has become the norm for the 'survivors." As Arthur Donner (quoted in The Atkinson Letter, Oct. 1999) notes:

> "Companies are making poor trade-offs. They are burning out their workers. The current distribution of working hours is dysfunctional for families and individuals"

These experiences have left employees feeling devalued, distrustful, and cynical (Lowe, 2000). Recent data would suggest that Canadians are less willing than they used to be to trust either government or the private sector to take leadership with respect to issues such as work life balance, stress and meaningful work. Rather they see these institutions as being part of the problem rather than part of the solution (Lowe, 2000). Organizational inertia, therefore,

has exacerbated work life balance issues for many workers who have, for the most part, been left on their own to cope with the new realities of the workplace.

2.3 Government Forces:

The role of the government in Canadian's lives has also changed over the past decade While the work-life needs of Canadian families has increased throughout the 90s, the scope of government activity in this area has narrowed substantially during this same time period. Scott (2000) notes the following examples:

- Governments across Canada have tackled financial deficits throughout the 1990s. As a result, government spending on important supports for families have eroded.
- Funding for key community supports such as childcare and home care has not kept pace with the demands for these services. Increasingly, such services are being offered on a cost recovery basis.
- Spending on income support programs such as Employment Insurance (EI) and social assistance has also declined. This has, in turn, negatively impacted the financial security of many Canadian families
- Average transfer payments from federal to provincial governments have declined since 1994. To compensate for this decrease many governments have restricted program eligibility and benefit levels (Statistic Canada, June 1998).

Scott (2000) also notes that throughout the 1990s there was a significant rollback in two key leave programs in Canada (maternity and parental leave) with eligibility and program benefits being tightened year after year. These changes culminated in 1996 with the introduction of Employment Insurance (EI) which, among other things, increased the minimum number of hours needed to qualify for EI benefits (including maternity and parental leave provisions) from 300 to 700. As a result:

- the percentage of unemployed workers who are covered by EI has dropped precipitously, falling from 74% of the unemployed in 1989 to 36% by 1997 (CLC, 1998b), and
- maternity claims fell by 7.3% between 1996 and 1997 (CLC, 1998a).

The introduction of the Canada Health and Social Transfer (CHST) in 1996 (a block grant for federal contributions to provincial health, welfare and post-secondary education systems) is another example of a government action that has negatively affected work-life balance. Historically the federal government has provided funding to community services through cost sharing agreements and equalization payments to the provinces. While it is the responsibility of provincial governments to plan for, fund, establish standards for and regulate community services, federal funds have ensured a relatively consistent range of services in each province. When the federal government introduced the CHST they not only changed the form of the funding, they also reduced the cash proportion of the transfer. This, in turn, prompted rollbacks in service provision at the provincial level. Overall, these two actions (i.e. block grant and reduced funding), when taken in concert, have resulted in a tremendous variation in the availability and affordability of community supports and services: services which have traditionally made it easier for employees to balance work and family. While the federal government took steps in the 1999 budget to restore health funding to 1995 levels, no funding was allocated to programs for Canadians in need of family support (i.e. home care).

The erosion of government supports and the introduction of user fees throughout the 1990s has placed renewed time pressures and financial constraints on Canadian families and meant that, for the most part, families have had to fend for themselves when trying to adapt to the changes noted in Section 2 (Scott, 2000). Cutbacks in community services such as childcare have exacerbated the problems faced by working families (Scott, 2000). While the marketplace expanded to meet the void left by the withdrawal of public services, the evidence would suggest that market solutions are often not ideal when it comes to things like child care or elder care. Concerns with for-profit solutions to work-life problems include worries about the quality of care and the costs of these supports to the end user (costs which may make it difficult for all but the most financially advantaged households to take advantage of them) (Scott, 2000). Greater details with respect to the government's changing role with respect to dependent care are given below.

Dependent Care

People cannot come to work (or, if at work, focus on the tasks at hand) unless their dependents are properly cared for. The main stresses associated with dependent care include finding it (high quality care is hard to find) and paying for it (i.e. expenses associated with dependent care puts many families under financial strain). Work by Duxbury and Higgins (1998) found that the following dimensions of dependent care were particularly problematic for Canadians: cost of care and the need to provide emergency care (this was particularly problematic for those living in smaller rural communities that did not have the same supply of services as larger cities).

Lack of quality dependent care is the critical issue for many families (Scott, 2000). Good child care and elder care remain very difficult to find in Canada. The data indicate that while the demand for childcare services has increase substantially throughout the decade the supply has not kept pace, particularly for licensed spaces for infants and school aged children (Scott, 2000). The cost of available care is also an issue especially for families who do not quality for subsidies and cannot find or afford licenced care to cover their working hours (CCSD, 1998).

Furthermore, work by the Canadian Home Care Association (CHCA) (1998) indicates that the growing population of seniors also poses significant challenges for families. The CHCA found, for example, that many Canadians are worried that Canada's health care system and existing community supports are not enough to care for our population of seniors. They also determined that recent cutbacks in home care and the loss of many long term and acute care hospital beds have shifted the responsibility for care onto the family (Scott, 2000). While Canada has one of the highest rates of institutionalization of the elderly among industrialized countries, for every person with a severe disability who has been institutionalized, three remain outside (Beaujot, 1991). Long term care facilities are becoming overloaded and waiting lists for beds (particularly subsidized beds) in long term care facilities are the rule rather than the exception (Scott, 2000).

3.0 Quantifying the Challenge

To what extent is work-life balance an challenge for Canadians and Canadian employers? The answer to this questions can be inferred by looking at changes in work-life balance and employee mental health over time. The data presented in this section comes from research done by Duxbury and Higgins in 1991 and 2001. Documentation on the 1990-92 study are

readily available (i.e. see Duxbury, Higgins and Lee, 1991; Higgins, Duxbury and Lee, 1992) and will not be repeated here. Data collection for the 2000-01 study (funded by Health Canada) began in October 2000. Just over 25,000 responses representing over 100 public, private and not-for-profit sector geographically diverse organizations were available for analysis purposes at the time this paper was written. This paper focuses on the work-life, employee and organizational attitudes and outcomes that were measured in exactly the same way in the 1991 and 2001 surveys. The interested reader can find full details on the attitudes and outcomes being examined in this paper (including definitions and the name of the scale used to measure the construct) in Duxbury and Higgins, 2001.

Demographic information on the samples are shown in Appendix A. A comparison of the 1991 and 2001 samples indicates that, with two exceptions (% of respondents who have responsibility for elder care, job type), the samples are quite similar[3]. Approximately the same proportion of each sample are female, parents, managers and technical employees. The age data is also quite similar (though not directly comparable as different categories were used in 1991 than in 2001). The fact that a greater proportion of the 2001 sample had elder care responsibilities (half of the employees in the 2001 sample versus 6% in 1991) is consistent with Statistics Canada (2000) data showing that the proportion of the Canadian population over 65 has increased over the last decade: a trend that is predicted to continue. The higher percent of respondents working in professional positions and the concomitant decline in clerical/administrative employees is also consistent with the increase in the number of knowledge workers and changes in the gender composition of the Canadian workforce (i.e. more female professionals in 1999 than in 1987) (see Statistics Canada 2000).

Work-life conflict a problem for many Canadians

The 2001 work-life conflict data are presented in Figure 1. These data show that six out of ten of survey respondents report high levels of role overload (i.e. feel that they have too much to do in the amount of time available, feel rushed, feel that they do not have time for themselves, feel physically and emotionally exhausted). One in three report high levels of work interferes with family (i.e. demands of job make it difficult to spent time with family and friends, relax at home, be the kind of parent they would like to be, work schedule interferes with personal like) and one in ten report high levels of family interferes with work (i.e. family life interferes with responsibilities at work, ability to work overtime, keeps employee from spending the amount of time they would like on their job/career). These data are cause for concern as high levels of role overload have been found to be strongly associated with physical and mental health problems, increased absenteeism, and a higher incidence of work-related injuries and accidents (Duxbury and Higgins, 1998, 1999, Johnson et al., 1997). High WIF, on the other hand, has been found to be associated with decreases in morale and loyalty to the organization, higher intent to turnover, and poorer mental health (Duxbury and Higgins, 1998, 1999, 2001, Johnson et al., 1997).

It is also interesting to note that in the 2001 sample three times as many respondents report high work to family interference than high family interferes with work. This finding is consistent with other work in the area (Frone et al., 1992; Duxbury and Higgins, 1998, 1999; Leiter and Durup, 1996) and suggests that many Canadians are accommodating work

[3]While the actual statistics are not shown in this paper, all reported differences are significant at .0000

demands at the expense of time with their family - behaviour which is consistent with the "myth of separate worlds" paradigm presented earlier.

Figure 1: Work Family Conflict: 2001

Work-life conflict has increased over the decade

The data (see Figure Two) show that, despite all of the talk about work-life balance, all the new programs and policies touted in the popular press and organizational media releases, all the empirical evidence linking work-life conflict to the bottom line (i.e. Duxbury et al., 1999) and all the talk about the "new HR" and responding to the needs of the new workforce, the employees who filled out our survey in 2001 have significantly more role overload, interference from work to family (WIF) and interference from family to work (FIW) than their counterparts in 1991 (i.e. less work-life balance). Role overload has gone up the most, increasing from 47% with high role overload in 1991 to 59% with high role overload in the year 2001. Other data in the 2001 survey would suggest that much of this increase in role overload can be linked to office automation and portable technology (i.e. laptops, e-mail, cell phones) and organizational norms that still reward hours at work rather than output.

Figure 2: Comparison of Work-Family Outcomes: 1991 versus 2001

While employees in 2001 are still more likely to meet work demands at the expense of time with family (in both samples interference from WIF is substantially higher than interference from FIW), the extent to which an employees' family responsibilities interfere with their ability to work appears to be on the rise (5% high in 1991 sample versus 10% high in the 2001 sample). High WIF increased by 3 percentage points in the same time period. The number of respondents with medium interference from family to work also rose in the past decade. In 1991, 27% of our respondents reported moderate levels of family to work interference. This increased to 31% with moderate interference in 2001. During this same time period, the amount of time respondents with dependent care spent in family activities (i.e. childcare, homechores) decreased from approximately 16 hours per week to just under 11 hours per week. This would suggest that the increase in role overload observed in the data can be attributed to increased demands at work rather than increased time in family role activities.

Part of the increase in work-life conflict due to fact Canadian employees spending more time in paid employment

The data indicates that work demands have increased between 1991 and 2001. The typical respondent to the 2001 survey puts in 43 hours a week working at the office (versus 40.8 in 1991). Over half of those in the 2001 sample (52%) work at home outside of regular office hours or on their days off (versus 31% in 1991). These employees spent just over 4.0 hours per week on average performing supplemental work at home (SWAH) (verus 3.6 hours in 1991). In other words, the average respondent to the 2001 survey devoted approximately 45 hours per week to paid employment - a substantial increase from the 42 hours spent by those who responded to the 1991 survey. These data are consistent with the data on role overload and work to family interference presented earlier as well as the employment practices (i.e.

downsizing, restructuring) and trends discussed earlier. These data are particularly interesting in light of research indicating that fatigue, work related accidents and repetitive strain injuries are all related to long hours of work (Report of the Advisory Group on Working Time and the Distribution of Work, 1994).

During The Past Decade the Mental Health of Canadian Employees Has Declined

Overall, the 90's appears to have been a tough decade for Canadians. The percent of survey respondents with high levels of perceived stress and depressed mood has increased over the past decade (see Figure Three). In 1991, 48% of the respondents to our survey reported high levels of perceived stress while one in three reported high depressed mood. By 2001 the percent of the sample with high stress had increased to 55% while the percent with high depressed mood had grown to 38%. Given these findings and the strong link between mental health and life satisfaction reported in the literature it is not surprising to find that life satisfaction declined over the decade (42% of respondents with high life satisfaction in 1991 versus 40% in 2001).

Figure 3: Change in Key Mental Health Outcomes over Time: 1991 versus 2001

While Those Reporting High Job Stress Has Increased

The data (see Figure Four) would also suggest that management practices over the past decade (i.e. downsizing, re-engineering, focus on hours not output, pay freezes, restructuring) have had observable, negative consequences with respect to how Canadian employees perceive their job and their employer. High job stress has become more problematic over the past decade with twice as many respondents reporting high job stress in 2001 than in 1991 (just over one in four employees (27%) in the 2001 sample experiencing high job stress versus 13% in the 1991 survey).

Figure 4: Change in Key Organizational Attitudes and Outcomes over Time: 1991 versus 2001

Job Satisfaction and Organizational Commitment Have Also Declined

High job satisfaction and organizational commitment also appear to have been casualties of the past decade. Whereas almost two-thirds of respondents to the 1991 survey were highly satisfied with their jobs (62%) and committed to their organization (66%), fewer than half reported high satisfaction (45%) or high organizational commitment (49%) in 2001 (Figure Four). Such findings are cause for alarm given the projected labour shortages discussed earlier. They are not, however, surprising given the increased incidence of perceived stress, depressed mood and work-life conflict noted earlier.

3.2 Who is at risk with respect to high work-life conflict

The research literature would suggest that to fully appreciate how employees' ability to balance work and non-work demands have changed over the past decade it is necessary to recognize the fact that factors such as gender, job type, parental status and time in dependent

care may have a strong impact on their experiences (Bowen and Pittman, 1995). Consequently, we extended our analysis beyond a simple contrast of 1991 to 2001 data to comparisons which take into account the following demographic variables: (1) gender, (2) job type, (3) parental status, and (4) time in dependent care. While this list is by no means exhaustive it does focus on those factors which previous research has shown influence both the nature of an individuals' participation in work and family roles and/or shape the meaning individuals give to family and work and the identities they develop. An understanding of these modifiers is critical for policy makers and employers who need to be able to identify who is at risk. It should also allow for the development of solutions which are specific to the various groups.

Gender and Work-Life Balance

There is a large body of literature to attest to the fact that women experience higher levels of work-family conflict than do men. Why this is so is still the topic of some debate. Some suggest that women may be biologically "programmed" (through sex-based hormonal systems, for example) to respond differently to stressors (Jick and Mitz, 1985). This hypothesis is borne out by differences in symptomatology shown by women versus men (i.e. whereas women tend to respond to stress by exhibiting emotional symptoms, such as depression, mental illness, and general psychological discomfort, men tend respond by manifesting physiological disease, such as heart disease and cirrhosis).

Others argue that gender differences in the stress response are attributable to differences in socialization processes and role expectations that expose women to a higher level of stressors. In the home domain, women, irrespective of their involvement in paid work, have been found to be significantly more likely than men to bear primary responsibility for homechores and child care (Statistics Canada, 2000). In the workplace, women have been found to be disproportionately represented in occupations with "built-in strain" such as clerical work, which couples high work demands with little discretionary control (Statistics Canada, 2000). Although it is difficult to determine which of these mechanisms is most responsible for women's differential response to stress, there is little doubt that women are exposed to different (if not more) stressors than men at both work and at home.

Job Type and Work-Life Balance

There is a large body of research available supporting our contention that the type of job an individual holds may affect work-life balance (Quick et al., 1997 or O'Neil and Greenberger, 1994). Some of these studies suggest that managers and professionals are more able to achieve balance than their counterparts in non-professional positions. Those who espouse this view offer the following evidence to support their beliefs:

- Managers and professionals are more likely to occupy occupations which afford more flexibility and personal control over the timing of work. Increased flexibility and control have been linked to greater balance.
- Professionals typically hold jobs that offer greater extrinsic rewards (e.g., salary) which can offset some of the "costs" that demanding jobs entail (i.e. allow those with higher incomes to purchase goods and services to help them cope).
- Non-professional employees are more likely to work in high demand, low control jobs. Seminal work by Karasek (1979) indicates that employees in these types of positions typically report higher levels of stress and poorer physical and mental health.

Others note that job type may also act as a surrogate measure for other important demographic context variables such as education, income, commitment, and identification with the work role which are, in turn, linked to work-life conflict and stress. Managers and professionals have been reported to be more highly educated, to receive greater remuneration, to spend more time and energy in the work role, to have greater job mobility and to be more highly committed to and involved in their work than their counterparts in non-professional positions. Each of these factors has been linked to an increased ability to cope with work-family conflict and stress, and more positive work outcomes (i.e. higher commitment, higher job satisfaction).

Parental Status and Work-Life Balance

A large body of research links the parental responsibilities of working couples to the incidence of work-family conflict (Bowen and Pittman, 1995 for a good review of this literature). Non-parent couples can act relatively independently as they do not have the constraints of caring for children. The addition of the parent role complicates the couple's life situation, however, as it places greater demands on them at the same time as it adds constraints.

The Approach Used in this Paper to Examine Gender Differences in Work-life Conflict

This paper takes a fairly unique approach to the analysis of gender impacts on work-life conflict by examining gender differences within job type and parental status. Gender and job type (operationalized as manager/professional versus non-professional) are considered simultaneously (the data are shown in Figure 5) to accommodate for the fact that in Canada job type and gender are highly confounded (Statistics Canada, 2000) with Canadian women being "compressed" into many of the lower paying positions within organizations. For example, in 1999, 70% of all employed women (versus 29% of employment men) worked in occupations in which women have traditionally been concentrated: teaching, nursing. One in four women worked in clerical or administrative positions (Statistics Canada, 2000).

Gender and parental status are also considered simultaneously in this analysis (the data are shown in Figure 6 (to accommodate the literature which suggests that "motherhood" is different than "fatherhood".[4] Virtually all of the literature in the work-life arena notes that working mothers assume a disproportionate share of family responsibilities and that even in the new millennium society judges women's worth by their performance of family roles (i.e. mother, elder care giver, cook, homemaker) while men's merit is judge by their success as a "breadwinner." As Vanderkolk and Young (1991, pg. 45) note most eloquently:

> "Even as women's attitudes and needs have changed regarding the world of work, corporate America has by and large been stuck in the '50s with a TV image of "Harriet" keeping the home together while "Ozzie" goes off to the office or the plant. The fact of the matter is that "Harriet" has now taken on both roles"

[4]The following references present arguments or data illustrating the difference impacts of motherhood and fatherhood: Vanier Institute, 2000, Statistics Canada, 2000, Hochschild, 1989, O'Neil and Greenberg, 1995; Bowen and Pittman, 1995

A number of comparisons were undertaken in this analysis to increase our appreciation of the link between dependent care responsibilities and work-life. In particular we looked at the impact of being a parent, time spent in dependent care (includes time spent in both childcare and eldercare) and life cycle stage (i.e. no children, all children under 5, all children 5 to 12, all children over 12 still living at home). Such an analysis recognizes that Canadian men and women have different realities and that it may be these realities, rather than gender itself, that impact the attitudes and outcomes being examined in this analysis. This type of analysis should be invaluable to policy makers who need to know if the supports and interventions should be targeted to a particular group (i.e. women, mothers) or an environmental condition (i.e. low control jobs).

Figure 5a: Role Overload by Gender and Job Type
Figure 5b: WTF by Gender and Job Type
Figure 5c: FTW by Gender and Job Type
Figure 6a: Role Overload by Gender and Parental Status
Figure 6b: WTF by Gender and Parental Status
Figure 6c: FTW by Gender and Parental Status

What Does The Data Tell Us? Which Groups Are High Risk With Respect to Work-Life Conflict

The increase in role overload during the decade appears to be ubiquitous, increasing for both men and women respondents, professionals and non-professionals, parents and non-parents and those with dependent care and those without dependent care alike. In both 1991 and 2001 samples, professionals reported higher role overload than non-professionals, women reported higher role overload then men, parents reported greater role overload than non-parents and mothers reported higher role overload than fathers. In both time periods, women professionals reported the highest role overload and men non-professionals the lowest role overload. Professional mothers experienced the highest levels of role overload (by quite substantive margins) in both 1991 and 2001 samples. These data suggest that professional positions and motherhood are not compatible in that they both impose heavy demands on their incumbents.

Finally, it is interesting to note that role overload was not associated with the age of the children living at home. Rather it was positively associated with time in dependent care in both 1991 and 2001 samples. In other words, with respect to role overload, it appear to be not how many children you have or how old they are that matters but rather how much time you spend looking after them.

The group who high risk for work interferes with family appears to be somewhat different from the group who is high risk with respect to role overload. In both 1991 and 2001 samples, men (regardless of the type of job they held or parental status) were more susceptible to this type of work-life conflict than women. Fathers in both 1991 and 2001 samples reported higher work to family interference than men without children. It is also important to note that the proportion of men in our samples reporting high WTF interference has increased over time, suggesting that Canadian men still believe that their primary role within the family is that of breadwinner and that their first priority is to work rather than family. In others words, male gender role expectations do not appear to have really changed all that much over the past decade despite the increased number of in women in the workforce and disappearance of the traditional family.

Family to work interference appears to be a function of parental status and dependent care responsibilities rather than gender or job type. In both 1991 and 2001 samples, parents, mothers and employees who spent more time in dependent care were more likely to report medium and high family to work interference. This form of work-life conflict was also the only form of role conflict that varied with lifecycle stage with family to work interference increasing when one first becomes a parent, peaking when ones' children reaches their teens, and declining when the children are over 18 and no longer at home. While the pattern of association was the sample for both men and women in the 1991 and 2001 samples, mothers did report higher levels of family to interference than fathers at all stages of the lifecycle. These findings suggest that mothers place a different priority on the family role than fathers.

4.0 Why Should Organizations and Government Care About Work-Life Balance?

The 90's can definitely be described as a decade of change for Canada. Extrapolation of our findings to Canadians employed in medium and large organizations would suggest the following. Compared to ten years ago:

- Work-life conflict (particularly role overload) has increased indicating that a greater proportion of the workforce is having difficulties balancing the competing roles of employee, parent, spouse, and eldercare giver.
- Employees have become more stressed and physical and mental health levels have declined as has satisfaction with ones life.
- Jobs have become more stressful and less satisfying.
- Employees have become less committed and loyal to their organization.
- Employees are devoting a greater amount of their time to work at the office and are more likely to extend their work day by taking work home to complete in the evenings and on the weekend.

In many ways these findings, while depressing, are not surprising. The Canadian press have been preoccupied over the past several years with things such as the "Canadian time crunch" "going back to a simpler lifestyle" and "coping with stress". Anecdotally, we know that people are having more difficulties balancing. Empirically, researchers in disparate disciplines (i.e. business, psychology, sociology, economic, gerontology, nursing, social-work, legal human resource, and technology) are dealing with the issue of work-life balance and research in this area.

It is also important to note that high work-life conflict is not a recent phenomena as the conditions that contribute to work-life conflict have been apparent in Canada for the last several decades. Neither is it a problem that will "just go away" without some form of intervention. For the problem to go away we would need to return to the gendered division of labour that characterized Canadian society for generations. This is unlikely to happen since: (1) many Canadian women enjoy working for pay outside the home, (2) many Canadian families are economically dependent on a second income, and (3) with a looming labour shortage Canadian employers cannot afford to abandon half their workforce.

Unfortunately, however, organizational efforts to address the issue of work-life balance have been slow and sporadic at best. As Scott (2000) notes:

> "despite efforts to publicize the benefits of having work-life programs and policies, few employers see it as being in their financial self interest"

Many organizations and governments focus on the costs associated with making it easier for employees to balance work and family and ask "but can we afford to make these changes." This section of the paper takes a different tact and looks at the costs of not reducing work-life conflict from the perspective of key stakeholders (i.e. employees, organizations, and society. In other words, it focuses on the costs of NOT changing. It is hoped that the data presented in this section will familiarize business and government leaders with the business case for change in this area.

What does high work-life conflict "cost" employees?

Conflict between work and family demands has been found to be problematic for employees and their families. With respect to families, high levels of work-life conflict has been found to negatively affect the strength of families and marriages (i.e. work-life conflict positively associated with marital problems, impaired parenting, reduced family and life satisfaction) (Scott, 2000; Frone and Rice, 1987; Lamert, 1990, Barling, 1990, Mathews et al., 1996; Duxbury and Higgins , 1998, 1999, 2001). In fact, research shows that work is more likely to have a negative impact on families that the reverse (Scott, 2000, Duxbury and Higgins, 1998, 1999, 2001). In addition to the above, employees with families are more likely to miss career opportunities when they need to put their family responsibilities ahead of their work.

With respect to the impact of work-life conflict on employees, a number of researchers (i.e. Frone et al., 1996; Frone et al., 1997; Duxbury and Higgins, 1998, 1999, 2001) have found that high work-life conflict contributes directly and indirectly to poor physical and mental health. These studies have found work-life stress to be positively associated with a variety of negative outcomes including anxiety and depression, drug abuse, decreased work productivity, absenteeism and high turnover. It also appears to be an important causal factor in physical diseases such as high blood pressure, serum cholesterol, gastrointestinal disorders, cardiovascular disease, allergies and migraines (Schlussel et al., 1992).

Other research would suggest that while paid employment per se is not associated with negative child outcomes, the stresses related to balancing work and family (i.e. financial and time deficits) do affect children (Hochsfield, 1997; Scott, 2000). Finally, while there is not much research in the area, that which is available suggests that families today need assistance in balancing work and family demands to foster the best environments to raise healthy children (Scott, 2000).

Costs to Organizations

From the employer's perspective, the inability to balance work and family demands has been linked to reduced work performance, increased absenteeism, higher turnover, lower commitment and poorer morale (Duxbury and Higgins, 1998, 1999, 2001). Work-life conflict has also been linked to productivity decreases associated with lateness, unscheduled days off, emergency time off, excessive use of the telephone, missed meetings, and difficulty concentrating on the job (Vanderkolk and Young, 1991; Ganster and Schaubroek, 1999; Scott, 2000). A recent study by the authors of this report estimated the direct cost of absenteeism in Canadian firms due to an inability to balance work and life at just under $3 billion dollars per year (Duxbury, Higgins and Johnson, 2000). This same study determined that employees with high work family conflict missed an average of 13.2 days of work per year - a substantially higher number than the 5.9 days missed by employees with low work-life conflict. Other researchers (Bond et al., 1997) have also linked high work-life conflict to

greater absenteeism. Statistics Canada, for example estimated the costs of stress related absenteeism to Canadian business to be approximately $12 billion per year (cited in Duxbury et al., 1992).

Finally, an excellent report done by the UT-Houston Work-Life Taskforce (2001) looked at the flip side of this issue and identified both qualitative and quantitative benefits associated with helping work-life balance. Quantitative benefits cited in this report include employee time savings, increased output due to increased focus and motivation, increased employee retention, increased income, decreased expenses, decreased health care costs, lower levels of stress related illness, and reduced absenteeism. Qualitative benefits cited include improved employee morale and loyalty, enhanced employee recruitment and enhanced public and community relations. Actual estimates of the amount of money that can be saved due to each of these factors is outlined in detail in the report.

Costs to Canadian Society

From the perspective of governments, the current challenges facing Canada's health care system suggest that provincial and federal policy makers can also ill afford to overlook the significant links between work-life conflict and physical and mental health. Although the state of health of the population in Canada is unarguably among the best in the world, Canada is in a less enviable position with respect to health expenditures. Canada devotes between 9 and 10% of its GDP to health; compared to other OECD countries: only the U.S. spends a higher share of its GDP on health care than we do (National Forum on Health (1996). Cost-containment strategies have generated considerable concern and debate over the financing and delivery of health care services, to the point where many Canadians have come to view Canada's health care system as being in "perpetual crisis". Whereas it is critical that governments respond to the health care "crisis" by continuing to explore new ways of achieving efficiencies, it may be equally important to step back from the debate in order to investigate ways of reducing the demand for health care services in the first place. A recent study by Duxbury, Higgins and Johnson (2000) found that the extra trips to the doctor made by employees with high work-life stress cost at least $425 million annually. Our most recent research (Duxbury and Higgins, 2001) indicates that people with high work-life conflict have significantly more hospital visits, hospital stays, and medical tests. They also make significantly more use of medical practitioners (i.e. nurses, physiotherapists, psychologists) and spend more on prescription drugs. These data would suggest that reducing the level of work-life conflict among Canada's workforce may represent an important step toward improving the health of Canadians and reducing health care expenditures.

Other, less quantitative research, would suggest that Canadian society will benefit if employees are able to devote more time and energy to their roles of parent, neighbor and volunteer. This body of work notes that both families and communities will benefit if people have the time and energy to develop meaningful relationships with their neighbors and actively participate in the lives of their spouses and children. The Vanier Institute (2000, pg. 84) puts it most eloquently when they note that:

> "Each person in the labour force, when considered as a family member, is a vital strand in the web of relationships that sustain not just the economy but also our families, our communities and our nation."

Recruitment and retention

Interest in work-life balance has also been fueled by the concerns of employers as they seek strategies to attract and retain committed and productive employees. As demographers predicted in the late 1980s (Johnston and Packer, 1987), the new millennium has brought with it a shortage of educated and skilled labour as baby boomers retire and the number of Canadians entering the labour force shrinks. The average age of employees in Canada is higher than at any time in recent history and available forecasts suggest that the shrinking of the labour force entry pool will continue well into the new century (Statistics Canada, 1997a). The problem is further compounded by the fact that the education and skills of many seeking employment are often inadequate for the new types of jobs that are vacant (i.e. specialized skill requirements).

At this point in time the demand for labour now exceeds the supply in many areas (i.e. IT, teachers, nurses). Furthermore, the reduced supply of entry level workers will make finding, keeping and developing skilled employees a top priority in the years ahead. These trends, more than any other, has awakened employers to the business risks inherent in ignoring the needs of this new workforce; a need which includes balance and places a high priority on a meaningful life outside of work (Duxbury, Dyke and Lam, 2000). Recent research (i.e. Duxbury, Dyke and Lam, 2000; Conger, 1998) would suggest that many younger employees are attracted to an organization by its policies and practices supporting work-life balance. As such, employers are now more motivated than ever to explore options that give employees more flexibility and control and are adopting programs which are designed to help employees balance work and life (i.e. flextime) under the assumption that they will improve recruitment and retention (Lowe, 2000).

Recruiting a good workforce is only part of the puzzle. Organizations also have to ensure that workers stay and flourish. Companies with high turnover pay a significant price. It has been estimated, for example, that the costs of replacing professional employees can be up to five times the employees' annual salary (VanderKolk and Young, 1991). These costs do not include indirect costs associated with accumulated human knowledge, lost future potential, and poor morale in areas with high turnover. Employee retention helps the company contain the costs associated with identifying, recruiting, retaining and moving talent. Indirect costs associated with client dissatisfaction are also higher in companies with high turnover (Gionfriddo, and Dhingra, 1999). Provision of a supportive work environment which emphasizes balance has been shown to partially stem the flow of good employees out of an organization.

Changing attitudes around work

North America's baby boomers hold decidedly different values regarding the place of job or career in their lives than did workers in previous generations (Kamerman & Kahn, 1987; Galinsky et al., 1991; Vanderkolk & Young, 1991). Research indicates that today's workers value a greater balance in terms of gender roles, greater equality for women, an acceptance of diverse family structures, and are committed to flexibility, individualism and diversity (Kamerman & Kahn, 1987). The business practices that motivated the homogeneous, male breadwinning workforce of the past, therefore, may simply not work for today's employees (Galinsky et al., 1991). Growing evidence indicates that many "baby boomers" are willing to trade off the fast track for a life with a better balance between work and their personal interests and needs (Galinsky et al., 1991).

Researchers are also seeing a different set of attitudes in individuals just entering the workplace (the so called "nexus" group or "echo boomers"). As Conger (1998, pg. 21) notes:

> "In a nutshell, they distrust hierarchy. They prefer more informal arrangements. They prefer to judge on merit rather than on status. They are far less loyal to their companies. They are the first generation to be raised on a heavy diet of workplace participation and teamwork. They know computers inside and out. They like money but they also say they want balance in their lives."

Research also indicates that this group values a greater balance in terms of gender, an acceptance of diverse family structures, and are committed to flexibility, individualism and diversity (Conger, 1998).
Individuals who are now entering the workforce tend to be the children of parents who both held jobs. While these individuals benefitted from the extra family income being in a dual-income family entailed, many felt that they were deprived of their parents' company, a situation aggravated by the fact that a very high percent were the children of divorce (Conger, 1998). Many in this new generation of workers say that they do not want the sort of lives their parents led. Rather, they want to spend more time with and be more available to their families (Conger, 1998).

This increased desire and quest for a "real balance between work and private life" has major implications for today's workplace, especially with respect to recruiting and retaining this cohort. This generation can be expected to insist that organizations find more flexible ways to integrate time for family and private lives into demanding careers (Conger, 1998). The business practices that motivated the homogeneous, male breadwinning workforce of the past, therefore, may simply not work for this group of employees. Conger (1998) also suggests that this yearning for life balance may increase conflict for this new generation of workers as their value for interesting work, which is often accompanied by longer hours and greater demands, conflicts with their desire for happy marriages, meaningful family time and weekends they can call their own.

5.0 What can be done to reduce work-life conflict?

To this point in the paper we have suggested that work-life conflict has increased in the past decade while employee physical and mental health has deteriorated and attachment to the organization and satisfaction with ones' job has declined. We have also ascertained that high work life conflict has a negative impact on the organization's bottom line, impairs an employee's health (both physically and mentally), reduces participation in and enjoyment of family roles and increases health care costs. We also have a good idea of who is at risk of greater work-life conflict (those with greater family responsibilities, those who devote more time to work). Only one question remains to be answered - what can be done to reduce work-life conflict? The last two sections of the paper address this issue by examining what organizations and governments can do to help employees balance competing work and family demands.

5.1 What Can the Organization Do?

Recognition of the needs of the new workforce has prompted a number of Canadian organizations to investigate ways in which they might play a part in helping their employees obtain a better integration of their work and non-work lives. The types of support offered and the level of organizational commitment to work-lifestyle issues, however, varies widely across companies. The broadest definitions of supportive employer policies include the provision of traditional employee benefits, such as a decent living wage, health insurance, and the right to a paid vacation (Kingston, 1990; Vanderkolk & Young, 1991; Johnson et al., 1997). Although it is acknowledged that these traditional benefits are indeed necessary if employees are to meet their most basic needs, it is our contention that such benefits are not sufficient in terms of relieving the heavy burden on today's employee. This paper, therefore, will focus only on benefits that fall into one of four categories which represent a more common definition of the term "supportive" (Galinsky, 1991; Paris, 1989):

- work-lifestyle benefits and services;
- leave benefits;
- alternative work arrangements;
- supportive work environments

Following is a brief overview of each of these benefit categories. These summaries are by no means exhaustive, but are intended to familiarize the reader with the scope of initiatives that have been offered by employers. Descriptions of these initiatives have been pieced together from a number of sources. Readers interested in more information are referred to the original sources: Johnson et al, 1997, Friedman & Johnson, 1996; Galinsky et al., 1991; and Lord & King, 1991.

Work-lifestyle benefits and services

Work-lifestyle benefits and services include a wide variety of options, ranging from the more familiar employee assistance program (EAP) to direct supports for dependent care, such as on-site daycare or respite programs. Key work-life benefits include:

- Resource and referral services which provide employees with information on the availability of child or elder care services in the community and counsel employees as they make their choices. Services are either provided directly by the employer, or contracted with an outside agency who can provide information and resources.
- On-/Near-site child care are employer-sponsored centers located on or near the worksite. Centers can be owned and managed either by the employer or by a third party. Corporate involvement ranges from the provision of start-up money to complete coverage of operating costs for the center and subsidies for lower-income employees. Consortium child care centres are similar to on- or near-site centers, but are established and operated by a group of employers for their employees.
- Voucher systems allow the employer to pay part of the worker's child care cost at a program selected by the employee. Employees may be reimbursed, or the care provider may be paid directly.
- Emergency/sick child care provides care for children who are mildly ill or in instances where a regular child care arrangement has broken down. Sick child care may be offered in the employee's home or attached to an existing child care center.
- Respite care provides full or partial reimbursement of the costs associated with hiring a caregiver so that employees with responsibility for caring for a dependent adult family member can have a break.

- Employee assistance programs help employees deal with a variety of personal problems, such as substance abuse, marital difficulties, and mental health. EAPs often deal directly with work-lifestyle issues by including the resource and referral services listed above, or by aiding employees in dealing with the stress resulting from conflicting work and homelife demands.
- "Cafeteria" benefits plans are designed to let employees pick and choose among a variety of health and insurance benefits according to their needs. These plans provide an alternative to traditional health benefits programs which have tended to offer a uniform benefit selection, often leading to duplication and additional expense. "Cafeteria" or flexible benefit plans offer standard choices of medical, dental and disability coverage, but may also include vacation, sick and personal leave options, wellness and recreation options, parental care, retirement programs, financial planning, and legal assistance. The rationale behind the provision of flexible benefits is that employee needs change over the lifecycle and that allowing employees to customize their plans can contain benefits costs for everyone.

Leave benefits

In their broadest sense, leave policies provide employees with time off from work to attend to personal or family matters. Generally, this time off is triggered by a birth, adoption , or serious illness of a family member, but can also include time for study, or for personal/professional pursuits. Options range from a few hours or days off to attend a funeral to extended child "nurturing" leaves of several years' duration granted to parents who would like some time out of the workforce in order to raise their children. For the purposes of this discussion, the term "leave" will be used to refer to both short- and long-term leaves which are paid or unpaid and which allow employees time off beyond their statutory (parental, vacation, and sick leave) entitlements.

Personal days is a policy permitting paid time off for short periods of time (days, hours) to deal with personal matters. These options allow employees to take time off for matters other than their own illness and preserve their sick days for their own use.

Parental/family leave is an extended period of several months or years, beyond the employee's legislated entitlement, to allow time for parenting or the care of adult dependents. These leaves may be paid or unpaid, and normally guarantee either the same job or a comparable job upon return. Seniority may or may not be accrued.

Alternative work arrangements

Organizations who are interested in reducing work-life conflict should also consider the provision of flexible work arrangements for employees. Alternative work arrangements provide employees some measure of flexibility in either work time or work place to help them accommodate their personal needs. Schedule modifications range from schedules that can be varied on a day-to-day basis, to those which require employees to choose a schedule well in advance and adhere to the hours selected. Work place modifications include such options as work at home arrangements and satellite offices established at sites remote from the primary workplace aimed at reducing employee commute times. Following is a list of the most popular flexible work arrangements.

- Flextime arrangements permit flexible start and stop times so long as a standard number of hours is worked. Flextime schedules usually center around "core hours" of

required duty. For example, all employees may be required to be at work during the core hours of 10 am to 3 pm, but may have "flexbands" at the beginning and end of each day allowing them to vary their start and stop times.

- Part-time work allows employees to work a specified number of hours below the standard work week. In order to be considered a true "alternative" in terms of work-lifestyle balance, part-time work options must be *voluntary,* and employees who take advantage of the option must maintain their entitlement to full or prorated *benefit coverage.*
- Job share arrangements allow two workers to voluntarily share the responsibilities of one full-time job with salary prorated. Again, benefit coverage should be maintained (or at least prorated) if this is to be considered an employee-supportive option.
- Compressed work week (CWW) schedules condense the standard 40-hour work week into fewer than the standard 5 days. The most common formulas are four 10-hour days, three 12-hour days, or the 9-day fortnight.
- Telework, telecommuting, or flexplace allows employees to work at home or at another site during regularly scheduled hours on a regular basis.

In all cases, research shows that the criteria under which these flexible arrangements can be used should be transparent and there should be mutual accountability around their use (i.e. employees need to meet job demands but organizations should be flexible with respect to how work is arranged). With respect to work arrangements, employers should also let employees determine whether or not they wish to work overtime.

Supportive Work Environments

Organizations who wish to become best practice in the area of work-life balance should also focus on the development of a supportive work environment. What do we mean by this? First they need to get supportive policies in place (i.e. develop and implement policies around flexible work arrangements). Second, they need to recognize that these policies are necessary for balance but not sufficient. The organization also needs to make sure that employees are encouraged to use the polices and feel safe doing so (i.e. career not in jeopardy because take family leave). They also need to support their use by having senior management modeling the appropriate behaviour in this regard and increasing the number of supportive managers within the organization. Finally, they need to measure the use of the different policies, reward best practices in these areas and question managers in those areas where use is low. To make the work environment more supportive the organization also has to move away from a focus on hours to a focus on output. To do this they need to reward output not hours or face time and what is done, not where it is done. They also need to publically reward people who have successfully combined work and non-work domains not promote those who work long hours and expect others to do the same.

Our research in the area (Duxbury and Higgins, 1995, 1997, 1998, 1999, 2001) indicate that supportive management is key to the creation of supportive work environments. Empirically, we have determine that supportive managers display the following behaviours: good communicators who provide positive and constructive feedback, listen well, coach and mentor their subordinates, and focus on output not hours. In other words, supportive managers are good at the "people part of the job."

The question then becomes: How can organizations increase the number of supportive managers? Our previous research in this area would suggest that this can be done by giving managers the skills, tools, time and incentives to manage people. Managers can learn these

"soft skills" through appropriate training. Managers also need the appropriate tools to help them be supportive. Such tools could include appropriate policies and guidelines, mentors who are themselves supportive, and information on why support matters. In addition to the above, organizations need to recognize that managing people and being supportive takes time. Organizations who want to increase the number of supportive managers, therefore, need to give their managers enough time to manage the people part of their job. People management is not just an "add on" to the rest of their job. Rather, it is a key part of what they do. Finally, organizations who want supportive management need to measure and reward support. Managers do what they are rewarded for. If the organization perceives that supportive management is key to competitive advantage (our results would suggest that it is) they need to design measures to quantify support, and introduce accountability around the "people part of the job" (i.e. make people skills part of the hiring, promotion and management selection process, introduce balanced scorecard which includes 360 feedback to assess how good a job managers are doing of "people management"). In other words, people management should be treated just like financial management with goals, objectives, measurement and accountability.

Another factor that appears to be key to work life balance is perceived control. Research in this area has shown that employees who feel they have more control over their work and personal lives report more balance and less stress (i.e. Karasek, 1979). Our previous work in the area would link greater perceived control to many of the factors discussed previously in this work: supportive management, flexibility around when and where one works, supportive work environments, and socio-economic factors such as income and education. Other work factors linked to higher perceived control include autonomy, empowerment, the increased use of self-directed work teams and better communication (laterally, vertically) within the organization.

Prevalence of work-lifestyle initiatives in Canadian organizations

Although prevalence data are not available on the full range of work-lifestyle options described above, there are several recent surveys that can provide some indication of the current level of employer responsiveness to work-lifestyle issues in Canada. Data have been obtained through two routes: employer surveys, which sample *employers* across Canada and question them regarding their human resource practices in the work-lifestyle area (Paris, 1989); and employee surveys, which derive their information by sampling Canadian *workers* and asking to what extent they have access to supportive programs in their places of employment (Akyeampong, 1997; Duxbury et al., 1991; Higgins et al., 1992; Lero et al., 1993; Duxbury and Higgins, 2001).

Table 1 provides a comparative overview of 6 Canadian studies that have sought to estimate the availability of employee-supportive practices in Canadian workplaces (see Johnson et al for a more extended discussion of this research). The Paris (1989) study was conducted by the Conference Board of Canada, and represents the only Canadian employer survey. The remaining 5 studies reflect surveys of employees. Two employ nationally representative data collected in conjunction with the Canadian Labour Force Survey (Akyeampong, 1997; Lero et al., 1993). Three reflect independent academic studies involving samples drawn from the public sector (Duxbury et al., 1991) the private sector employees (Higgins et al., 1992), and public, private and not for profit sectors (Duxbury and Higgins, 2001). 2001 data on the availability and use of various work-life benefits are shown on Figure 7.

Table 1: Overview of availability of employee-supportive programs in Canada
Figure 7: Availability and Use of Work-Life Benefits, Duxbury and Higgins, 2001

While differences in samples and methodology preclude direct comparisons from study to study, this overview does allow us to make several observations regarding the level of employer responsiveness to work-lifestyle issues in Canada. First, it should be noted that the employer survey (Paris, 1989) suggests a much higher level of organizational involvement in work-lifestyle initiatives than do any of the employee surveys. The disparity in findings is likely attributable to two factors:

1. Samples of employers are typically not representative of the broader population due to the very low response rates associated with these studies (i.e. the Paris study yielded a response rate of 25%).
2. Executives tend to indicate that their organizations offer a given benefit if they offer it to *any* of their employees (i.e. a company representative may say that telework is available at his or her firm, when only one or two professionals have been granted this option)

Whereas employer surveys offer important insights into the organization's perspective on work-lifestyle issues, this type of response bias, combined with the low response rate typical of this type of study, means that employer surveys can grossly overestimate the availability of employee-supportive benefits.

Surveys in which *workers* are asked whether or not they have access to various initiatives, therefore, are probably the better indicators of the true prevalence of work-lifestyle initiatives. The 5 employee surveys presented in Table 1 reveal that:

- Access to employee-supportive work arrangements in Canadian workplaces is low
- Initiatives which involve work schedule flexibility are much more prevalent than those which involve work location flexibility.
- Schedules involving work hour reductions are more common among women (the Lero et al sample, which was restricted to those with primary responsibility for childcare was 95% female)
- Public sector employees appear to have greater access to flexible arrangements than do private sector workers (same trend apparent in 2001 data but not shown in this paper)
- Workplace child care centers are extremely uncommon in Canada.
- The availability of "family friendly" practices has not increased over time (it appears, in fact, to have diminished), and
- Employers appear to be more likely to offer employees unpaid time off to deal with family and personal problems than paid time off. This is consistent with the "myth of separate worlds" approach to management.

The above discussion leads us to make the following specific recommendations with respect to how organizations can address the issue of work-life balance:

1. Organizations need to devote more of their efforts to improving "people management" practices within their organization. They can increase the number of supportive managers within the organization by giving managers at all levels:

a. *the skills* they need to manage the "people" part of their job (i.e. communication skills, conflict resolution, time management, project planning, how to give and receive feedback),

b. *the tools* they need to manage people (i.e. appropriate policies, the business case for support, training on how to implement alternative work arrangements, web sites and other resources on how to handle different human resource problems, referral services to help employees deal with specific problems such as childcare and eldercare)

c. *the time* they need to manage this part of their job (people management has to be seen as a fundamental part of a managers role, not just an "add on" that can be done in ones spare time - an overworked manager finds it difficult if not possible to be a supportive manager)

d. *incentives* to focus on the "people part" of their jobs (i.e. measurement and accountability, 360 feedback, rewards focused on recognition of good people skills, performance of the "people" part of the job should be part of promotion decisions, hiring decisions, etc.)

2. Organizations need to provide employees with more flexibility around when and where they work. The criteria under which these flexible arrangements can be used should be mutually agreed upon and transparent. There should also be mutual accountability around their use (i.e. employees need to meet job demands but organizations should be flexible with respect to how work is arranged). The process for changing hours of work or the location of work should, wherever possible, be flexible.

3. Organizations need to create more supportive work environments. While the recommendations that precede this one will all act to make the work environment more supportive, we would recommend the following specific steps be taken by organizations who wish to focus their efforts on cultural change:

a. First, work with employees to identify the types of support they would like (i.e. diagnosis the situation) and which types could be accommodated within the organization. Not all supportive policies are feasible and practical in every content.

b. Second, develop and implement appropriate supportive policies. The development phase should include an analysis of the potential problems associated with the implementation of each policy and suggestions on how these problems could be addressed.

c. Third, communicate to employees the various policies that are available. Indicate how these policies can be accessed and any restrictions to their. Repeat these communications on a regular (i.e. every couple of months) basis. Publish these data on the company's intranet.

d. Fourth, encourage employees to use the polices by having senior management model appropriate behaviours, conducting information sessions on the policies and how they can be used (i.e. lunch and learns), communicating how these policies are being used successfully in this organizational and others (i.e.

communicate best practice), etc. Employees must be made to feel that their career will not be jeopardized if they take advantage of supportive policies.

e. Fifth, measure the use of the different supportive policies and reward those sections of the organization that demonstrate best practices in these areas. Investigate those areas where use is low.

4. Organizations should provide a limited number of days paid leave per year for childcare, eldercare or personal problems.
5. Organizations need to introduce initiatives to increase an employee's sense of control. The literature suggests a number of mechanisms which should be investigated including increased autonomy and empowerment at the individual employee level, the increased use of self-directed work teams, increased employee participation in decision making, increased communication and information sharing, time management training, training on how to plan and prioritize, etc.

5.2 Government Actions and Work-Life Balance

There has been, in Canada, a tendency to think that work-life conflict is exclusively an issue for families, employees and employers. Historically, however, employers have rarely taken the lead with respect to offering employee benefits (Scott, 2000). Rather, this role has been left to governments, both provincial and federal.

In 1987 the federal and provincial governments made a commitment to develop strategies to help Canadians integrate their work and family lives. Over the last decade the Ministers Responsible for the Status of Women have concluded an agreement on the economic equality of women (see Yukon Declaration on Economic Equality of Women, 1992) and have sponsored research into the area of work-life balance. The Federal Government outlines its own commitment to fostering changes in the workplace to promote the equitable sharing of work and family responsibilities in *Setting the Stage for the Next Century: The Federal Plan for Gender Equality* which was prepared for the Fourth Unity Nations World Conference on Women held in Bejing in 1995 (Status of Women, 1995).

In Canada, an extensive array of government services and supports have grown up over the years to directly foster the well being of Canadians and their families as well as help offset the demands of work and family (Scott, 2000). Key supports include provisions re economic security and family leave.

Economic security

Research has determined that the economically secure family is in a much stronger position to cope with the demands of work and family (Scott, 2000). The federal government plays a major role in providing economic security for Canadians and their families. On the one hand, it has a variety of macro-economic policy levels at its disposal to address economic insecurity, ranging from monetary policies to large scale job creation initiatives. On the other hand, it pursues specific policy and programs that directly influence the economic well being of families such as setting the wage floor through federal minimum wage laws, providing targeted income support through the tax system for low income Canadians, or by attempting to address high rates of women's poverty through such things as employment equity programs

(Scott, 2000). Scott (2000) notes that "these programs and policies are often unacknowledged planks in the government's response to work-life conflict."

Tax deductions

The other direct way in which the federal government has assisted Canadian families with the expense of work-family supports has been through the tax system (i.e. child care and medical care expense deductions, the new tax credit for individuals who care for elderly or infirm family members in their homes). Each of these programs (as well as similar provincial programs) provides important tax relief.

There is broad agreement that the government should build on these measures (Scott, 2000). For example, there is an ongoing debate about turning the child care expense deduction (which provides the greatest tax benefit to high income families) into a tax credit for all families who use child care services. The new tax credit for caregivers, introduced in the 1998 federal budget is an important first step but it should be broadened to include those who provide informal care to relatives who are not resident in their homes (Scott, 2000).

Family leave policies

Family leave policies are the most visible recognition of worker's family responsibilities and one of the most variable. Because of the unique division of powers across the country Canada has a patchwork of federal and provincial provisions for family leave. The federal government included maternity leave provisions in the Canada Labour Code in 1970 and by 1988 all provinces had enacted legislation to protect women's right to employment during and after pregnancy. Income replacement for maternity leave was introduced in 1971 as a special benefit under the unemployment insurance plan. In 1990 income replacement for parental leave was introduced. For the first time fathers and adoptive parents could claim caregiving benefits (Scott, 2000).

What Can governments do to support work-life balance?

How can the government support work-life balance? We offer the following suggestions.

1. Reform provincial and federal labour codes

Since labour codes establish the basic working conditions in most industries, reforming both provincial and federal labour codes has been identified as a key strategy that governments can use to reduce work-life conflict. Scott (2000) offers the following suggestions in this regard: mechanisms to reduce chronic overtime (i.e. providing the right to take time off in lieu of overtime or the right to refuse overtime), prorating benefits for part-time and temporary workers, introducing new forms of part-time work (i.e. long part-time), ensuring the portability of employee benefits between jobs, improving work security through severance, improving family leave rights. New labour code provisions could also cover new forms of paid employment such as homework, telework, and job sharing (Scott, 2000).

2. Improve and standardize the legislation and regulations governing family leave

While many collective agreements contain arrangements and benefits which address employees' needs with respect to work-life balance there is a need for consistency with respect to labour standards and legislative requirements pertaining to work-life balance. For example, at the present time, labour standards legislation in most Canadian jurisdictions [5] (exceptions include Manitoba, Ontario and Saskatchewan) does not provide employees with an explicit right to refuse overtime. Similarly, many jurisdictions do not allow employees the right to time off in lieu overtime. Such standards would provide a starting point for organizations in developing workplace policies and practices that address work-life balance issues. Standardization is needed in the following areas: the type of family related leaves, eligibility requirements, lengths of leaves and the guarantee of rights to return to paid employments. Standardization is especially important for the many workers who do not enjoy the protections afforded by federal labour law or collective agreements.

Securing broad access to leave policies goes hand in hand with improving leave policies more generally. By international standards, Canada's package of public leave provisions (i.e. length of leaves and benefit replacement levels) is not very generous when compared to European countries such as Germany, Denmark, France, Italy and Sweden (see Kamerman and Kahn, 1997, Gautier, 1996, Baker, 1995, Scott, 2000). What distinguishes countries which support work-life balance from those that are less progressive in this regard? Research in this area has found that countries with supportive family leave policies are more likely to recognize that:

- society has a role to play in caring for children,
- parents, when given the choice, would prefer to spend more time with their very young children, and
- a parent's income and future participation in the labour force should not be sacrificed because of their caring responsibilities.

In addition there is broader support for other types of family leave that allow family members to take on intensive caring roles (i.e. caring for a relative who is dying) without sacrificing their employment.

Given the above discussion we would recommend that governments who are concerned with work-life balance issues consider implementing legislation:

- which stipulates that an employer's management rights do not include an implied right to require an employee to work overtime except in the case of an emergency,
- that gives employees the right to time off in lieu of overtime pay,
- that stipulates that employee are entitled to unpaid leave each year to meet responsibilities related to the care, health or education of a child in the employee's care or the care or health of any other member of the employee's immediate family, and
- which includes specific language around long-term unpaid leave for the care of a parent.

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[5]The exact wording of this legislation and other legislation quoted in this section can be found in Rochon, C. (2000). Work and Family Provisions in Canadian Collective Agreements, HRDC Labour Program, Strategic Policy Division, Ottawa.

3. Co-ordinate government programs and initiatives

The government can provide assistance outside of legislation. There is also a high need to co-ordinate government programs and initiatives that address work-life conflict. At the macro level governments have tools at their disposal to address the root causes of economic insecurity that have fueled the drive for longer work hours throughout the 1990s (Scott, 2000). At the micro level, governments can also institute specific initiatives such as employment insurance (EI) job sharing programs where EI funds are used to offset the lost income of workers who agree to share the available work by working fewer hours than normal. They could also revise the legislated payroll taxes in order to reduce the cost of new hires and thereby eliminate a powerful incentive for employers to encourage overtime among existing employees. These types of measures could promote the redistribution of working time, foster greater economic security and reduce unemployment while at the same time offering individuals greater control over their working hours (Report of the Advisory Group on Working Time and the Distribution of Work, 1994; Scott, 2000). Accordingly, we would recommend that governments who are interested in reducing work-life conflict consider the following actions.

- develop and implement a national child care program which address the needs of children of all ages (i.e. affordable, quality day care, supervision for older children, before and after school care, extra-curricular programs),
- develop and implement a national elder care program, and
- make it easier for family members who wish to stay home to care for their children or elderly dependents (i.e. options in this regard could include tax credits).

In addition to the above, as one of the largest employers in the country, the federal government should, themselves, become a best practice/model employer in the area of work-life balance (i.e. introduce appropriate policies, enact forward thinking legislation, change accountability frameworks). Provincial governments should also take this tact. Such an approach will give governments the moral authority to ask for changes in this area from others.

Governments could also contribute to work-life balance initiatives by funding research in the area, disseminating relevant information to key stakeholders, and developing and offering appropriate educational programs (i.e. educate companies on the bottom line impact of imbalance; educate employees and families on how to cope).

Finally, it should be noted that policy makers will miss the needs of real families if they continue to base public policy on outmoded definitions of what a family is. Many policies are based on definitions of the 1950's male breadwinner family or on the idealized nuclear family of mother, father and dependent children. Changes in longevity, divorce, remarriage, and non-traditional family structures have changed what a "family" is: public policy should reflect this.

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Table 1: Overview of availability of employee-supportive programs in Canada (selected studies)

	Paris, 1989	Akyeampong, 1997	Lero et al., 1993	Duxbury et al., 1991	Higgins et al., 1992	Duxbury and Higgins, 2001
Work Arrangement	**% of respondents reporting benefit**					
Flextime	49	24	32	24	18	19
Part time	30	19	53	3	- -	7
Job share	19	1.5	24	- -	- -	1
CWW	28	- -	- -	17	1	14
Telework	11	9	- -	0.2	0.5	1
Daycare at workplace	5	- -	6	- -	- -	7
Source of data	Employer survey: 385 large (2000+ employees) Canadian public and private sector organizations	Labour force survey: nationally representative of Canadian employees aged 15 to 69	Labour force survey: nationally representative of Canadian employees with primary responsibility for child care **	Employee survey: 6,000 + employees working in 6 Canadian federal public sector departments	Employee survey: 17,000 + employees working in 37 Canadian private sector organizations	Employee survey: 25,000 + employees working in 107 Canadian public, private and not for profit organizations

Notes: 1. All studies cited are the most recent available in the Canadian context. Paris (1989) provides the only known survey of Canadian employers rather than employees. The discrepancy between the employee and employer data on availability would suggest that while the organization may offer the benefit, not all employees are entitled to or able to use it.

2. - - not available

3. ** 95% of those in this sample were female

Appendix A: Demographic Information on 1991 and 2001 Samples

Comparison of 1991 and 2001 Samples

Variable	1991	2001
Number in sample	21,228	24,022
% Female	56%	58%
Job Type:		
⇨ % Managers	11%	16%
⇨ % Professionals	22%	38%
⇨ % Technical	15%	16%
⇨ % Clerical/Administrative	34%	20%
% Parents	64%	68%
% With Eldercare	6%	54%
Family Income:		
⇨ % under $40,000	15%	10%
⇨ % $40,000 to $60,000	18%	18%
⇨ % $60,000 to $99,999	42%	46%
⇨ % 100,000 +	25%	26%
Age: 1991 / Age: 2001		
⇨ under 30 / ⇨ under 35	22%	24%
⇨30 to 39 / ⇨ 36 to 45	38%	36%
⇨40 to 49 / ⇨ 46 to 55	28%	31%
⇨ 50 + / ⇨ 55+	21%	10%

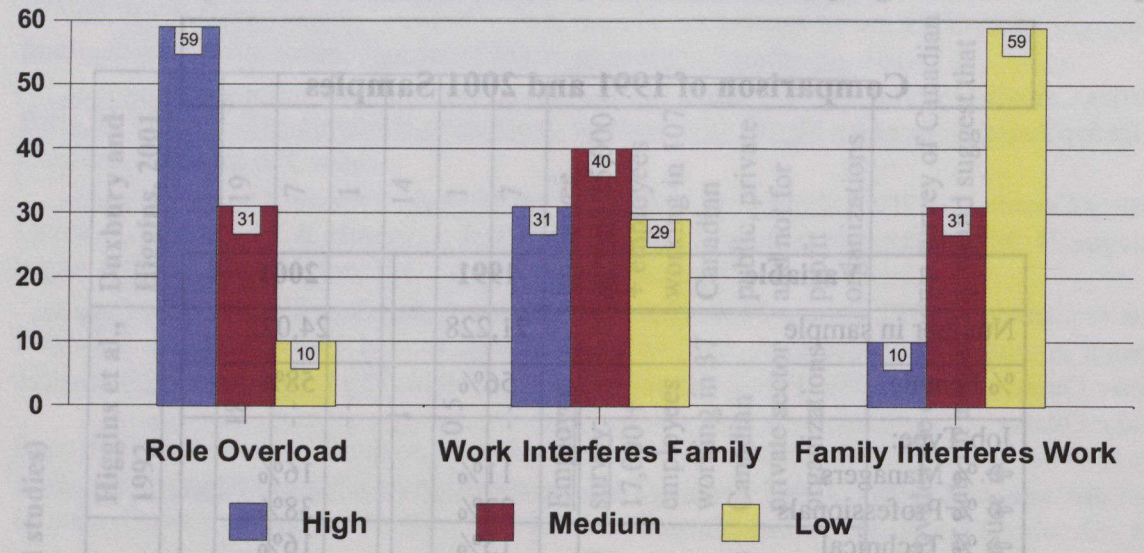

Figure 1: Work Family Conflict: 2001

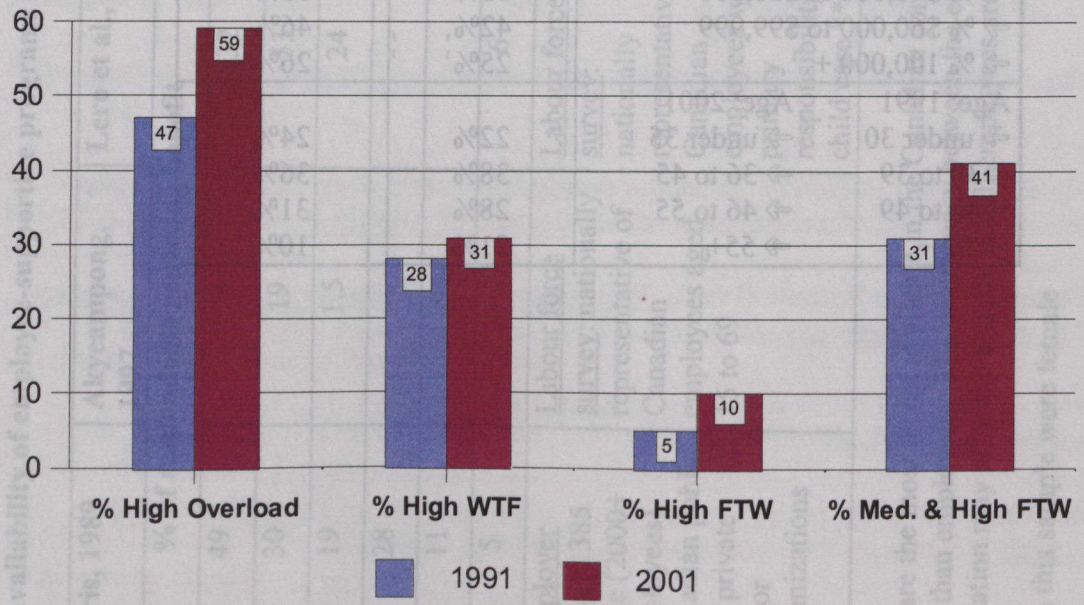

Figure 2: Comparison of Work-Family Outcomes: 1991 versus 2001

WTF = Work to Family Interference
FTW = Family to Work Interference

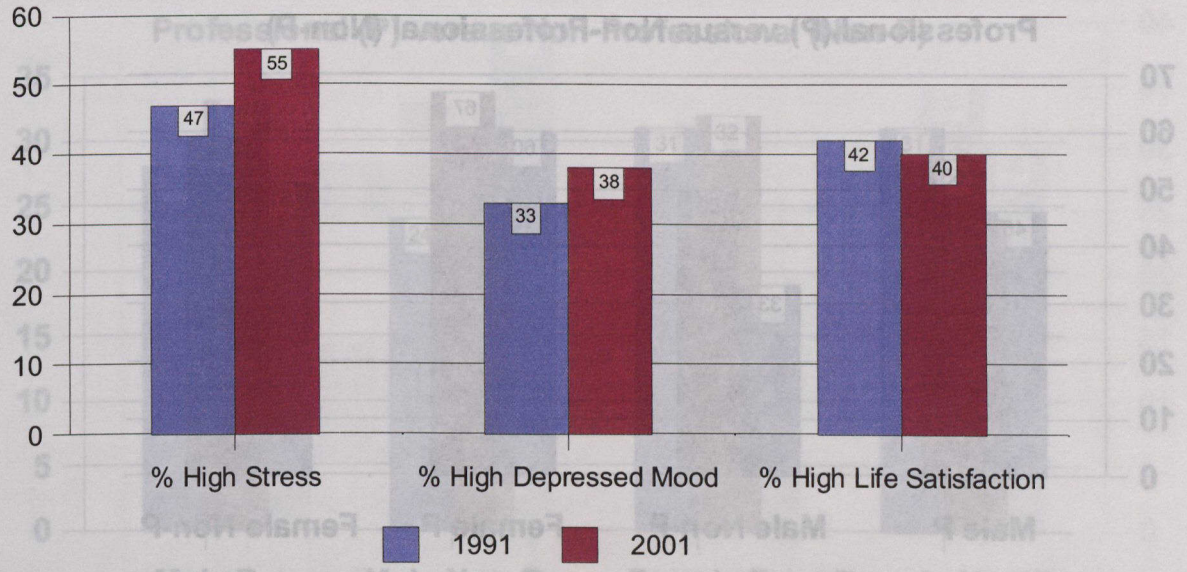

Figure 3: Change in Key Mental Health Outcomes over Time: 1991 versus 2001

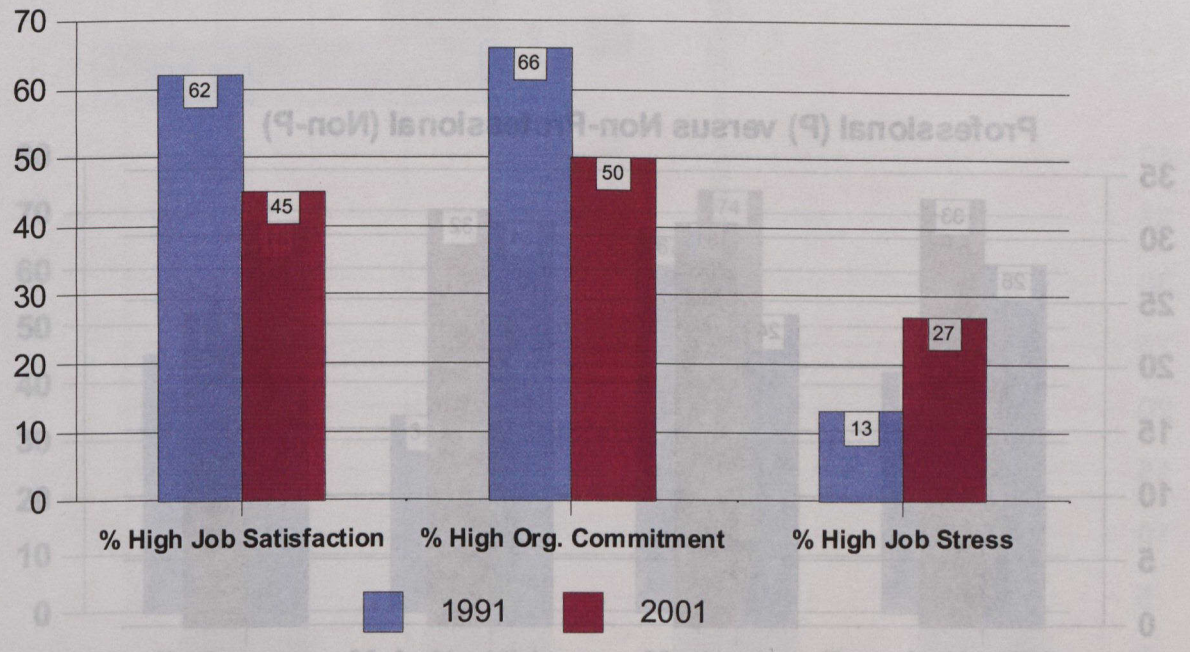

Figure 4: Change in Key Organizational Attitudes and Outcomes over Time: 1991 versus 2001

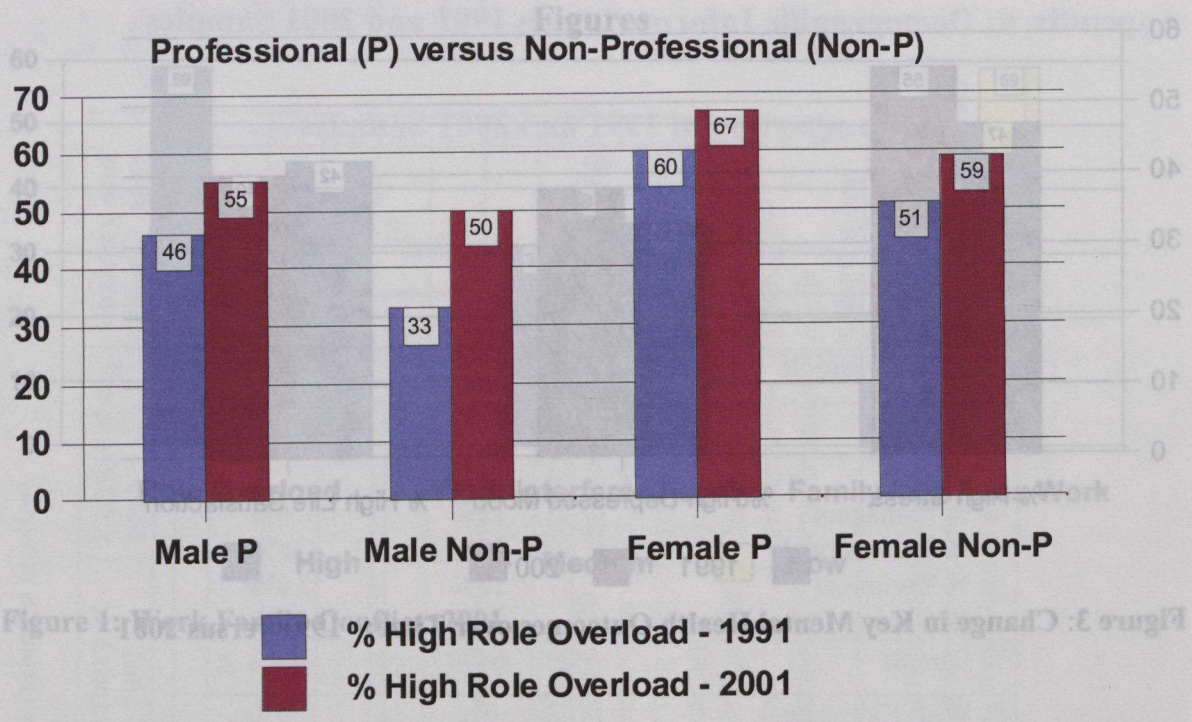

Figure 5a: Role Overload by Gender and Job Type

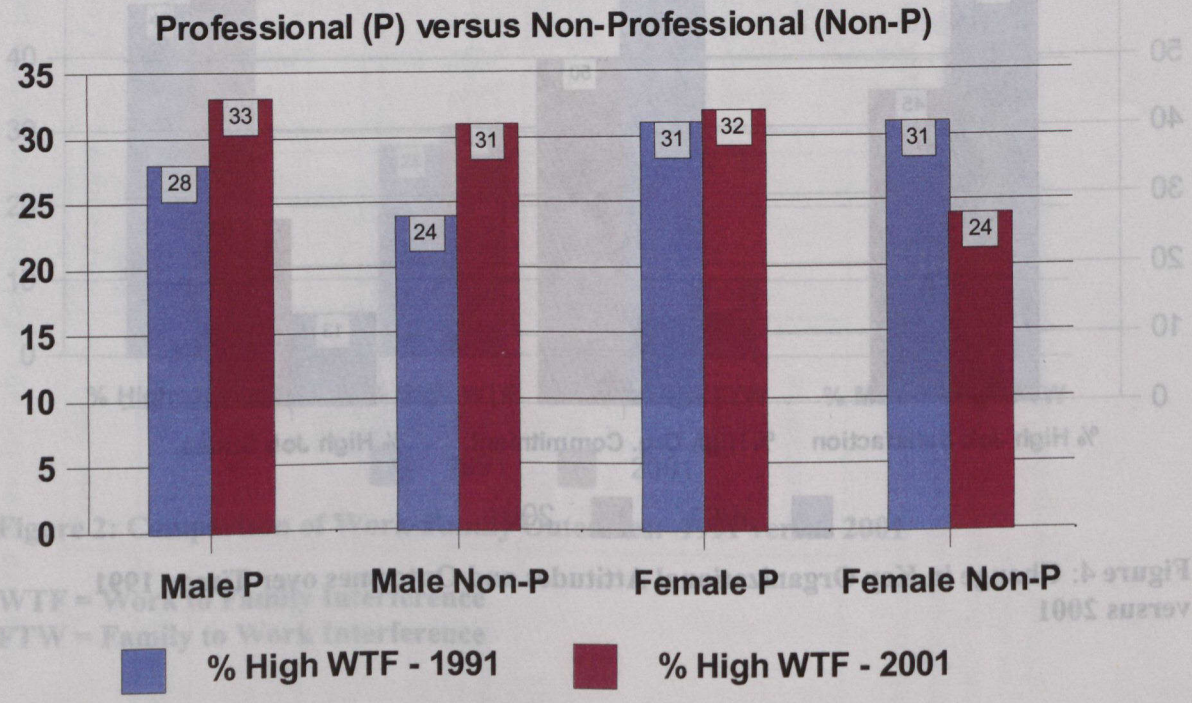

Figure 5b: WTF by Gender and Job Type

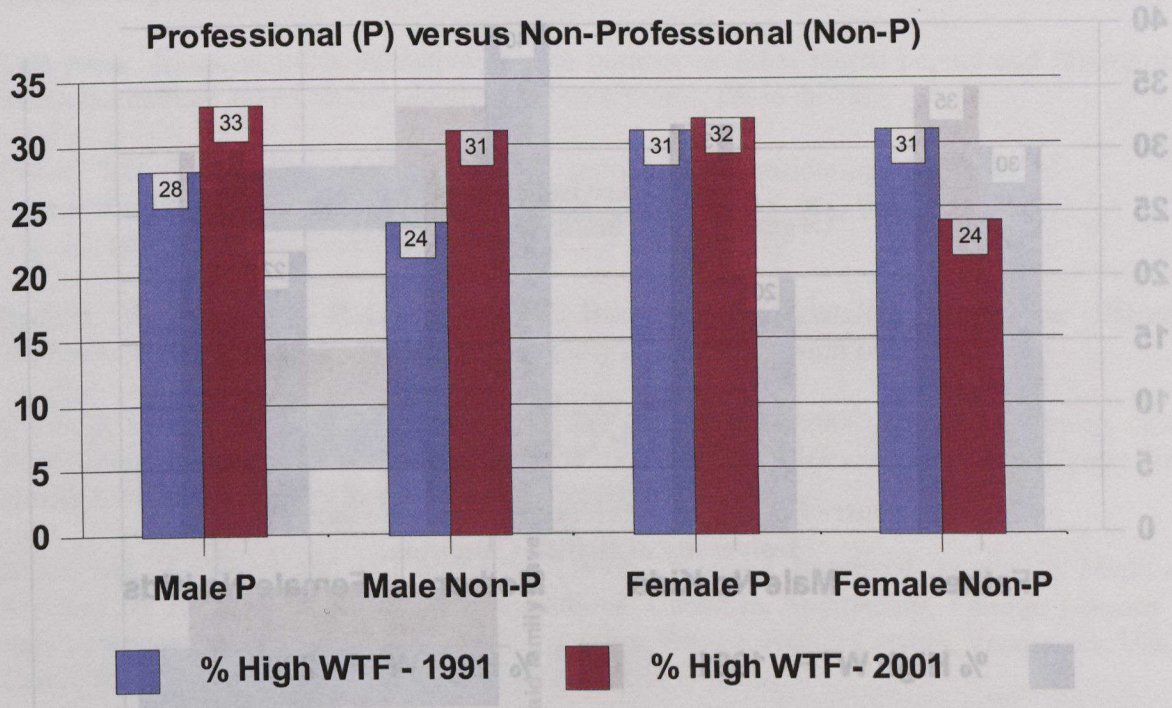

Figure 5c: FTW by Gender and Job Type

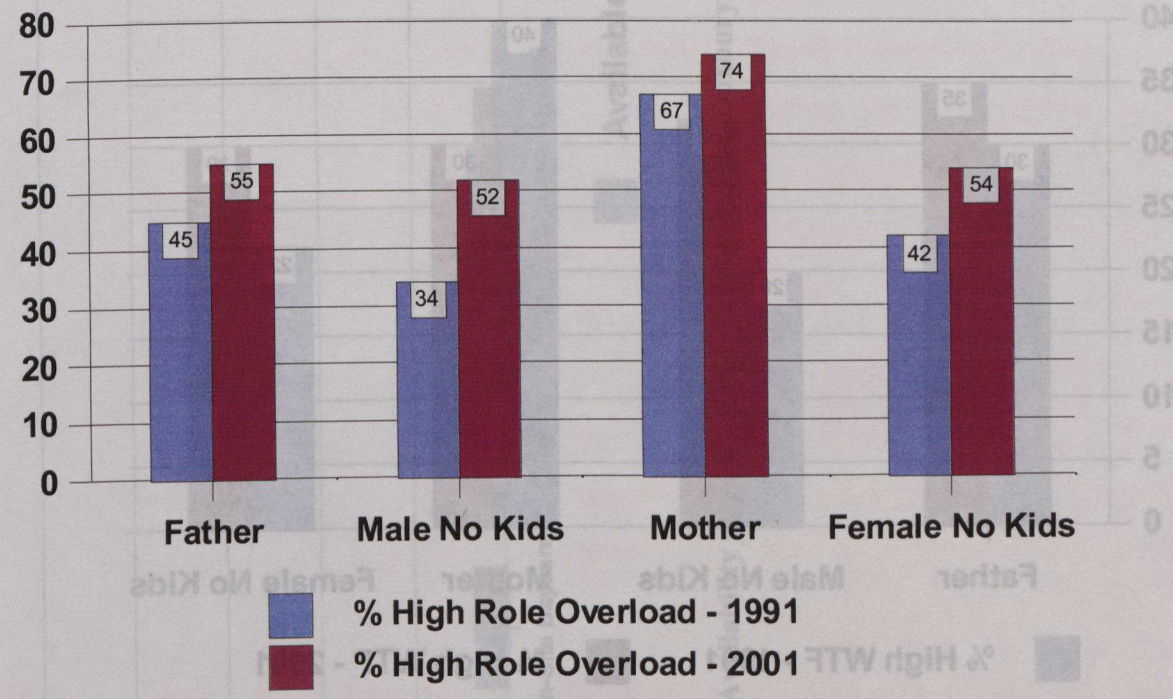

Figure 6a: Role Overload by Gender and Parental Status

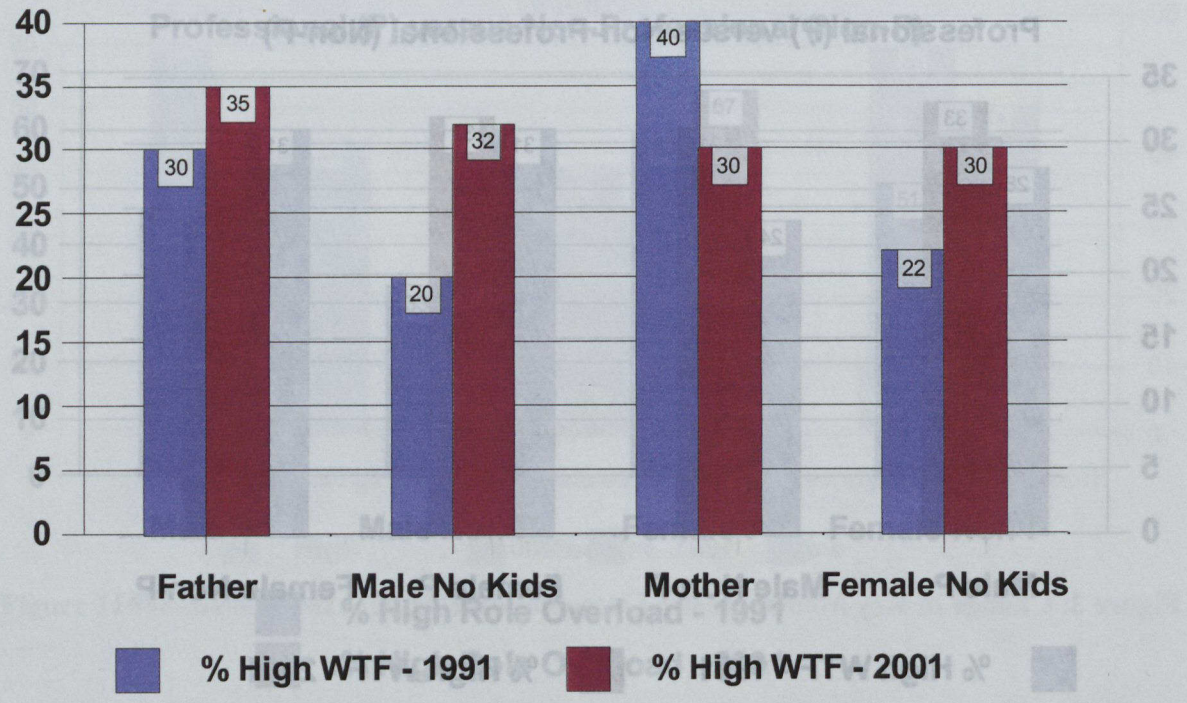

Figure 6b: WTF by Gender and Parental Status

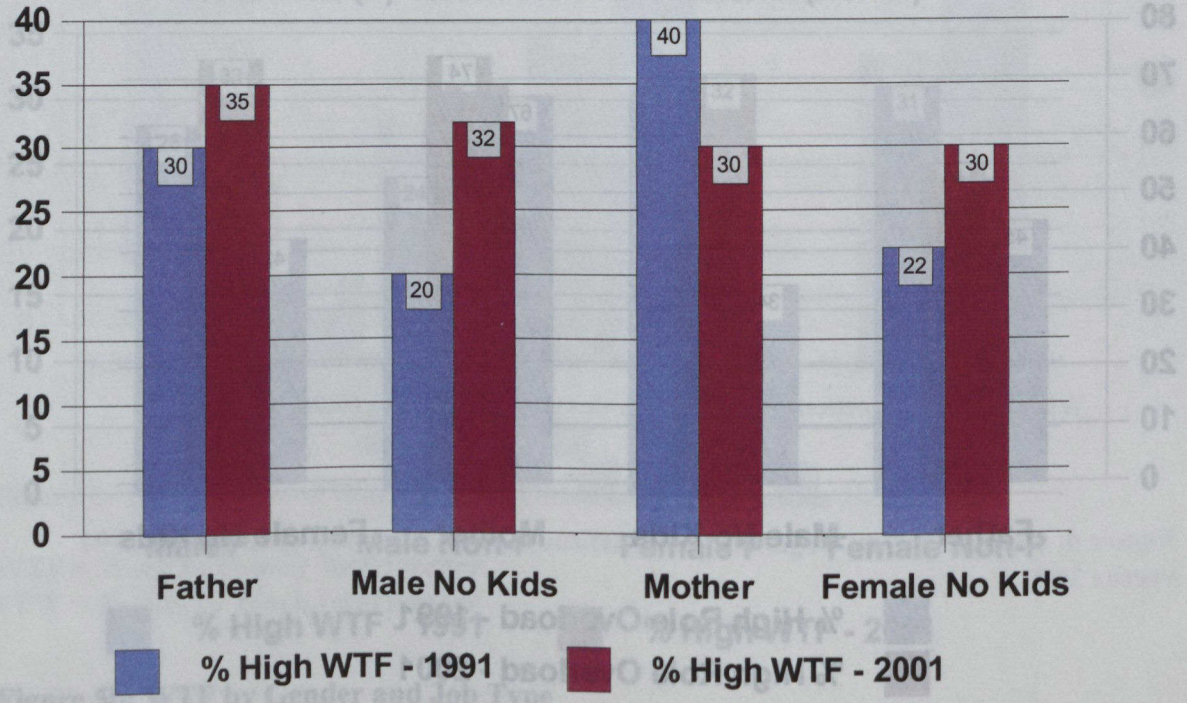

Figure 6c: FTW by Gender and Parental Status

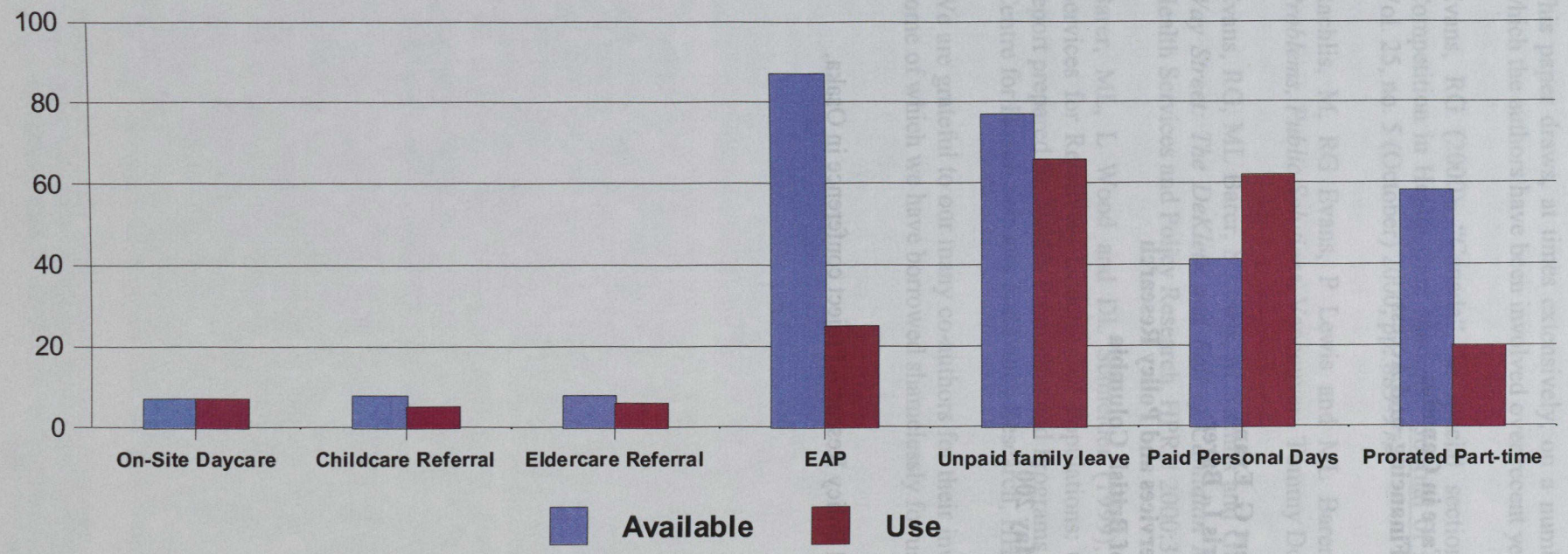

Figure 7: Availability and Use of Work-Life Benefits, Duxbury and Higgins, 2001

Health Care in Canada:
Organization, Financing, and Access

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Evans, RG (2000), "Canada", in special section: "Reconsidering the Role of Competition in Health Care Markets," Journal of Health Politics, Policy and Law Vol. 25, no. 5 (October) 2000, pp. 889-97.

Rachlis, M, RG Evans, P Lewis and ML Barer (2001), *Revitalizing Medicare: Shared Problems, Public Solutions*, Vancouver: Tommy Douglas Research Institute

Evans, RG, ML Barer, S Lewis, M Rachlis and GL Stoddart (2000), *Private Highway, One Way Street: The DeKlein and Fall of Canadian Medicare?*, Vancouver: UBC Centre for Health Services and Policy Research, HPRU 2000:3D

Barer, ML, L Wood and DL Schneider (1999), "Toward Improved Access to Medical Services for Relatively Underserved Populations: Canadian Approaches, Foreign Lessons", report prepared for Health Promotion and Programs Branch, Health Canada, Vancouver: UBC Centre for Health Services and Policy Research, HHRU 99:3

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The Canadian health care system took its modern form between 1968 and 1971, and its fundamental principles and basic structural features of organization and finance have remained the same since that time. The system has evolved over the past three decades, and has adapted more or less successfully both to significant changes in the external environment and to the changing needs and possibilities of health care services themselves. But it remains easily recognizable as the same system that was established more than thirty years ago.

Broadly speaking, health care in Canada is provided by private practitioners – physicians, dentists, pharmacists and members of a number of other, much less populated professions – and by not-for-profit hospitals, each overseen by a Board of Trustees. Most health professional groups in most provinces are regulated by independent professional Colleges, under authority delegated by provincial governments. Most practitioners are paid on a fee-for-service basis and are predominantly self-employed in their own private practices – solo or small group partnerships – though some are employed full- or part-time in practices owned by other professionals. Hospitals, by contrast, receive an annual global budget from the Ministry of Health of the province in which they are located. Institutional care outside hospitals is provided by facilities reimbursed on a *per diem* basis. Some are for-profit, owned by individuals or corporations; others are run by community groups.

The principal form of public insurance covers the services of physicians and acute and extended care hospitals. All Canadian residents are fully covered for all "medically necessary" hospital and medical care, without deductibles or co-insurance.[1] (Certain forms of elective cosmetic service are excluded.) Thus, a person who feels a need for care will seek out a physician of his choice, and if accepted as a patient, will be cared for without any financial implications. The services provided are paid for by the government of the person's province of residence, according to a uniform fee schedule negotiated between that government and the provincial medical association. (If a patient is cared for in another province, reimbursement will be at the fees in effect in the province of service.)

Diagnostic tests ordered by the physician are also paid for according to the negotiated fee schedule, as are referrals to specialists. Roughly half of all physicians in Canada are generalists or family practitioners, so the normal pattern of care-seeking is for the patient to go to the family doctor and, if necessary, be referred from there. Patients may self-refer to specialists, but this is discouraged. The specialist receives a larger fee for a formal referral; but, perhaps more fundamentally, the (deliberately) limited numbers of specialists permits them to concentrate on truly specialized work, rather than competing with generalists for patients. If hospitalization is indicated, the physician arranges to have the patient admitted. With a few exceptions, physicians are not employed by specific hospitals; rather, they have admitting privileges at one or more facilities.

Patients have "free choice" of general practitioner; they are not restricted to a particular source of care. If referral is indicated they can request referral to a particular specialist. (The physician also has a choice as to whether to accept the patient.) A patient wishing to be admitted to a particular hospital might select a physician on the basis of his admitting privileges. In practice, however, when the patient selects a general practitioner, he has also implicitly selected the set of specialists with whom that physician has ongoing referral relations, as well as the hospital where he or those to whom he refers have admitting privileges. In any case, financial considerations play no part because all hospitals, like all

[1] Extended care hospital patients pay a per diem charge that is based, not on actual cost, but on the prevailing rates of income assistance for the low-income elderly. The intent is to "claw back" this payment, less a "comfort allowance", so as not to subsidize basic living costs twice.

physicians, are included in the public insurance program. Thus the delivery of health care in Canada is predominantly "private" -- the public plans pay for care provided by private practitioners, and hospitals that are not government agencies, without restrictions on choice. The Canadian form of Medicare is not "socialized medicine", but rather "socialized insurance."

This universal public coverage applies, however, to less than half of total health care expenditures. Hospitals and physicians account, on current (year 2000) estimates, for 31.8% and 13.5%, respectively, of a total of $CAD 95.1 billion (9.3% of GDP) spent on health care. Another 36.7% was spent on drugs (principally prescription drugs), services of other professionals (principally dentistry), and institutional care outside hospitals.[2] Patterns of public coverage for these components are much less uniform – varying from one province to another – and less complete, ranging from about 70% for institutional care to slightly more than 40% for prescription drugs, to about 6% for dentistry and zero for non-prescription drugs. Overall, public sources covered 71% of total health spending in 2000, one of the lowest ratios among developed countries (CIHI, 2001; OECD, 2001). Canada thus provides more comprehensive public coverage than most countries for hospital and physician services, but less for other forms of health care.[3]

The Relationship Between the Federal and Provincial Governments

While the system described in this brief outline has not changed substantially since the early 1970s, the description masks some important changes in the relationship between the federal and provincial governments, particularly with respect to the fiscal transfers to the provinces that underpin the plan. The details of federal-provincial fiscal arrangements are arcane and highly specialized, and impinge little or not at all on either the individual patient or the individual provider in day-to-day practice. Over the long run, however, the survival or dissolution of the present system depends critically on decisions made at this level.

For fundamental constitutional reasons, as well as good practical ones, the governments of the Canadian provinces have virtually all responsibility for both regulating and funding health care within their borders. They can set up health care insurance programs any way they choose, or not at all. The federal government, however, sets the standards for "conforming" provincial programs, and provides both cash payments and access to part of the income-tax base for provinces operating such conforming plans. Effectively, then, the federal government can determine some of the fundamental principles governing provincial plans – so long as it also contributes to the plans' cost. Under current legislation, federal standards and corresponding contributions have applied only to the coverage of "medically necessary" hospital and physician services.

The principles of universal coverage, universal access "on equal terms and conditions," comprehensiveness of benefits, portability of benefits across provinces, and public administration are fundamental to all provincial programs. In particular, the access provision has been interpreted by the federal government as ruling out any form of direct charges to covered users of insured services. The federal *Canada Health Act* of 1984 provides that the federal cash grant to a provincial government will be reduced, dollar for dollar, by the amount of all such payments made by its residents.

Over time, both the nature of the federal contribution and its relative size have changed greatly. In the beginning the federal government shared a proportion (roughly half) of actual program costs; this was changed in 1977 to block grants independent of actual costs. But this grant consisted of both a cash payment, and the transfer of "tax room" -- the federal

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[2] The remainder is public health, research, capital investment, insurance administration, and "other".

[3] Private insurance covers just over one-third of the private expenditure, and Canada, like the United States, supports this private insurance with a public "tax expenditure subsidy" that offsets about a third of its cost.

government lowered its rates of income tax to permit the provinces to increase theirs by a corresponding amount. In the 1980s and early 1990s, the federal cash contribution was on a steady downward trend. If this cash contribution were to become so small that the federal government could no longer withhold significant amounts from non-conforming provinces, then it is a virtual certainty that the present system would immediately begin to crumble. In 1997, the federal government began increasing the cash contributions to the provinces; this trend continues today.

The health status of Canadians, at least as proxied by such measures as infant mortality rates and life expectancy, continues to improve, and is among the highest in the world. Life expectancy at birth for Canadian males born in 1997 was 75.8 years; for females, 81.4 years. These are up from 73.6 and 79.9 a decade earlier. Canada's infant mortality rate in 1997 was 5.5 deaths per thousand, down from 7.3 per 1000 in 1987. This was a new low for Canada, but still well behind the 3.7 rate for Japan (OECD, 2001). But these measures, though widely used, are incomplete measures of the health status of a population. Furthermore, the extent to which they reflect the impact or quality of a health care system, is questionable. The aggregate health status of populations has been shown to depend more on the quality of the physical, social and economic environments in which people live and work, than on health care system performance (e.g. Evans et al., 1994; *Daedalus*, 1994; Hertzman et al., 1996; Keating and Hertzman, 1999).

In any case, such statistics have little to do with aggregate health care spending, at least among industrialized nations. The Japan-Canada comparison makes the point: Japan spent about 7.6% of its GDP on health care in 1998 while Canada spent 9.5% of its larger (per capita) GDP.[4] The United States spent the world's largest share -- 13.6% -- of the world's largest per capita GDP. Yet this enormous expenditure was associated with significantly worse health outcomes: female and male life expectancies in 1997 of 79.4 and 73.6 years respectively, and an infant mortality rate of 7.2 deaths per 1000. Canadians were significantly healthier, and the Japanese, healthier still.

An alternative measure of system performance may be found in the satisfaction of those it serves, as reflected either in periodic surveys or in public commentary. From the inception of Canadian Medicare until the early 1990s, Canadians have generally expressed a high degree of satisfaction with their health care system, and strong support for its fundamental principles. A 1989/90 international Harris poll reported them to be more satisfied than the respondents from any of the other ten countries surveyed -- including Japan (Blendon et al., 1990).

Over the last decade, however, surveys have shown a sharp deterioration in satisfaction with the state of the Canadian health care system. Thus, while 56% of Canadian respondents to the 1989/90 survey indicated that "The system works pretty well"; only 20% of respondents gave this response to a similar question in a 1998 survey. The proportion of respondents who indicated that "The system needs complete rebuilding" rose over the same period from 5% to 23% (Blendon et al. 1990; Donelan et al. 1999). A recent Canadian survey suggests that Canadians are still highly supportive of the fundamental principles on which the system was built, but are expressing growing concern about its ability to deliver when they need it (Maclean's, 2000/01).

Yet despite this general and rather dramatic erosion in public confidence, Canadian patients continue to express high levels of satisfaction with their own personal encounters

[4] These data are based on OECD definitions of GDP. The difference between the 9.5% and the 9.3% reported in Canadian sources, arises from a slight difference in the GDP concepts used by the OECD on the one hand, and Statistics Canada on the other.

with the health care system – "the system is getting worse, but you wouldn't know it from my personal experience." For example, in the international survey quoted above 54% of Canadians said that the medical care they or their family received in the last 12 months was excellent or very good (Donelan et al., 1999). This raises some interesting questions about the sources of information that underpin public opinions about the state of the health care system more generally.

The 1989/90 survey, however, showed a strong relationship between real per capita health care spending and public satisfaction (with the notable exception of the U.S., where spending was highest and satisfaction lowest). One might then have anticipated that Canadians' high level of expressed satisfaction would be vulnerable to a decline in spending. And indeed this appears to have been exactly what happened.

Although its primary intent was to expand public access to health care, the Canadian Medicare system also turned out to be relatively successful as a device for controlling overall costs, at least in a North American context. Prior to 1970 the Canadian and American cost experiences tracked each other very closely. Beginning with the establishment of universal public coverage for physician services in Canada in 1971, the two countries' experiences have diverged sharply (see Figure 1). While in 1971 both countries were spending just over 7% of their national income on health care, a decade later a gap of almost 2% had opened up. This grew to over 3% by the early 1990s, and was as of 1999 creeping over 4% of GDP.

Comparisons of Canada's cost control experience with that of other countries provides a quite different perspective. Canada is among the high cost countries of the OECD. But considering the extensive similarities between Canada and the United States, and the latter's enormous influence on all aspects of Canadian life, the extraordinary divergence in cost performance is striking. Higher physician fees and system administrative costs, and more resource-intensive hospital treatment have been found to account for this difference (Evans et al., NEJM, 1989).

As a percent of GDP, Canadian health care expenditures topped out in 1992 (10%; CIHI), and then dropped sharply, hitting a trough in 1996 (9%; CIHI). All of this decline was in public sector spending, which actually **fell** between 1992 and 1996 while the population was growing at a rate of over 1% annually.[5] Little wonder, then, that patient satisfaction declined sharply over this period. Once the public, and the people who draw incomes from that system, become accustomed to a particular level of spending, responses to changes in that level will be highly asymmetric – additional funding will be embraced; cuts will be bitterly resisted. This resistance has been successful. Since 1997, substantial additional financing has flowed into the public system, and the percent of national income spent on health care is once again on the rise (Figure 2).

Of course these aggregate indicators of system performance are not only imperfect, they mask underlying differences in the experiences of individuals. While Canada has made considerable gains in health status as measured by life expectancy and infant mortality, substantial differences remain across different groups in the population. In particular, Canada shows a significant gradient in health status by income class, with virtually all measures showing health to be closely correlated with socioeconomic status (Mustard et al., 1997). A recent report on the health of Canadians, for example, noted that:

- A 1991 study showed that Canadian men in the highest income quartile had life expectancies 6+ years longer than those in the lowest;
- A 1993 study showed a strong inverse relationship between mortality between ages 65-70 and lifetime annual average earnings prior to retirement;

[5] Indeed, if the rate of change in private spending had been the same as that in public, the % of GDP spend on health care would have declined to about 8.5% by 1997.

- Potential life years lost before age 70 were almost twice as high for men as for women, and almost three times as high for men ages 20-34.
- Life expectancies for Canada's aboriginal population remain well below those for the entire population (Federal/Provincial/Territorial Advisory Committee on Population Health, 1999).

These gradients have persisted, however, despite the fact that there is no corresponding gradient in the use of health care services. Rather, people at the lower end of the income distribution use more services, not less (Mustard et al., 1998). And indeed, one of the key results of the establishment of the Canadian form of public health insurance was precisely to eliminate any income-based bias in access to, or use of, health care services (Enterline et al., 1973a, b). Recent studies have indicated that those in greatest need of services were, indeed, the highest users (Roos and Mustard, 1997; Finkelstein, 2001). Nevertheless, the health status deficits remain.

These striking relationships between socioeconomic status and health are occupying increasing amounts of attention from health services and population health researchers in Canada. However, they have not captured the imagination of the public, and correspondingly remain of little more than sporadic, and even then rhetorical, interest to politicians. In contrast, **geographical** disparities in access to care have been a source of public concern and political and policy interest at least since the establishment of Canadian Medicare. Despite any compelling evidence of corresponding geographic differences in health status, attempting to reduce or eliminate differences in geographic access remains a high profile policy preoccupation (and continues to defy easy solution).

The relationship between access, health status and health policy concern thus presents something of a paradox. On the one hand, differences in socioeconomic status are associated with very real differences in health status, but these do not correlate with differences in access and have not aroused much policy response. On the other hand, geographic differences in access, are not associated with differences in health status, but have been the source of policy concern over many years. Of course this observation may not be surprising if considered in light of responses to a mid-1990s survey conducted by Ekos Research Associates (Toronto) for the Canadian federal government. Canadians reported themselves far more concerned about "Equal access to health care for all Canadians" than about the "Health of Canadian population".

There is an additional distributional issue that has, however, received relatively little attention, either from analysts or in public debate, yet which appears to lurk in the shadows of many of the current key health care system issues. The distribution of system costs across the different members of Canadian society depends critically on decisions about financing mechanisms. The Canadian Medicare system as it exists today, being funded almost entirely out of general tax revenues, is financed purely on the basis of ability to pay, without reference to utilization or need. The system costs therefore bear proportionately most heavily on those with the highest incomes. Private financing (whether through private insurance or out-of-pocket payments), imposes costs independent of ability to pay. In the case of private insurance, premiums are based on expected risk status; direct charges are based on actual utilization. In Canada, over half of prescription drugs (out-of-hospital), and nearly all of dental care, are financed through such means (see above).

Accordingly, while Canada's Medicare is one of the most progressively financed systems in the world, it ranks relatively low among OECD countries in terms of the proportion of all health care costs that are financed publicly.[6] All proposals for changing the

[6] Progressive financing means that the proportion of income a person contributes increases with income; regressive means the reverse.

mix of financing sources necessarily include an implicit or explicit proposal to change this pattern of burden distribution.

Current Issues

As noted above, Medicare is facing a crisis in public confidence. While there is still broad public support for universal comprehensive medical care, Canadians are increasingly concerned that the cost of our current system is unsustainable and—at a more personal level—that care will not be available when they need it.

This drop in public confidence has occurred over the course of the 1990s. It is likely to bring about a major reshaping of the management and delivery of medical services in Canada. It could help redefine the current scope of services and programs, breathing new life into the original vision of a just and affordable health care system. Or it could bring about the end of Medicare, tying Canadians more and more tightly to what a former editor of the New England Journal of Medicine, Dr. Marcia Angel, has called the most expensive and inadequate health care system in the developed world: the American system (Angell, 1999)., BECAUSE I THINK IT MAY INTRODUCE A SERIES OF PRETTY CRITICAL ARTICLES ON THE US SYSTEM THAT STARTS WITH A PIECE IN THAT ISSUE BY IGLEHART. That is not what most Canadians want, but the possibility is increasingly real.

The original architects of Medicare were well aware that "socializing" the payment system was only the first step toward major change in the way in which health care is organized and delivered. In introducing the first provincial Medicare legislation, in Saskatchewan in 1961, the then premier, Tommy Douglas, described "remov[ing] the financial barrier between those who need health care and those who provide it" as only the first step. "The second step... will be to establish a new type of delivery system in the health field," a system that includes community-based care, preventive medicine that focuses on maintaining health and functioning, and alternative mechanisms for paying care providers (Douglas, 1984).

Forty years later that second step has yet to be taken. But the pressures in the current system are continuing to build; Medicare is facing very real challenges rooted in the organization and management of its delivery system. One way or another these must change. The National Forum on Health and numerous provincial reports have acknowledged both the need to reform this system and the ability for reform to be accomplished within the current public, non-profit model (National Forum on Health, 1997).

The crisis in public confidence, however, is being fuelled by quite different messages:

- We can no longer afford Medicare.
- The principles on which the system is based are no longer relevant.
- Moving more of the delivery of care to private, for-profit companies will lead to a more accessible and less costly system.

Each of these claims is demonstrably false. They serve to obfuscate rather than to illuminate, and tend to focus policy attention away from those very real organizational and management issues. Yet they have been made for the past thirty years with striking regularity, and for quite understandable reasons.

Something old

While Medicare has broad support among Canadians, that support is not and never has been universal. This, in large part, is because a number of individuals and organizations have an economic interest in Canada adopting an increasingly mixed public/private system more similar to that in the United States. While they argue that such changes will improve efficiency and accessibility, their opposition to Medicare is really based on economic self-interest and the inescapable logic of two fundamental accounting truths:

- Every dollar spent in health care, regardless of whether it buys more services or contributes to better health, is a dollar received - it is someone's income; and
- In all collectively funded health care systems (i.e., private group insurance, as well as publicly funded care), some people pay for more care than they use, and some people use more care than they pay for.

As political scientist Aaron Wildavsky pointed out a quarter-century ago, health care systems are not self-limiting; "...costs will increase to the level of available funds." (Wildavsky, 1977). This means that no matter how positive a society may feel about increasing funding for health care, eventually it will have to impose some form of cost control. This, inevitably, leads to conflicts over funding between those who pay for and manage resources, and those who get paid for providing care.

Medicare is, in part, a cost control mechanism. Since its introduction, more profit-oriented health care providers—including equipment suppliers, pharmaceutical companies, and financial and administrative service corporations, as well as a number of physicians—have attempted to circumvent its constraints by regaining direct access to the patient's own resources. For example, although overt extra-billing by physicians ended with the introduction of the Canada Health Act in the 1980s, some continued the fight to overcome limitations on their incomes, most recently by advocating for "improving" or "reforming" the health care system through support for private clinics and two-tier health care.

> Surely to heaven we are not going back after all these years... to a system in which the quality of care which patients receive depends on their financial capacity to pay. T.C. Douglas

Medicare's effect on expenditure trends is clearly shown in Figure 1 above. Had Medicare not been introduced, and if health care as a percentage of GDP in Canada had continued to track U.S. figures, there would now be about $40 billion more in the health care sector in Canada than we find today -- $40 billion in additional and /or higher incomes.

The second truth—participants in collectively funded health care systems do not pay according to the care they use—speaks most strongly to those groups for whom public coverage implies greater costs than benefits. Moving health care costs from public (taxes) to private budgets (user pay or private insurance) moves costs from the shoulders of the more wealthy to those of the less wealthy. As most care for the poor will continue to be paid for publicly, a greater portion of the public costs are shifted to middle-income earners. The fact that private payment is associated with a transfer of the financing burden from higher to lower income groups is clearly demonstrated by the experiences of the United States and countries of the European community (van Doorslaer et al., 1999; Wagstaff et al., 1999).

A natural consequence of these two truths is an alliance between the wealthy—who want lower taxes—and profit-oriented health care providers—who oppose limits on their incomes. Both of these groups gain, at the expense of the Canadian public, from any expansion in the scope of private payment. This alliance is not new; it was present before Medicare began. But it appears to be increasingly influential. Its members have every incentive to feed public uneasiness.

Something new

As noted earlier, the health care sector came under severe financial pressure during the mid-1990s. Between 1992 and 1997 total health care spending per capita, when adjusted for inflation, fell by 1.1 %. This absolute decline is unprecedented. Those areas primarily affected were hospitals, where per capita spending (adjusted for inflation) fell by over 16%, and per capita expenditure on physicians, which, when adjusted for inflation, fell by 6% (CIHI, 2001).

At the same time private sector spending - principally on drugs, dentistry, and the private part of institutional care - rose by 16.4%. This growth in real expenditures, combined with more rapid private sector price increases, pushed the private share of health care spending from just under 26% nationally in 1992 to more than 30% in 1997. This relative expansion in private sector expenditures has NOT come at the expense of, or in response to, public sector cost containment. These have been, and continue to be, largely non-overlapping sectors. The differential experiences do, however, demonstrate the relative effectiveness of the two sectors in cost control capability.

As noted earlier, since 1997 there has been a considerable reinvestment in the public sector. Overall public sector spending increased almost 23% between 1997 and 2000, and is now well above its 1992 level. But in 2000, per capita real (inflation-adjusted) expenditures on hospitals were still about 5% below 1992 levels (Canadian Institute for Health Information, 2000). The jobs eliminated by the mid-1990s cuts—many of them nursing jobs—have not all been restored. A strong case can be made that inpatient care had been over-provided in Canadian hospitals for decades and that a dramatic reduction in inpatient beds—a reduction taking place in most western health care systems—was long overdue. In fact, while the stresses of downsizing have been considerable, the number of patients cared for in Canadian hospitals has been maintained, even as beds closed.

The underlying realities of bed utilization have, however, had little influence on media reports, on the public's perception of the success of Medicare, or on hospital workers, whose reaction to the loss of jobs and income has been predictable. In an attempt to use public pressure to restore funding, unions representing hospital workers (and particularly the registered nurses) have claimed that the health care system is in a state of imminent collapse.

This message of crisis, continuously repeated by a group known to support Medicare, may inadvertently be supporting Medicare's traditional enemies, by convincing an increasing number of Canadians that the health care system either cannot adequately respond to their needs now, or certainly will not be able to do so when they need it in the future. There appears to be a real and serious problem of nursing supply but it arises from short-sighted personnel policies over at least the last decade. Some of these have been promulgated by professional nursing associations themselves. But these policies were not a consequence of the particulars of Canadian financing or organization. And, indeed, a shortage of nurses appears now to be a widespread international problem, which serves to reinforce the local message of crisis.

Something borrowed

In addition to old and new pressures within the Canadian health care system, there are important external developments that add to the seriousness of the present crisis. Primary among these has been the transformation in the United States of private insurers into managed care organizations that sell a combination of insurance, service delivery and management. These firms claim to achieve economies through superior management techniques, claims increasingly disputed even in the United States where managed care has fallen out of favour with the general public. Nevertheless, the rise of managed care organizations has greatly expanded the scale and scope of corporate, for-profit firms involved in organizing and delivering health care. These corporations, now firmly established in the United States, have moved into markets in Central and South America, and are attempting to penetrate Canada and Europe.

Like other care providers, managed care organizations depend on expenditures (public and private) for income. As with other profit-oriented providers constrained by public programs (e.g. Medicare), these corporations try to undermine or circumvent these programs.

To increase shareholder value in Canada, Medicare must be pushed out of the most profitable parts of the markets for insurance and care.

While the primary thrust of for-profit providers has been to try to open up private markets, they are quite prepared to accept large public subsidies in these markets. In fact, the sales of private health insurers in Canada such as Liberty Health (formerly Ontario Blue Cross) and Aetna are subsidized through tax concessions with an annual value of about $3-$4 billion. These arise because employer-paid insurance premiums are both deductible from the employer's taxable income as a business expense and non-taxable in the hands of employees. Absent this largely invisible public subsidy, the market for private insurance would probably shrink dramatically.

Managed care organizations are by no means the only external agents with an interest in altering or dismantling Medicare. Many groups, such as the right-wing National Institute for Policy Alternatives in Dallas, Texas, and the American pharmaceutical industry shell organization, Citizens for Better Medicare, are committed opponents of public insurance with allies in Canada (such as the Fraser Institute in Vancouver) and abroad. In March of 2000, CBM actually launched a multi-million dollar multi-media campaign in the United States "urging American seniors to reject the Canadian model of health insurance and coverage of prescription drugs." (This campaign glides smoothly over the fact that prescription drugs (out-of-hospital) in Canada are **not covered** under the universal Medicare programs – "the Canadian model of health insurance"). These American media campaigns flow freely across the long border between the two countries, and help to shape Canadians' perceptions of their own system.

Something blue

The last two decades have seen a remarkable increase in the degree of income inequality generated through private markets, particularly in the United States and Britain, but also in Canada. In Canada, the effects of this increasing concentration of wealth among the very wealthiest were largely offset, at least into the mid-1990s, by a relatively progressive tax system, supporting a number of social programs that transfer both money and non-money income to lower income families. As incomes and wealth have become ever more concentrated, the tax and transfer systems have redistributed more money from those at the top to those farther down.

One consequence of this tax/transfer system is that the potential payoff to Canadians in the top income brackets from lowering taxes and dismantling social programs such as Medicare has also increased. This places those programs at risk from a conservative tax cut/smaller government agenda. The resulting attacks on social programs are both direct– "they distort economic efficiency" –and indirect– "taxes crush economic prosperity." The indirect attacks have been particularly successful: It is hard, after all, to build a coalition to oppose lower taxes. Cuts to the social transfer programs in the mid-1990s were followed at the end of the decade by significant tax cuts (which continue), primarily favouring upper income groups. These more recent changes have eroded the overall progressivity of Canada's tax and transfer structure.

The increasing concentration of incomes over the past two decades has had a counterpart in Canada's media where ownership and control is now in the hands of a very few, very wealthy individuals. At least one of these individuals has made no secret of his intent to use the media as a platform for his own political views, including a deep distaste for public programs that "tak[e] money from people who have earned it and redistribut[e] it to people who haven't", thereby restricting the power of those with wealth to use it as they

choose. He believes, in short, that Canada should welcome a "friendly American takeover bid" which "Canadians.... might find irresistible" (Black, 2000).

This agenda, based on narrow economic interest, has powerfully reinforced the inherent tendency of the media to hyperbole and exaggeration. The result has been a steady flow of stories and opinion pieces predicting disaster unless various forms of private payment and for-profit health care are introduced immediately, or sooner.

These stories of impending doom now both cloud and shape public debate, making it virtually impossible for a member of the public to get a clear sense of what the problems facing Medicare really are, or of the plausible, evidence-based, supportable solutions that do exist. Instead of providing reasoned discussion, the media have, to a large extent, become a vehicle whereby a small minority of Canadians can undermine the confidence of an increasing proportion of middle-income earners, the very group who will suffer the greatest financial burden from the reduction or demise of Medicare.

Something Real

Beneath all the rhetoric and thinly concealed agendas bent on dismantling Canadian Medicare lurk some very real issues. The overriding challenge for the Canadian health care system is to find that elusive balance between providing timely access to an increasingly broad range of potentially effective services, and constraining the total share of national income being consumed by health care to an acceptable level. As demonstrated in the mid-1990s, the public programs have the necessary administrative mechanisms to contain and even roll back costs – at least for a time. But the public perception that access was severely compromised has led to the current general dissatisfaction and lack of confidence in the system. The resulting political pressure has forced a renewed expansion in spending at rates that Finance officials view as "unsustainable" – without as yet, any sign of a turn-around in public confidence. The clamour from providers, seeking to convert the new funds into increases in incomes rather than into better access has if anything grown louder and more disturbing.

The achievement of a balance depends, as it always has, both on "doing the right things" and "doing things right", i.e. making sure that the care provided is appropriate, effective and timely, and is produced in as efficient a manner as possible. But attempts to introduce innovations that would pare away inappropriate and unnecessary servicing, and improve the efficiency with which care is delivered, run head on into intense resistance from provider groups, because such innovations threaten their incomes, as well as established patterns of practice.[7] Their solution is always more servicing, with minimal external scrutiny of effectiveness or efficiency, supported by more money, whether public or private.

Perhaps the best illustration of this three-horned dilemma is provided in the pharmaceutical sector. The share of national income spent on drugs has been increasing steadily since the early 1980s. Even during the period of restraint in Canada (1992-1996), drug costs per capita increased by 16% (3.8% annually). Since then (down to 2000) they have increased at an annual average per capita rate of 8.5%, and the public component increased even faster (over 10% per capita per year) (CIHI, 2000)!![8] Such rates of increase feed the perception that "Medicare is fiscally unsustainable", even though rates of growth in the larger

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[7] This situation is in no way unique to Canada. "Health care may be the most entrenched, change-averse industry in the United States." (Christensen, et al., 2000)

[8] As noted above, the majority of drug expenditure is private, either insurance or self-pay. But each province does provide some coverage for some of the population. For example, every province ensures that its seniors have the majority of their prescription drug costs covered.

public programs (hospital and physician services) that provide full universal coverage, have been much lower.

This growth has occurred primarily through the introduction of new and expensive drugs replacing old, much less expensive, products, the latter often now off-patent. Yet there is considerable reason to doubt the superior effectiveness of many of these new products. The increase in pharmaceutical costs appears to represent, to a significant degree, "cost without benefit" – a rise in the price of achieving particular therapeutic outcomes. Attempts by both levels of government to constrain these de facto price increases have, over time, been systematically attacked and effectively destroyed by the pharmaceutical industry lobby. Through the 1970s and 1980s, Canada operated a system of compulsory licensure that created a genuinely competitive market for prescription drugs (Morgan, 2001). This is widely viewed as having had a significant dampening effect on drug prices in Canada. It was abandoned under pressure from the United States, and is now effectively barred by international trade agreements.

Canadian provincial Ministries of Health have introduced programs to encourage generic prescribing; British Columbia has been particularly aggressive in this respect. These, too, have been quite effective in containing pharmaceutical costs, but their effectiveness is being attenuated as the availability of generic substitutes dries up in the face of extended patent protection. B.C.'s response to this erosion was to introduce a program of "reference pricing" that required substitution across therapeutically equivalent chemical entities. While apparently quite effective, this program was of limited scope. Nevertheless it has been bitterly attacked by the pharmaceutical industry, and the right-wing Liberal government elected in 2001 has not yet made clear whether the program will survive.

The experiences in the pharmaceutical sector are of particular importance because they illustrate starkly the direct conflict between the public objective of effective health care efficiently provided, and the private objectives of sales and profit maximization. A number of innovative programs have been tried; if successful, they have been squashed by the political influence of the industry.

Similar tensions arise in the area of health care personnel. There is a widespread perception of current and looming future shortages of physician, nursing and some technical personnel. The policy solution offered by representatives of these professions has been to increase the incomes paid and to expand university training programs. Yet these seem to be certainly the most costly and probably not the most effective forms of response.

Physicians

According to extensive media reporting and a growing number of physician organizations, there is a dramatic and worsening shortage of doctors in Canada. The perennial problems in rural and remote areas are allegedly getting worse, and now even Canadians in some urban areas are encountering the same difficulties. Claims of a worldwide shortage of physicians create an increasingly menacing backdrop.

From the 1960s until the late 1980s, the supply of physicians in Canada increased at rates well in excess of the growth in the population. This was fuelled in the early years by rapid immigration and then later by a major expansion in medical school capacity. Medical costs expanded in line with the increased physician supply. For the last decade, the physician:population ratio in Canada has been relatively stable. This has been associated with increasing concerns about an impending physician shortage, and increasing agitation for expansion by the country's medical schools. Overlayed on this concern has been considerable publicity about Canadian physicians migrating in droves to the United States, lured by higher incomes and more and better equipment.

The reality is, in fact, much more complex. It would seem that a fixed training capacity combined with a growing population must, eventually, result in a decline in the physician:population ratio. Yet this ignores the effect of immigration. Extensive publicity is given to out-migration, but virtually none to in-migration. But in fact Canada is now a net gainer from the migration of physicians, and recent changes to federal immigration regulations are likely to increase the flow into the country substantially (Barer and Webber, 2000). Only a small proportion of Canadian doctors leave the country in any one year. The outflow actually peaked in 1978 when 873, or 3.5% of all Canadian doctors, departed and only 192 returned (net loss = 681 or 2.7% of all physicians). In 1999, only 585 doctors left Canada, while 343 Canadian doctors returned for a net loss of 242 or 0.4% of the physician workforce. In addition, in 1997 (the most recent data available), almost 850 non-Canadian physicians entered Canada either as landed immigrants with pre-arranged employment or on "temporary" employment visas—visas that often become permanent. Meanwhile the American market for medical services is becoming increasingly crowded.

Nevertheless, there are at least pockets of real access problems in the country. Rural and remote regions have had problems since the inception of Canadian Medicare (and well before), with attracting and retaining physicians. And patients in a number of urban areas are now reporting problems with finding a general practitioner, and long delays in accessing certain specialties. Of course, increasing medical school enrolment will not solve any of these problems in the short run, and is unlikely to solve some of them even over the longer term (Barer and Stoddart, 1999a,b). The geographical access problems persisted throughout the decades of rapid increase in physician supply that were fueled by new medical school capacity, and the problems of access in urban areas, now emerging, are at a time when overall physician supply in the country has never been higher -- one doctor to every 550 Canadians compared to one to 950 in the 1960s.

Underlying the apparent contradiction of more physicians than ever before and poorer access is the fact that, on average, each doctor is providing less comprehensive services. In general, fee schedules pay much more on a fee-for-time basis for procedural than for cerebral services. Put more crudely, the health care system pays more to cut and prod than listen and think and during the past 30 years, physicians have responded to that by gradually shifting their practices away from those services that take up relatively more of their time per dollar of reimbursement.

For example, in Ontario in the year 2000:

- gastroenterologists were paid 61% more for a complete endoscopic examination of the colon than for a full consultation, even though the consultation might take three times as long;
- an ophthalmologist received nearly ten times as much for a cataract extraction as for a consultation, even though the cataract procedure might take only 15 minutes; and
- an obstetrician/gynecologist was paid 26% less for a normal delivery than for a hysterectomy even though the delivery could take much more time and is fraught with much greater potential for a malpractice suit.

The financial rewards are even more skewed for physicians who are able to provide services privately (e.g., ophthalmologists providing laser vision correction, or dermatologists providing cosmetic surgery) and the expansion of these private markets draws an increasing proportion of the time of such specialists away from the public sector.

General and family practitioners do not have the same opportunities to increase their reimbursement per unit of time by substituting higher- for lower-paying services; the bulk of their income is derived from office visits. But they can (and increasingly do) achieve the same result by selecting for patients who will require only short visits. The result is increasing difficulties in access for elderly patients or those with complex problems. In urban

areas, and in some rural communities, ever fewer family doctors provide on-call services. Although many of these perverse incentives have existed in Canada for decades, there does appear to have been a recent accelerated 'flight toward quantity' (of dollars).

We see similar trends toward limiting practice among specialists. For example, obstetrician/gynecologists are dropping obstetrics. Some geriatricians spend much of their time with younger patients because their problems are less complicated. Until relatively recently, most physicians did everything within their discipline including providing on-call coverage. When doctors provided services that paid poorly (e.g., obstetrics) or not at all (e.g., taking a phone call from a worried patient, or phoning in a prescription refill to a local pharmacy) they knew that there was compensation from the other parts of their practices that paid very well. However, as doctors have gradually restricted their practices, the financial inequities within medicine have become magnified. One family practitioner doing everything by the book (e.g., hospital care, home visits, etc.) could work very hard 60-70 hours per week and have a net (after expenses, before taxes) income of less than $100,000. Another family practitioner working only 40 hours per week in a "revolving door" practice might have a net income of over $200,000.

In short, with supply of physicians in Canada sitting at an all-time high, it is difficult to believe that a shortage of physicians lies behind the current claims of overall shortage. There are undoubtedly some specialties and some regions facing shortages that can only be addressed with increases in local supply. However, the flexibility provided to physicians by the open-ended fee-for-service reimbursement system appears to lie behind many of the current access problems. The solutions must surely lie, at least in part, in making more effective use of the extensive physician resources currently available, rather than producing ever more physicians for an environment which encourages them to concentrate on a narrow range of profitable services and patients.

Nurses

Nursing personnel are generally perceived also to be in very short supply all across Canada, and indeed in a number of other countries. Access to hospital-based services appears compromised by staff shortages or work actions in a number of provinces as this is being written. Yet the use of hospital inpatient care has been dropping steadily; in the thirty years since the inception of Medicare acute patient days per capita are down by roughly two-thirds.[9] The patients now in hospital beds are accordingly now (on average) in significantly greater need of nursing care but the **total** workload is clearly much lower, making the apparent shortage all the more puzzling.

The field of nursing personnel is much less well mapped in Canada than that of physician supply, and it is hard to be sure of the sources of this particular "crisis". Its roots may lie, for example, in much broader social changes in the role of women in the workforce. A generation ago, nursing was one of the relatively few occupations for respectable young women prior to marriage; few made it a lifetime career. The workforce was young, fit, and low-paid. Today a much older nursing workforce is closer to the top of pay and benefits scales, including vacation and disability time, all tending to raise the wages per hour worked while lowering the average hours worked per nurse employed. At the same time the vast expansion in career opportunities for women has made recruitment much more competitive.

In addition, however, personnel policies within Canada have probably contributed significantly to the present problems. Most obviously, the continuing pressure by

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[9] This decline is a consequence of "innovations" in hospital-based practice, particularly shortening stays and much greater use of day care surgery and medical clinics. But these innovations date from the late 1960s and early 1970s; their widespread adoption had to wait for severe financial pressures (and perhaps a new generation of physicians).

professional nursing associations to require a baccalaureate degree for entry to practice has clearly made the training process much more expensive for students and educational institutions alike. On balance this would tend to reduce both the rate of applications and the number of training places available. (If non-BScN nurses return for further qualification, as some have, this further reduces the effective supply.) This policy has never been justified by evidence of benefit in terms of patient outcomes, but it has undoubtedly achieved other objectives related to professional prestige, influence and incomes.

Provincial governments have also failed to establish forward-looking personnel policies. Nurse hiring by hospitals has been "stop-and-go", driven by fluctuating provincial budgetary policies. The present shortage was preceded by a time when nurses could not find jobs. And post-secondary educational programs are the responsibility of Ministries other than Health, making difficult the co-ordination of training capacities and needs.

Whatever the failures of public and private policy, however, they do not appear to derive from the particular financing structure of Canada's Medicare system. The international nature of the problem carries the same message. Equally clear, if the shortage is national or international, then efforts by individual provinces to deal with their problems by raising wages will be ineffectual, serving only to drive up the general level of nursing wages (and absorb the new public money now flowing as increased incomes, not increased services). Equally certainly, this will be, and is, the response stridently advocated by nursing unions and other representatives.

The logical approach is two-fold, to increase the capacity of training programs for registered nurses outside the university setting, and to expand the use of licensed practical nurses (LPNs, less highly trained than registered nurses, RNs) in the hospital setting. The latter was recommended by a recent joint report of the Health Employers' Association of B.C. (representing hospitals) and the Hospital Employees' Union (representing LPNs) on ways of dealing with the shortage of nursing services. But both run directly counter to the objectives and lobbying activities of the professional nursing associations, whose objective is, as far as possible, to replace both LPNs and non-university RNs with at least university trained BScNs and in some cases with Master's degree personnel.

Of course, this tendency for more highly trained, higher priced personnel to replace those with fewer qualifications, regardless of the need for their extra capabilities, is not exclusive to nursing. It seems to be general across all health care systems. In medicine it shows up as the replacement of general/family practitioners by specialists – as in both the "capitalist" American and "socialist" Swedish health care systems, unless (as in Canada and the U.K.) very specific measures, both administrative and financial, are established to protect the generalists' "turf".

Similarly, despite decades of research demonstrating that many of the activities of physicians are well within the competence of suitably trained nurses, and widespread deployment in the United States, the nurse practitioner has made little or no headway in Canada (see below). Opponents are now arguing that it makes little sense to try to alleviate a physician shortage with nurse practitioners when nurses themselves are in even shorter supply. But this neglects the fact that the nurse practitioner in primary care is a very different career from that of hospital nursing, and may attract people who would not have been recruited to more traditional nursing roles. This seems to be what has happened in the United States.

Other Personnel

Shortages of nurses and physicians, apparent or real, dominate the headlines. But similar problems of access associated with inappropriate use of personnel emerge in other occupations as well. Therapeutic radiology has been a continuing hot spot in Canada, with

long waits for treatment and diversion of patients to American centres for urgent treatment. The public are told of a shortage of technicians, but note that at least in some jurisdictions in Canada, equipment is operated by two technicians simultaneously, each performing the same functions, so as to avoid error. But in the U.S., one technician does the work – and there is simply no evidence, one way or another, as to whether the U.S. approach is dangerous, or the Canadian simply wasteful (H. Walker, personal communication, March 2001). Treatment protocols vary from oncologist to oncologist, some using far more machine time than others, for the same problem. Again there is no evidence of differential outcome, suggesting the potential for significant improvements in throughput. But choice of protocol is a professional prerogative, and does not have to be justified by evidence. And management, probably wisely, chooses to bewail the inadequacy of public funding rather than to challenge the prerogatives of physicians – or the policies of unions.

How far these examples of costs without benefit could be multiplied throughout the health care system is simply unknown. They appear to account for a very large part of the escalation of drug costs, and offer considerable opportunities for improvements in productivity and access. But they are all readily explicable in terms of the interests of particular people and groups within that system – "entrenched, change-averse" (Christensen et al., *loc cit.*) When innovative approaches emerge, they are either "walled off", and do not generalize, or actively suppressed as in the case of pharmaceuticals.

Access to Care in Rural and Remote Regions

Canada, like many other countries, continues to struggle with the challenge of providing access to quality health care in rural areas. Unlike most others, however, it must find ways of addressing its fundamental human geography -- vast areas of sparsely populated territory combined with a number of urban centres strung in a thin band along the Canada-U.S. border. This make the challenge of ensuring reasonable access to health care services for all residents quite different from that faced in more densely populated countries such as the UK and Japan.

The barriers to recruitment and retention of physicians in underserviced communities are well known to analysts and policy-makers concerned about physician supply issues. They include:

- lack of adequate training for the unique circumstances associated with practicing medicine in rural environments;
- remuneration issues;
- onerous on-call duties and, more generally, heavy workload leading to burnout;
- professional isolation;
- lack of spousal employment opportunities;
- limited educational and extracurricular opportunities for children;
- severe climate;
- limited recreational and cultural opportunities;
- distance from family, friends (Chan and Barer, 2000).

For many of these key barriers, developing effective policy responses is difficult if not impossible, in Canada as elsewhere. Education, recruitment practices, practice opportunities and support facilities, working conditions, and financial support are all "modifiable factors" (Rourke, 1993). Finding effective ways of addressing the spousal and family concerns remains a more daunting challenge. Furthermore, some modifiable factors, particularly medical school and residency training, may, as noted above, have less effect than is often presumed, or hoped (Rabinowitz and Rattner, 1997; Xu et al., 1997).

All provinces in Canada have a long history of developing policies, sometimes uncoordinated, aimed at changing the geographic distribution of physicians. Many regions have had a variety of initiatives in place for decades, with questionable success.

Table 1 provides a highly summarized overview of policies at the time of a recent survey (Barer, Wood and Schneider, 1999).[10] The approaches have been grouped for expository convenience into six generic clusters:

- regulatory/administrative
- funding/payment
- education-related funding
- education/training
- market-based
- other (including communication technology).

In practice, these clusters are highly interdependent and overlapping. For example, many financial incentives are rooted in enabling legislation, but are classified within both regulatory/administrative and funding/payment clusters. And many of the education/training-related initiatives, which fall within both the funding/payment and the education/training clusters, include financial incentives to medical students and residents.

Provinces and territories are experimenting with a wide range of different policies. This is illustrated by the number of rows with at least one ✓, each such row representing a different lever being attempted somewhere in the country. Most provinces/territories currently employ policies from more than one of the generic clusters. A few of the rows in the table, however, contain no ✓. They are included because they are used in other countries and there is no practical reason why such policies could not be tried in Canada.

Financial incentives appear to be the predominant policy instrument. The funding/payment cluster has the largest number of rows, and many of these rows have ✓ marks in most, if not all jurisdictions. Particularly noteworthy here are the number of jurisdictions that were offering: a) either subsidized incomes or guaranteed minimum income contracts for physicians practicing in rural/remote/isolated areas; b) "return-of-service" practice bonuses and grants; c) funded rural area *locum tenens* programs; d) specific funding for rural area on-call coverage; e) student loans, grants and bursaries tied to "return-of-service" commitments; and f) funding to allow rural/remote physicians to take advantage of continuing education/skills upgrading opportunities. While a number of policies are based on alternative methods of payment (e.g. salaried or contract positions, non-fee-payments for on-call), many of the more-widespread funding/payment initiatives intended to improve access to care in rural or remote areas are still tied to fee-for-service reimbursement (with all its attendant problems; see above). A more recent push, not yet reflected in the table for most jurisdictions, appears to be additional monies for specialists' on-call time in these communities.

Despite their widespread deployment, questions remain about the effectiveness of financially-based initiatives in Canada. For example, the general experience of provinces providing return-of-service-tied grants, loans and bursaries to students and residents is that the recipients often buy their way out of the service commitment (although some provinces appear to have been more successful than others). Even when recipients complete their terms, these initiatives have limited effect on longer-term retention. This largely mirrors the American experience with the National Health Services Corps.

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[10] A more detailed description of the policies in place in each province in Canada as of 1999 can be found in this document.

In contrast to the plethora of funding/payment-based incentives, there is comparatively less being done in the education/skills areas. Aside from most provinces now offering dedicated rural area training/exposures during the years of undergraduate medical education, and a fair number of opportunities for rural residency experiences, particularly for family practice, other initiatives are less common. A promising development has been the recent re-emergence of interest in nurse practitioners. Three provinces have established training programs, and other jurisdictions are either planning or considering such programs. However, confusion still exists over what types of individuals ought to be trained, and for what purposes. In part, the debate is over whether one should train "advanced clinical nurses" with highly specialized nursing skills, but whose focus continues to be the "nursing function", or practitioners in primary care who can provide some of the services usually the domain of physicians, including making diagnoses, ordering tests and prescribing. Provinces appear to have different conceptions of how independently, and in what situations, they would like such extended scope personnel to practice. Furthermore, this may all be, in the words of that eminent health policy analyst Yogi Berra, "déjà vu all over again". Considerable interest in nurse practitioners was expressed in Canada in the early 1970s but nothing of substance was done to expand the capacity to train these individuals, likely because by the mid-1970s Canada was beginning to see the effects of the large expansion in medical school capacity. History may now be about to repeat itself.

As of 1999, three provinces had made amendments to existing Acts (subsets of Acts governing the practices of nursing, prescribing pharmaceuticals, and laboratory and radiology diagnosis) so that practitioners other than licensed physicians were legally able to perform a limited range of primary care functions. Other provinces, such as Manitoba and Saskatchewan, were contemplating, or in the process of enacting, similar regulatory changes.

Table 1 may be somewhat incomplete in excluding fund-raising activity at the local level intended to support recruitment or retention. Informal discussions at the time of the survey revealed that this sort of activity is, in fact, quite widespread, but little of it is as a result of official government policy (see, e.g. Arnold, 1999). Indeed, most Departments/Ministries would prefer this sort of uncoordinated initiative did not exist, because it creates a 'whipsaw' effect in many situations and, in turn, puts additional pressure for resources on the central Departments/Ministries.

The continued heavy reliance on financial instruments in Canada comes despite research on determinants of locational decision-making which suggests that other factors outweigh financial considerations. The fact that Canadian provinces have relied so heavily on these instruments, and that the problems remain so evident, and so high-profile, would seem to provide *prima facie* evidence that different approaches are going to be needed if progress is to be made in the future (Barer and Wood, 1997). Nevertheless, financial incentives continue to be featured prominently in the current menu of policies to improve access to care for residents of rural and remote areas in Canada.

Table 1: Contemporary Provincial/Territorial Policy Approaches

Policy Approaches	B.C.	Alta.	Sask.	Man.	Ont.	Que.	N.B.	N.S.	P.E.I	Nfld.	Yuk.	N.W.T.
Regulatory/ Administrative												
Billing numbers							✓	✓				
Provincial medical license tied to return of service in rural area												
Foreign medical Graduates with restrictions on practice location	✓	✓	✓	✓	✓					✓		
Enabling legislation for expanded role physician extenders/nurses		✓			✓					✓		
Direct Funding – Practice-related												
Subsidized income or guaranteed minimum income contract	✓			✓	✓	✓		✓		✓	✓	
Differential fees – bonus for practice in under-serviced region	✓			✓	✓	✓		✓		✓		
Differential fees – pro-ration for practice in over-serviced region					✓	✓			✓		✓	
Salaried and other 'alternate payment' positions	✓		✓	✓			✓	✓	✓	✓		
Grants/bonus tied to return of service	✓	✓	✓		✓	✓		✓		✓		
Special travel allowances for rural practice	✓		✓		✓	✓	✓			✓	✓	
Special program/funding for locum support	✓	✓	✓	✓	✓			✓	✓	✓		✓
Assistance with practice establishment costs			✓			✓						
Financial support for vacation (paid time off)					✓		✓			✓		
Special on-call payments for specialists	✓					✓				✓		
Special on-call payments for emergency coverage	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓		
Direct Funding – Education Related												
Undergraduate/post-graduate student loans/grants/bursary with return of service			✓	✓	✓	✓				✓		✓
Special funding or loans for residency and specialty skills development	✓	✓	✓	✓	✓	✓	✓	✓		✓		✓
Special travel allowance for students to get to summer placements or residencies		✓	✓	✓	✓							
Financial support for continuing medical education	✓	✓	✓	✓	✓	✓	✓	✓	✓			

Policy Approaches	B.C.	Alta.	Sask.	Man.	Ont.	Que.	N.B.	N.S.	P.E.I	Nfld.	Yuk.	N.W.T.
Education/Training												
Rural training/exposure for undergraduates	✓	✓	✓	✓	✓	✓	✓			✓		
Rural placements/ teaching units in association with a rural practice residency or specialty	✓	✓		✓	✓		✓			✓		
Special (re-entry) access to residency and/or new specialty skills development		✓	✓	✓			✓	✓		✓		
Special recruitment policies/criteria for new undergraduate medical students, e.g. aboriginals, rural		✓	✓	✓	✓							
Special recruitment policies/criteria for graduate level residency training	✓											
Development of continuing education capacity using new communication technologies		✓	✓					✓		✓		
Promotion of rural practice in medical schools				✓			✓	✓		✓		
Nurse practitioner or similar program			✓	✓	✓					✓		
Market-based Initiatives												
Recruitment fairs/tours		✓	✓		✓	✓	✓	✓		✓		
Allow locally raised funds to directly support provision of physician services (e.g. housing subsidy etc.)						✓		✓		✓		
Other Initiatives												
Funding for new remote diagnostic technologies e.g. Tele-radiology etc.	✓	✓	✓		✓		✓	✓		✓		
Spousal Support Initiatives												
Education Support for Children (e.g. boarding school for older children etc.)												
Physician Resources Co-ordinator			✓							✓		

But there have been some successes. Small communities such as Beechy and Kyle in Saskatchewan, and Marathon in Ontario, have found innovative, but quite different, ways of recruiting and retaining physicians (Chan and Barer, 2000; Rachlis et al., 2001). The solution in the former has been to build around a group of advanced practice nurses. In Marathon, an innovative non-fee-for-service funding model, and superb community support, were able to attract a number of new physicians to the community.

Of course geography is not the only dimension across which one finds marked disparities in access (Health Canada, 2000). Little has been done in Canada to address these issues. Some approaches to improving access for other sub-populations are likely to overlap those intended to address geographic disparities (e.g. education/training initiatives focused on

attracting medical school applicants from rural communities). But some of these populations represent challenges that will not be addressed effectively by any of the policies designed to address geographic distribution issues. For example, training-based initiatives to increase awareness of, and the special problems faced by, marginalized populations, may be a key to improved access. In this respect, academic health centres across the country will need to take on more of a leadership role as part of their embracing of a broader "social responsibility" or "meeting needs" agenda.

Emerging Issues

The recently heightened concerns among Canadians' regarding access to care, however, go far beyond the problems of rural/remote communities (where, as we noted above, such problems have existed for decades). Nor do they arise only from perceptions of the effects of cost-cutting on access to a family practitioner, or timely access to surgery or specialist care. They are also a reaction to the growing spectre of the re-emergence of financial barriers to accessing care. Recent initiatives in Alberta (Evans et al., 2000) and rhetoric in Ontario (McCarthy and Chase, 2001; Mackie, 2001) suggest a new willingness, at least among politicians, to take on the sacred Canadian trust of Medicare.

The arguments tend to be couched in language about the public system not being able to afford to provide all necessary care, or the private system providing efficiencies not available in the public. Each of these can be shown to be unsupported by evidence (Evans et al., 2000), but evidence plays no part in these discussions. They are motivated by a conservative "smaller government, tax cuts" agenda that is being strongly influenced by forces south of the border. Since health care represents a major share of all provinces' budgets (in the range of 35-45%, and rising in most jurisdictions), publicly financed health care stands squarely in the way of any significant tax cut agenda. If some components of the health care budget can be shifted "off-line", and onto private pockets, then governments have more scope for tax cuts.

But there are other, less well-understood, forces at play here. They may not be of concern to those committed ideologically or for reasons of personal economic interest, to the belief that private health care is by definition a "good thing". But they should be of increasing concern to ordinary Canadians already fussing about access to care. Both the North American Free Trade Agreement (NAFTA) and the General Agreement on Trade in Services (GATS) of the World Trade Organization have as their over-riding objective the removal of all barriers to international trade in goods and services *in any form, including health care services,* and correspondingly the reduction in the jurisdiction and powers of governments. NAFTA "irreversibly protect[s] the trend towards private health care, while eroding the ability of governments to reverse this trend." (Appleton, 1999). Member governments are permitted to reserve certain sectors of their society from its provisions, and preserve their scope in these policy arenas, and Canada has done so with respect to "health". But the language of this reservation is far from clear.[11] The Canadian government favours a broad interpretation of the terms "social service" and "public purpose", thus ensuring a continued wide scope for public policy. But as of 1995 the U.S. Office of the Trade Representative "[held] that where commercial services existed, that sector no longer constituted a social service for a public purpose." (*ibid.* p.96).

Two major points emerge from the NAFTA that are reiterated and reinforced in the GATS. First, all sectors that are not explicitly *and exclusively* reserved for public action are

[11] The relevant Canadian reservation reads: "Canada reserves the right to adopt or maintain any measure with respect to the provision of...the following services to the extent that they are social services established or maintained for a public purpose: income security or insurance, social security or insurance, social welfare, public education, public training, health, and child care" (NAFTA, ann. II-C-9 as quoted in Appleton, 1999, p. 95).

to be open to international trade and to intrusion by commercial interests, if not immediately then as soon as possible. Signatories bind themselves to accept this objective. Under Article 19 of the GATS, member countries are expected to pursue "a progressively higher level of liberalization" in any service sector involving a mix of public and private ownership. Governments that fail to do so, perhaps because of strong opposition, democratically expressed, will expose their countries to economic sanctions until that contrary popular will is broken. In a 1998 background note (WTO, 1998, as quoted in Sanger, 2001) the World Trade Organization Secretariat gave their interpretation of GATS to imply that countries where the hospital sector is a mix of public and private ownership, or where there is private insurance or user fees, cannot argue for exemption under Article 1.3.[12]

Second, this opening is a one way process. Once an Article 1.3 exemption is withdrawn it is unclear whether or how it could ever be restored. In any case for Canada, NAFTA is clearer. If a government chooses to enter a new field of activity, or return to one previously vacated, it incurs potentially prohibitive penalties in the form of compensation to any commercial interest that can claim lost business opportunities (Appleton, 1999). Once the dike is breached, it becomes financially impractical to get the water back onto the other side.

And since Canada, not any individual province, is signatory to the GATS, under WTO rules the failure by a province to meet the conditions of the Article 1.3 exemption would be interpreted as a Canadian failure, and would in all likelihood open all of Canada to foreign corporate competition in the sector in which the 'violation' had occurred. The fact that the Government of Canada may thus have signed away authority it does not possess, authority that by the Constitution is assigned to the provinces, is of no interest to the WTO.

Here, as everywhere in the "Brave New World" of international trade agreements, what is most clear is that nothing is clear. As Appleton points out, disputes will have to be resolved by various tribunals applying international, not domestic, law, and until the case law has emerged from this process, the outcomes are impossible to predict. International law does not even define terms like "social services" and "public purpose".

What is certain, however, is that no province that permits private financing in areas of health care currently covered under the terms and conditions governing Canadian Medicare, can know, let alone control, the sequelae. The recent enactment of legislation in Alberta to permit private hospitals to provide overnight stay care, clearly expands the scope of private provision of health care, by corporate entities that have international links (Taft and Steward, 2000). Whether or not that legislation will initiate a NAFTA or WTO claim from corporate interests in the U.S. (or elsewhere for that matter), is impossible to know at this point. But it certainly raises the probability, and (at least in the case of the WTO) for all of Canada. The genie that may be let out of the bottle is not one whose behaviour anyone can predict. Whatever assurances may be given about the limited and controllable effects of Alberta's initiative, there is no way for anyone to know whether they can be backed up. When the Alberta government's web site (http://www.health.gov.ab.ca/health_protection/questions.htm) responds to questions about NAFTA vulnerability with "Absolutely not", their confidence is absolutely baseless. On the international trade stage, Alberta is not even a player. And so Canadians already concerned about access may have reason to be paranoid, and to be wary of "globalization" more generally.

Future Prospects

The Canadian Medicare system has succeeded in its primary objective, of removing all financial barriers to access to hospital and medical care and spreading the burden of payment

[12] This Article exempts "government services" from other provisions of the GATS. A "government service" "is supplied neither on a commercial basis, nor in competition with one or more service suppliers."

equitably across the population according to ability to pay. This has significantly equalized access to care across socio-economic classes, but equalization of access to care has not led to equalization of health status. There are also remaining differences in access related to factors other than ability to pay, such as geographic isolation, and these remain matters of public concern. Interestingly, however, differences in access, or at least use of services, do not appear to be correlated with differences in health outcome, yet it is the former, rather than the latter that are matters of continuing public concern.

The Canadian financing system has also turned out to be relatively efficient, at least in a North American context. It embodies powerful mechanisms for cost control, providing that there is the political will and capacity to use them. As noted above, prior to the universal, first dollar coverage of physicians' services in the late 1960s, costs in Canada (as in many other OECD countries) were escalating at about the same rate, relative to national income, as in the United States. Universal public coverage was associated with an abrupt flattening of this trend, and the emergence of a widening gap between Canada and the United States, which now amounts to some four percentage points of GDP. Most other OECD countries developed their own cost control mechanisms at different times during the 1970s, however, so the Canadian experience was not unique, except insofar as it was achieved in a system and a society so similar to, and so heavily influenced by, the United States. While far more efficient, and less costly, than in the United States, health care in Canada is relatively expensive in world terms – in the same range as France or Germany, and much above Japan or the UK.

Not surprisingly, Canada's Medicare has been extremely popular, and strongly supported, by the Canadian people over most of its life. Until very recently, its opponents have judged it politically unwise – suicidal – to launch direct attacks. Rather they have advocated various "improvements" or "reforms" designed to undermine its cost control capacity and/or to provide preferential access for those with greater ability to pay, while reducing their share of the burden of total costs.

Starting in the early 1980s, however, Canada's overall economic performance deteriorated markedly. Federal and provincial governments began to run growing deficits, leading to unsustainable growth in public debt. By the early 1990s these debts had reached crisis proportions, and all governments began to impose significant cuts on public spending. These have been very successful in restoring fiscal health, but their impact on the health care sector has been severe.

There seems little doubt that access to particular services has been significantly impaired, though the nature and extent of such problems is difficult to discern amid the strident rhetoric from providers whose distress is all too evident. In this atmosphere those who stand to profit handsomely from wrecking Medicare have been much emboldened, and have increased their attacks. Large increases in public funding over the last five years have not served to restore public confidence, and have instead alarmed finance ministries who are now arguing that medicare is "unsustainable" – in effect that more of the costs of care should be transferred from public to private budgets, from the wealthy to the sick.

This capsule history provides virtually a textbook illustration of Homer-Dixon's analysis of intra-societal conflict, recently summarized in The Ingenuity Gap (Homer-Dixon, 2000). The progress of human societies is marked by the continual emergence of more or less severe problems that threaten their well-being, their continued progress, or even their survival. Meeting these threats depends upon their ability to mobilize ingenuity, in the form of both physical technology but even more importantly as institutional adaptation, to meet or surmount these challenges. So, in the organization and management of health care, Canada like other societies faces the challenge of developing and adapting our institutions so as to

provide our populations with the services that meet their needs, at an acceptable overall cost – to do the right things, and to do them right – in a continually changing environment.

But societal fragmentation poses a serious threat to the mobilization of ingenuity. Under stress, cleavages may open up between conflicting social interests. Ingenuity becomes diverted from addressing the shared social problems, into strategies for capturing a larger share of the threatened social resources, and ensuring that others bear the costs of adaptation or of scarcity. Such internal conflict not only diverts the inevitably scarce supply of human ingenuity, but is itself resource-using, increasing the severity of whatever challenges must be met.

Again, we are seeing precisely this process at work in Canada. Ingenious new approaches are being developed; changes in organization and management are known that could improve the efficiency and the effectiveness of health care delivery (Rachlis et al., 2001). But these are either not taken up, or if introduced do not spread. In the pharmaceutical case successful innovations that threatened to spread have been stifled by the commercial interests that they threatened. Innovative uses of personnel, and more effective uses of equipment and facilities, have been impeded or blocked by unions and professional associations, and by the resistance of individuals, as threats to incomes and/or professional prerogatives and ambitions. The political energy and leadership required to push them through has been diverted by ancient struggles over who pays what share of the bill – the endless "public/private financing" debates. These are typically dressed up as questions of relative efficiency and effectiveness – economists are particularly helpful for this form of deception. In reality the advocates of private financing are seeking either to increase the flow of funds into health care – and incomes out – or to increase the share of benefits received, and reduce the share of costs borne, by those with greater ability to pay and better health status. Or both.

Homer-Dixon and his colleagues have found that in countries without democratic government, and with significant ethnic or religious differences, the cleavages opened by increasing environmental stress, and the failure to mobilize a sufficiently ingenious response, lead to endemic communal warfare -- intra- rather than inter-state. In democratic countries they lead to major shifts in government philosophy. There are certainly signs of the latter in Canada at present. It may well be that Canada's Medicare will be one of the casualties in what appears to be an increasingly open struggle between those trying to maintain the very substantial redistributive programs – financial and non-financial – operated by governments, and those who seek to dismantle them in favour of greater inequality of both incomes and life chances.

The issue is still much in doubt, and it is by no means unique to Canada. What is certain is that this conflict is diverting a considerable amount of ingenuity away from, as well as blocking, potential innovations in the provision of health care – exactly as Homer-Dixon's analysis predicts.

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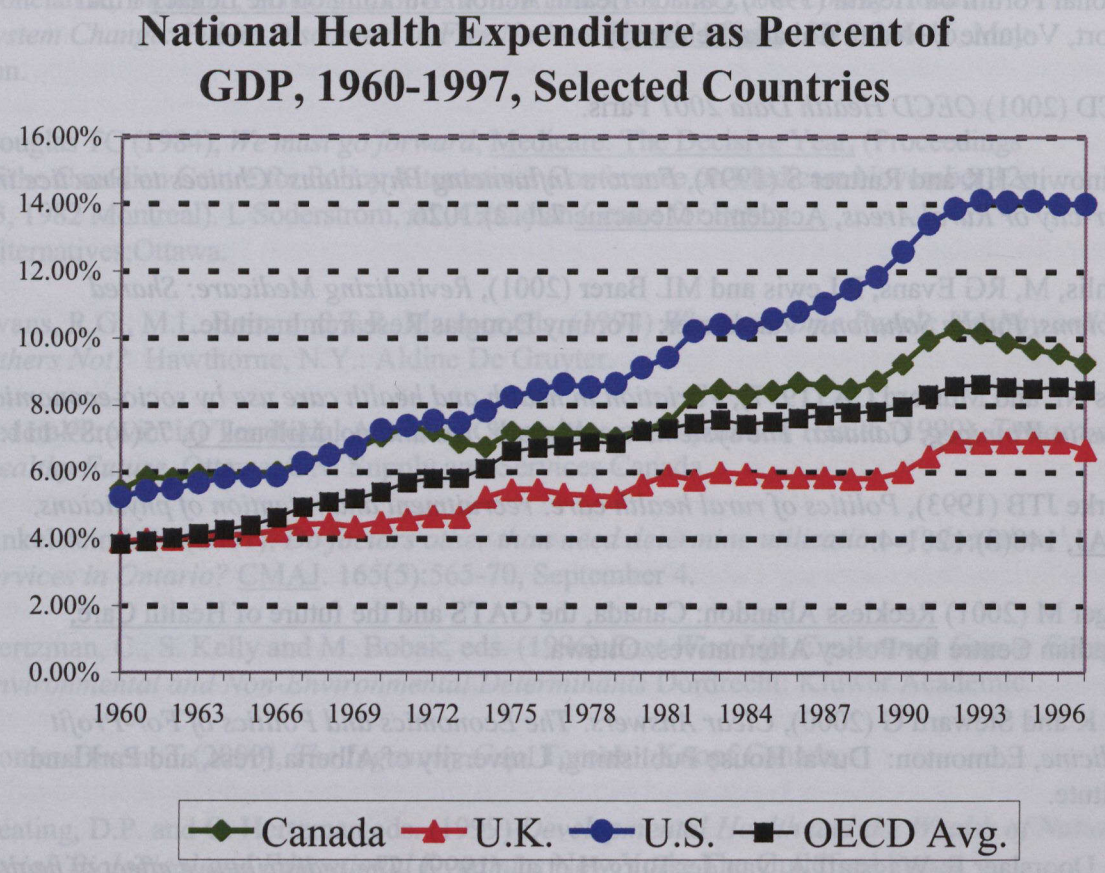

Figure 1

Figure 2

Publicly Funded and Privately Delivered: A Comparative Study on the Health Care Reform in Japan and Canada

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Japan and Canada are two of the most advanced market economy countries in the world and important neighbors across the Pacific. However, their health care policies are rarely compared. In Japan, the health care systems of Germany, France, UK and US have enthusiastically been studied not only among academics but also among policymakers. There is an extensive literature written in Japanese on the health care systems in those countries. On the other hand, Canada and Italy are exceptionally ignored G-7 countries in health care study in Japan. It is curious that information on health care in such an important country as Canada is not widespread in Japan. I am afraid that the reverse is basically the same in Canada.

In this essay, I will briefly sketch the current health care systems in both countries and provide an overview of some current policy issues. There are many features in common as well as differences in their health care systems. Such comparative studies in these two important market economies will be useful not only for academics but also for policymakers in considering the future health care reforms. I hope this brief essay will contribute to the development of comparative health care study in the two countries.

1. Major Health Data

In order to compare the health care systems in Japan and Canada, I will examine in this chapter major health statistics of both countries. I will use the Organisation for Economic Co-operation and Development (OECD) Health Data (1). Although it has some problems and limitations, it clearly provides one of the most useful internationally comparative health databases. Taking into account technical difficulties in international comparison, the following statistics should be read as providing a general outline of the characteristics of the health care in the two countries rather than providing in-depth comparative information.

Table 1 shows female and male life expectancy at birth in major OECD countries. In 1997, Japan has the highest for both men (77.0 years) and women (83.8 years). Canada also enjoys relatively long life expectancy rates, with 75.8 years for men and 81.4 years for women. Both Japan and Canada are already " long life " society (2).

Table 2 shows infant mortality rates in the same OECD countries. Japan has the lowest rate after Sweden. Canada has attained the average level in the OECD countries, which is lower than those in the United States and the United Kingdom.

The relationship between health care expenditures and economy is illustrated in Figure 1. Per capita GDP in each OECD country is measured along the horizontal axis in Figure 1. The vertical axis measures per capita health expenditures in each country. Figure 1 shows a well-known relationship that suggests that per capita health expenditures are determined partly by per capita GDP (3). In this Figure, Japan and Canada stand on each side of the trend line. According to OECD, health expenditures as a percentage of GDP in 1998 were 7.5% for Japan and 9.3% for Canada. In Canada they were at 7.3% in 1981. Therefore, the current situation in Japan can be said to correspond to Canada's situation in the 1980s, at least for the level of health care expenditures as a percentage of GDP.

Finally, health care supply data are shown in the following three Tables. In health economics, the quantity of health care supply is determined by basic inputs such as capital and labor through production function. The first two Tables show the number of inpatient beds representing capital and the last Table shows the number of doctors and nurses representing labor. First, Table 3 shows the number of total inpatient beds per 1,000 population in major OECD countries. Canada has very few inpatient beds per population after the United States, while Japan has exceptionally many (4). European countries with social health insurance like France and Germany are in the middle. The difference between Japan and Canada has increased since 1960. As Table 4 shows, the number of total inpatient beds per 1,000 population was 9.0 for Japan and 6.2 for Canada in 1960. Since then the number of total inpatient beds per population in Japan has continuously increased, while that in Canada has decreased particularly rapidly in the 1990s.

Second, Table 5 shows the number of practicing physicians and nurses per 1,000 population in the same OECD countries. Japan and Canada are almost at the same level in these statistics. Since the definition and work of medical professionals differ according to countries, simple international comparisons should not be made. For example, in Japan, the percentage of practical nurses compared to the total number of nurses is high and the medical acts by nurses are strictly limited. However, at least, according to OECD data, the labor supply of medical professionals in Japan and Canada is almost at the same level, smaller than in the United States and Germany, but larger than in the United Kingdom.

2. General View of the Health Care Systems

According to the World Health Organization (WHO) [2000], the health care systems both in Japan and Canada are highly rated in the world. In the ranking of overall goal attainment, including level of population health, health system responsiveness and fairness in financial contribution, Japan ranks first and Canada ranks 7th among 191 countries. As for the overall health system performance, Japan ranks 10th and Canada ranks 30th. There is much discussion about the selection of performance indicators to measure health systems in each country and the objectivity of ranking in the WHO assessment. However, relatively speaking, Japan and Canada no doubt have two of the most highly rated health care systems in the

world. In all nine performance indicators and composite ones used by the WHO report, both Japan and Canada show good performance.

The categorization of welfare states, Esping-Andersen [1990], provides a classic framework of three types of welfare capitalism : liberal, corporatist and social democratic. Canada is classified in the liberal category, which consists of Anglo-American countries like the United States, the United Kingdom, Australia and New Zealand. Japan does not seem to belong to any single category and is called a "hybrid" type. Esping-Andersen's categorization itself raises many questions. In particular, health care seems to be problematic. It is not convincing to classify the health care systems in Canada, the United States and the United Kingdom into the same liberal type category. There is much difference in coverage, funding, delivery and expenditures level of health care among these countries.

A hypothetical classification of health care systems in the major OECD countries is proposed in Figure2 in order to make a clear comparison of health care systems between Japan and Canada. The percentage of public health care coverage over the total population is measured along the horizontal axis from 100% (the United Kingdom, Canada and Japan) to 46 % (the United States). In this coordinate axis, the left represents a more "public" character and the right represents a more "private" one.

The funding system is divided into three categories: general tax, social insurance and private insurance. The United Kingdom and Canada have adopted general tax system for financing health care expenditures. Germany and France are typical social insurance type systems mostly financed by social insurance contributions. Japan has a mixed funding system of social insurance and general tax. As shown in Annex Figure 3, the share of social insurance contributions in the total health care costs in Japan is less than 60% and the share of subsidies by both central and local governments exceeds 30%. On the other hand, the Netherlands has a mixed system of social insurance and private insurance, in which the former is larger (5). The United States has adopted basically a private health insurance system, while it has public health care systems for specific populations such as the elderly, disabled and low-income families through Medicare and Medicaid.

Finally health care service delivery system is classified into A) national health service and B) mixed delivery system. The former is a public health care service delivery system managed by public health authorities such as the NHS (National Health Service) in the United Kingdom. The latter is a mixture of public and private providers in which the role of general practitioners in private clinics is particularly important. Canada and Japan clearly belong to this latter category. The Canadian health care system is often described as "publicly funded and privately delivered". This generalization basically applies to the Japanese health care system, although its public funding system is different from the Canadian one. In conclusion, Japan and Canada seem to have rather similar health care systems in comparison with other OECD countries.

3. Recent Health Expenditures Trends

Table 6 shows the total health care expenditures and GDP growth trends in major OECD countries. Several interesting features are found in statistics about Japan and Canada in the four decades since 1960 shown in the Table.

First, the health care expenditures in Japan increased much more rapidly than GDP during the 1960s and 70s. This relative growth rate of health care expenditures was higher than the OECD average. But it was not far from the general OECD trends during the 1960s and 70s. Through the relatively high economic growth periods of the 1960s and 70s, health care expenditures also grew very rapidly in Japan. This contrasts with the Canadian experience in the same periods. The health care expenditures in Canada showed relatively low growth in the 1960s and almost kept pace with GDP in the 1970s. Taking into account the fact that both countries introduced universal coverage into their health care system during those periods (Japan in 1961 and Canada in 1972), this contrast seems very interesting (6).

Second, such trends considerably changed in the 1980s and 90s. In Japan, health care expenditures grew more slowly than GDP and its percentage of GDP decreased in the 1980s. This contrasts with the OECD average trends in health care expenditures, which still continued to grow faster than GDP in the same period, although the pace of growth substantially slowed down. However, this situation reversed in the 1990s. Health care expenditures in Japan began to grow again faster than GDP, and its percentage of GDP rapidly increased (7). This again contrasts with the OECD trends as a whole, which followed almost the same tendency in the 1980s. Such changes in trends of health care expenditures in Japan during the 1980s and 90s constitute the basic background of the deterioration of public health insurance finance and the resulting discussion about health care reform these days. This seems to be similar to the German experience during the same periods. On the other hand, Canada has experienced just the opposite trends in health care and economy. In Canada, health care expenditures relative to GDP grew faster than in other OECD countries except for the United States in the 1980s. This reversed in the 1990s. Canada has seemed to control health care expenditures, keeping pace with economic growth at least until 1997.

Third, as a result, the percentage of health care expenditures in GDP in Japan increased from 3.0% in 1960 to 7.4% in 1997, almost a two-and-half-fold increase. The same figure in the OECD as a whole grew from 3.8% to 7.6% (twofold) during the same period. Japan experienced a little higher growth in health care relative to economy than the OECD average. Canada, on the other hand, recorded 5.4% in 1960 and 9.0% in 1997, resulting in a little lower growth than the OECD average. Canada ranked first or second at the beginning of the 1960s and ranked fifth in 1997 in its spending on health care as a share of its GDP.

4. Recent Reform Discussions

In February 2002, the Commission on the Future of Health Care in Canada created by Prime Minister Jean Chrétien submitted an interim report titled "Shape the Future of Health Care". The objective of the Commission is to undertake a dialogue with Canadians on the future of Canada's public health care system and to recommend policies and measures required to ensure over the long term the sustainability of a universally accessible, publicly funded health system. The work of the Commission is conducted in two stages, the first focusing on fact-finding, resulting in the interim report, and the second emphasizing dialogue with the Canadian public and interested stakeholders based on the interim report (8). The final report, based on the interim report and the work conducted in the stage two, with recommendations is to be submitted on or about November 2002.

In Japan, sweeping health care reforms have been discussed since 1997, when co-insurance of salaried persons in public health insurance schemes was raised from 10% to 20% of the total health care costs. The growth of health care expenditures in Japan exceeded that of GDP in the 1990s as shown in Table 6 and financial difficulties of the public health insurance schemes have worsened. Traditional cost containment measures such as raising co-insurance rates are not enough for the long-term stability and sustainability of the schemes. Ministry of Health, Labor and Welfare (9) issued a report in March 2001 and made public its views over the health care reforms. The report was based on the policy discussions in several government Councils including former Health Insurance and Welfare Council, in which not only scholars and experts but also stakeholders participated. It explains the present status and issues of health care and health care system in Japan and provides the points of view for health care reforms, focusing on the health care system for the elderly (10).

Canadian interim report addresses four key themes:

1. Canadian values and how they are and should be reflected in the *Canada Health Act*;
2. Sustainability and funding;
3. Quality and access; and
4. Leadership, collaboration, and responsibility.

These four themes are relevant to the health care reform in Japan. In the following part of this chapter, I will compare the recent health care reform discussions in Japan and in Canada according to the four themes.

First, the *Canada Health Act*. The present Act has famous five principles:

1. Public Administration
2. Comprehensiveness
3. Universality
4. Portability
5. Accessibility

As for the first principle of public administration, Japan has adopted a public health insurance system, in which co-exist a Franco-German type of social insurance schemes for employees and, for the others, a Canadian type of regional health insurance schemes managed

by local governments. All insurers are public or semi-public organizations and the administration of the health care plan is carried out on a non-profit basis (11). There seems to be no plain opposition nor criticism to this principle both in Japan and in Canada, although some economists prefer a more mixed system of public and private insurance.

The second principle means that all medically necessary services must be insured. The *Canada Health Act* covers only hospital and physician services. Home care, long-term care, dental care, prescription drugs unless provided in hospitals, preventive health programs and community-based initiatives are not generally covered in Canada. The extension of coverage to important health services other than hospital and physician services has been an issue in Canada. Generally speaking, Japan offers a broader insurance coverage in comparison with Canada (12). Since April 2000, under the new long-term care insurance system, *Kaigo-hoken*, home care and long-term care have, in principle, been covered (13). Both dental care and prescription drugs have been covered under health insurance. Preventive health programs, in particular, group medical checkups under health insurance system have been very popular in Japan. The reduction of coverage has been implemented in Japan mainly in amenity-related services, including private sickrooms and meals.

The third principle of universality is deeply rooted in the health care systems of both Japan and Canada. Universal coverage by public health care was established in 1961 for Japan and in 1972 for Canada. National Health Insurance (NHI) schemes managed by municipalities including cities, towns and villages, are the cornerstone of the whole Japanese universal system. The NHI, which is similar to the Canadian Medicare, covers all the residents other than those who are already covered by other public health insurance schemes such as the Government-managed Health Insurance (GHI) and the Society-managed Health Insurance (14). The remaining differences in coinsurance rates among public schemes have been reduced in the consecutive reforms since 1961 and there remains only very little differences between the NHI and other schemes. The principle of universality does not seem to be challenged in either country, although some argue that the private sector should play a more active role in meeting the needs of people.

The fourth principle of portability means that the coverage for insured services must be maintained when an insured person moves or travels within Canada or travels outside the country. Japan has maintained full portability in public health insurance benefits within the country from the beginning and extended it to outside the country afterwards.

The fifth principle of accessibility means that financial or other barriers must not impede the reasonable access by the insured to medically necessary services of hospital and physician. In Canada, in principle, neither coinsurance nor co-payments are required when insured persons receive insured medical services. On the other hand, in Japan, although the insurance coverage seems to be broader in comparison to Canada, the Japanese health insurance system imposes relatively higher coinsurance or co-payments on patients (15). In the recent health care reform laws submitted to the Diet in March 2002, a raise in coinsurance rate for employees from 20% to 30% is proposed.

The second theme is sustainability and funding. As shown in Table 6, Canada has successfully achieved cost-containment in health expenditures in the 1990s. However, total health expenditures again began to increase significantly after about 1997 mainly because of the increase in other expenditures than hospital and physician services. For all provinces, the proportion of their program spending that goes to health has increased considerably since the mid-1970s. Currently, provinces devote on average more than 35% of their program spending to health and some are worried that the requirements of the health care system are crowding out other essential services like education, roads, housing and social services. In order to maintain the sustainable health care system in the long run, not only effective cost control measures but also additional way of funding is necessary. The interim report raises some questions on this point for Canadians: Do we need to spend more money on Canada's health care system and if so, where should the additional funding come from? Should it come from provincial and/or federal budgets, from new sources of revenue such as new or dedicated taxes, or should individuals be expected to contribute more to the costs of their own care?

The questions raised in the interim report are almost common to the Japanese health care system. Japan currently spends a relatively smaller portion of GDP on health care in comparison with other OECD countries (Table 6). However, it is expected that it will rapidly increase because of technological developments and the rapid population aging. Additional funding is necessary even when cost containment measures are implemented. As shown in Annex Figure3, general tax, social insurance contributions and coinsurance and co-payments are the three main sources of funding for health care expenditures in Japan. In the recent reforms including the laws currently under discussion in the Diet, raises - both in coinsurance and co-payments paid by the patients and in social insurance contributions paid by the insured persons - have been proposed and implemented. On the other hand, some argue that more government subsidies should go to health care expenditures in particular for the elderly, and others argue that new sources of revenue such as earmarked taxes on alcohol or tobacco should be introduced. However, taking into account the general government spending pressures from pensions and social services in an aging society and the current public finance crisis in Japan, it is unrealistic to think that it is easy to get new additional funding for health care. This question needs to be tackled and solved in the broader policy perspective over the future of the society as a whole.

Third theme: quality and access. Excessive delays for health care services have become one of the main worries of Canadians. Concerns about waiting lists are especially high in specialist services, diagnostic procedures such as MRI tests, elective and non-emergency surgery, emergency rooms and long-term care facilities. Canadians have been famous for highly rating the health care system of their own country. However, according to several recent surveys, both Canadian providers' and consumers' confidence clearly dropped in the past few years (16).

Japan seems to face another problem of health care quality. Under the "free access" to hospitals and physicians by patients without referral system and fee-for-service payment system, medical facilities are almost always overcrowded with patients. Consultation time per

visit is very short. On the other hand, the number of inpatient beds and of MRIs and CTs per population is the highest among OECD countries. Japan has relatively abundant capital in health care resources, which results in the supply of a high volume of services. Instead of waiting lists problems, quality of services delivered has been under question here.

As for access, although both Japan and Canada have universal health care system, those who live in rural and remote areas often feel they are not getting sufficient access to the health services they need. This problem is common to both countries. In Canada, vast northern territories and in Japan tens of thousands of small islands are particularly difficult areas for policymakers to address. Steps are being taken to recruit and retain health care providers to rural and remote areas and provide incentives for them to stay. Advanced technologies such as telemedicine are being experimented as pilot projects in a number of those areas. One solution may be broader implementation of primary care models in the integrated health care networks with making greater use of telemedicine and information technology, as suggested in the interim report. To secure effectively access to necessary health care services by all residents will continue to be one of the ultimate goals of health care policy in developed countries like Japan and Canada.

Fourth: leadership, collaboration and responsibility. The interim report stresses the importance of dialogue among central and local governments, stakeholders such as provider organizations, experts and the general public. During the fact-finding phase, meetings with the people from provincial and territorial governments, health care experts including foreign scholars and interested stakeholders have already been held and hearings involving the Canadian public have been made by e-mail through the Internet. In the second consultation phase which follows the interim report, a full-scale dialogue will take place.

In Japan, policymakers within the government have experienced a very tough period since 1997, when consensus making process among interested parties has been very difficult due to several reasons (17). The traditional consensus making process within government Councils has not functioned well. For example, stakeholders proposed four reform ideas for the elderly health care system to the Health Insurance and Welfare Council; these were discussed for a long time, but no conclusion was reached (18). Lack of leadership, collaboration and responsibility may have been the salient features of recent health care policy in Japan. In 2002, health care reforms including cost containment through the lowering of fee schedule and the raise of coinsurance are to be implemented after a long chaotic political process. It is stipulated in the reform laws that sweeping health care reforms be examined after the 2002 reforms are realized (19). Japan can learn a lot from the Canadian policy making process.

5. Conclusions

As examined above, Japan and Canada have basically similar health care systems of publicly funded and privately delivered. Although there are several differences, their

positions seem to be very similar within the health care system spectrum of OECD countries as shown in Figure 2.

Health care expenditures in Canada have already surpassed 9% of GDP, while that in Japan still remains a little more than 7%. It is generally recognized that there exists a consensus among Canadians that health care expenditures in Canada are consuming an appropriate fraction of society's resources (20). According to Naylor [1999], Canada's publicly funded health care system is more than a social program; it is a unifying force, a national obsession (!), and, not least, one of the few features that allows Canadians to differentiate themselves from their neighbors to the South. In Japan, the positive rating of the universal public health insurance system seems to be common not only among the experts but also the general public beyond their positions. However, no consensus seems to have been made on the appropriate level of health care expenditures that should be spent from society's resources. Health care providers put great emphasis on the fact that Japan's health care expenditures as percentage of GDP are still low compared to OECD countries, while insurers and government policymakers stress the looming financial crisis in health insurance schemes to be caused by the rapid population aging. The former is concerned with the present and the latter with the future. Both views are correct. The problem is how to make national consensus on these seemingly incompatible views. Canadian experiences as a frontrunner in health care spending will be helpful for Japan in making consensus over this difficult question.

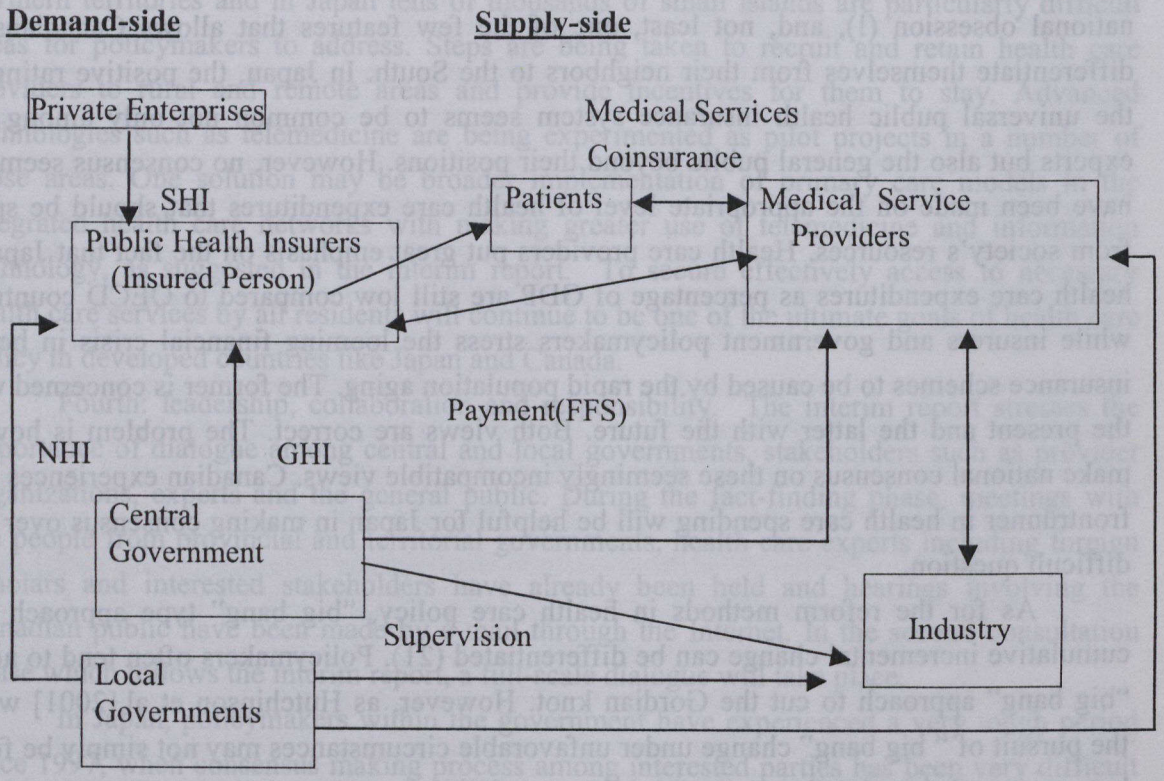
As for the reform methods in health care policy, "big bang" type approach and cumulative incremental change can be differentiated (21). Policymakers often tend to adopt "big bang" approach to cut the Gordian knot. However, as Hutchinson et al.[2001] write, the pursuit of " big bang" change under unfavorable circumstances may not simply be futile but may result in missed opportunities for cumulative incremental change. Both Japan and Canada can learn from the past experiences, and the importance of carefully assessing opportunities for change should be stressed.

According to OECD[1994]and Wessen[1999], the recent health care reforms in Canada have eschewed policies such as managed competition and the creation of internal markets, both of which were very popular policy approaches in the OECD countries in the 1990s (22). Rather, Canada has pursued cost containment policies by using the monopsonistic control afforded to provincial governments as principal payers of health care and by focusing on quality assurance. Canadian approach to health care reform which acknowledges the limited effectiveness of market forces in health care seems to be relevant to Japan.

Annex : Outline of Japanese Health Care System

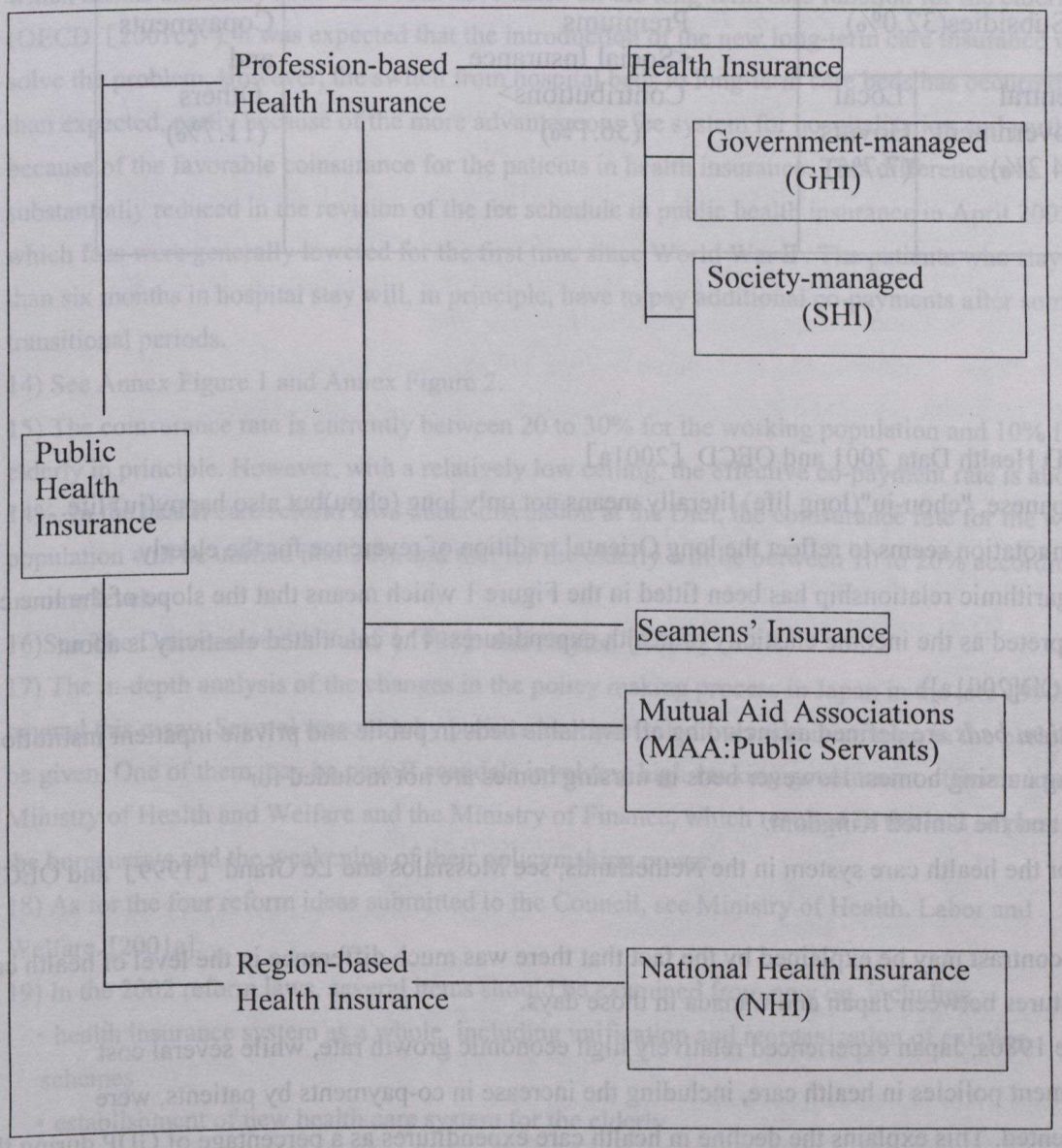
1. Basic Structure

Annex Figure.1 Major Actors in Japanese Health Care System



2. Structure of Demand-side

Annex Figure.2 Public Health Insurance System in Japan



Annex Figure.3 Sources of Funds for the Health Care Costs (FY1996)

Subsidies(32.0%)		Premiums <Social Insurance Contributions> (56.1%)	Copayments and Others (11.7%)
Central Government (24.2%)	Local Govnts (7.7%)		

Notes

1) OECD Health Data 2001 and OECD [2001a]

2) In Japanese, "chou-ju"(long life) literally means not only long (chou)but also happy(ju) life. This connotation seems to reflect the long Oriental tradition of reverence for the elderly.

3) A logarithmic relationship has been fitted in the Figure 1 which means that the slope of the line can be interpreted as the income elasticity of health expenditures. The calculated elasticity is about 1.3.(OECD[2001a])

4) *Inpatient beds* are defined as including all available beds in public and private inpatient institutions, including nursing homes. However beds in nursing homes are not included for Canada and the United Kingdom.

5) As for the health care system in the Netherlands, see Mossialos and Le Grand [1999] and OECD [2000].

6) This contrast may be explained by the fact that there was much difference in the level of health care expenditures between Japan and Canada in those days.

7) In the 1980s, Japan experienced relatively high economic growth rate, while several cost containment policies in health care, including the increase in co-payments by patients, were implemented. This explains the decline in health care expenditures as a percentage of GDP during the period. But after the collapse of so-called "bubble economy" in the early 1990s, the situation reversed. The economic growth rapidly slowed down and the Japanese economy fell into the longest recession since World War Ⅱ. Radical health care reforms were proposed but not implemented.

8) Canada Privy Council, 3rd of April 2001(Commission on the Future of Health Care in Canada 2002])

9) As a part of administrative reforms of the central government, Ministry of Health and Welfare and Ministry of Labor have been united since January 2001.

10) See Ministry of Health, Labor and Welfare [2001a] .

11) See Annex Figure.1 and Annex Figure.2.

12) According to OECD[2001a], public funding as a percentage of total health expenditures was

78.5% for Japan and 70.1% for Canada in 1998.

13) There are some transitional problems in the newly established long-term care insurance system. One of the most important problems is the phenomenon known as so-called "social hospitalisation", which means that many acute care beds have taken on the long-term care function for the elderly (OECD [2001c]). It was expected that the introduction of the new long-term care insurance would solve the problem. However, the switch from hospital beds to long-term care beds has occurred less than expected, partly because of the more advantageous fee system for hospitalisation and partly because of the favorable coinsurance for the patients in health insurance. This difference was substantially reduced in the revision of the fee schedule in public health insurance in April 2002, in which fees were generally lowered for the first time since World War Ⅱ. The patients who stay more than six months in hospital stay will, in principle, have to pay additional co-payments after some transitional periods.

14) See Annex Figure 1 and Annex Figure 2.

15) The coinsurance rate is currently between 20 to 30% for the working population and 10% for the elderly in principle. However, with a relatively low ceiling, the effective co-payment rate is about 14%. In the health care reform laws under discussion at the Diet, the coinsurance rate for the working population will be unified into 30% and that for the elderly will be between 10 to 20% according to income level.

16)See The Commonwealth Fund [1998] and Naylor [1999]

17) The in-depth analysis of the changes in the policy making process in Japan in the late 1990s goes beyond this essay. Several reasons why politics have prevailed over administration in the period may be given. One of them may be payoff scandals involving high-ranking government officials in the Ministry of Health and Welfare and the Ministry of Finance, which resulted in the loss of prestige for the bureaucrats and the weakening of their policymaking power.

18) As for the four reform ideas submitted to the Council, see Ministry of Health, Labor and Welfare. [2001a].

19) In the 2002 reform laws, several items should be examined from now on, including :

- health insurance system as a whole, including unification and reorganization of existing schemes
- establishment of new health care system for the elderly
- the system of fee schedule

20) OECD [1994]

21) See Hutchinson et al. [2001] , Ikegami and Campbell [1996] and Niki [2001]

22) See OECD [1999] and Saltman et al. [1998]

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Tables and Figures

Table 1 Female and Male Life Expectancy at Birth in Major OECD Countries (1997)

	Male	Female	
Japan	**77.0**	**83.8**	
Canada	**75.8**	**81.4**	
United States	73.6	79.4	
United Kingdom	74.6	79.7	
France	74.6	82.3	
Germany	74.1	80.3	
OECD*	73.5	79.6	*Weighted average

Source : OECD [2001a]

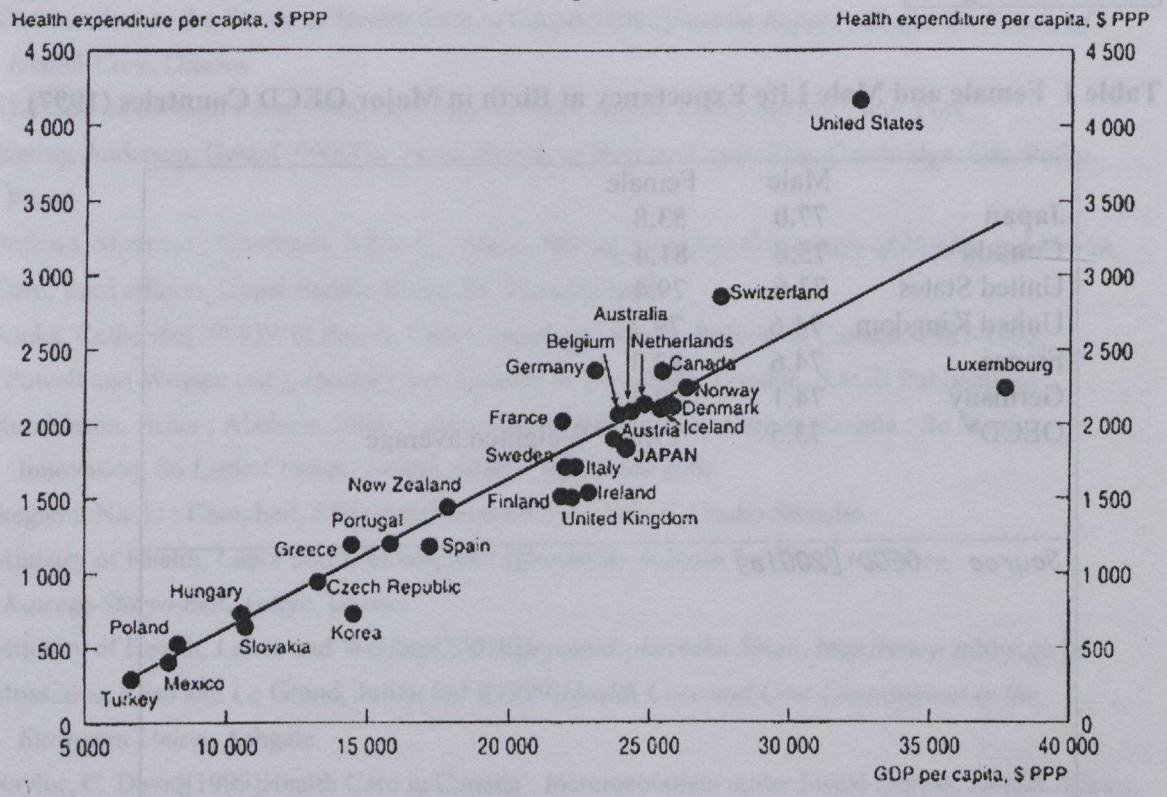
Table 2 Infant Mortality Rates in Major OECD Countries (The Number of Deaths per 1,000 Births, 1997)

Japan	**3.7**
Canada	**5.5**
United States	7.2
United Kingdom	5.9
France	4.7
Germany	4.8
OECD*	8.9

*Weighted average for 29 countries except for Korea

Source : OECD [2001a]

Figure.1 Health Expenditure and GDP per Capita (1998)



Note: The regression line is:
Health expenditure per capita = −353 + 0.0988 * GDP per capita
(−1.7) (10.1)

R squared = .786

Source: OECD.

Table 3 Number of Total Inpatient Beds per 1,000 Population in Major OECD Countries (1998)

Japan	**16.5 (9.0 in 1960)**
Canada	**4.1 (6.2 in 1960)**
United States	3.7
United Kingdom	4.2
France	8.5
Germany	9.3
OECD*	6.9

*Average for 25 Countries

Source : OECD [2001a]

Table 4 Trends in the Number of Total Inpatient Beds per 1,000 Population in Japan and Canada

	1960	1970	1980	1985	1990	1995	1998
Japan	**9.0**	**12.5**	**13.7**	**14.7**	**16.0**	**16.2**	**16.5**
Canada	**6.2**	**7.0**	**6.8**	**6.7**	**6.3**	**4.8**	**4.1**

Table 5 Number of Practicing Physicians and Nurses per 1,000 Population in Major OECD Countries (1998)

	Physicians	Nurses	
Japan	**1.9**	**7.8**	
Canada	**2.1**	**7.5**	
United States	2.7	8.3	
United Kingdom	1.7	5.0	
France	3.0	6.0*	*1997 Data
Germany	3.4	9.6	

Source : OECD [2001a]

Figure2 Hypothetical Coordinate Axis for Comparative Study of Health Care Systems

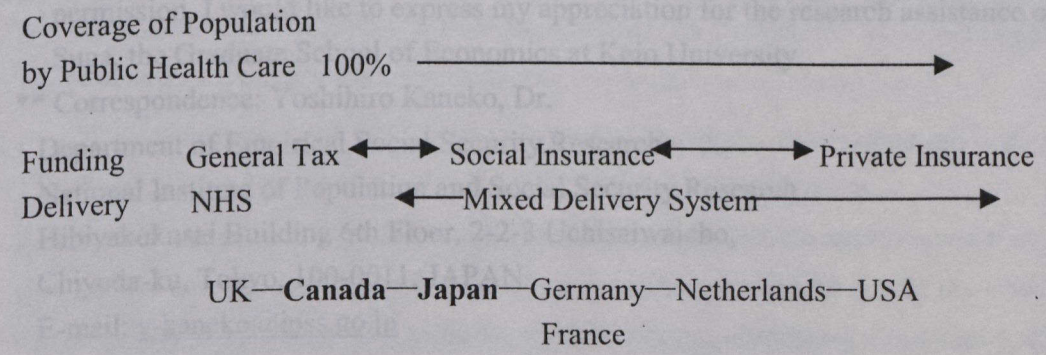


Table.6 The Growth of Nominal Health Spending (%)

	Average annual growth in excess of GDP				Percentage of GDP	
	1960-70	1970-80	1980-90	1990-97	1960	1997
Japan	5.0	4.1	−0.8	2.4	3.0	7.4
Canada	2.8	0.3	2.6	−0.4	5.4	9.0
United States	3.5	2.5	3.4	1.3	5.1	13.0
United Kingdom	1.5	2.6	0.6	1.8	4.0	6.7
France	3.9	3.0	1.8	1.3	4.1	9.4
Germany	2.2	3.8	−0.1	2.6	4.7	10.5
OECD Average	4.1	3.6	1.1	1.2	3.8	7.6

Source : OECD Health Data 2001

The Effects of Employment and Pension Policies on the Retirement Process of Elderly Persons in Japan: Looking for Policy Coordination within the Social Security System

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1. Introduction

The proportion of people aged over 65 years of the population as a whole has been rising more rapidly in Japan than in Western industrialized countries (See Table 1). To meet this challenge, the government passed the 1999 pension reform act in the Diet in March 2000. The main characteristics of this pension reform are that it provided for reducing pension benefits and alleviating the top pension insurance contribution rate for the purpose of achieving intergenerational equity in the public pension system. Because the Employees' Pension Insurance (EPI) is composed of an earnings-related portion and the Basic Pension, which is the same for all employees, self-employed and all other people, the pension benefits of EPI will be reduced in the following three ways: (1) The average pension benefits for fully insured persons is decreased by 5% by reducing the multiplier of the wage-related portion. (2) The age at which pension benefits will be paid to men (women) will be postponed from 60 to 65 years of age, in one-year steps every three years from 2013 (2018) to 2025 (2030). (3) The amount of Basic Pension provided to those aged over 65 years will be reduced by excluding the wage index and generally adjusting it in accordance with changes in the Consumption Price Index and real wages only when the difference between real wage change and real pension benefits is judged to be substantial.

Table 1 Ratio of the Population Age 65 and Older in Major Countries

Furthermore, the tax base for EPI contributions is extended to annual earned income (i.e. monthly salary plus bonus) in 2003 (in this year the contribution rate will be reduced from 17.35% to 13.58%, because the current tax base does not include bonus). Although 2000 Pension reform included these reductions of pension benefits and extended tax base of EPI, because of the advancement of aging in Japanese population that is described by Figure 1, the final pension contribution rates of the employees' pension insurance and the national pension insurance is estimated to be 24.8% and 29,600 yen a month respectively (the treasury load is kept to be a current level, that is 1/3 of the pension benefits). Without this pension reform, the top contribution rate of EPI would be more than 30%, 2000 Pension reform is now expected to contribute to achieving intergenerational equity in the social security system.

Figure 1 Trends in the number of the major age composition, 1950-2050: Medium Variant

But, as the pension age will be increased gradually from 60 to 65, it is necessary to encourage people aged between 60 and 64 years to participate in the labor force so that they can earn a living wage. For this purpose, the government introduced wage subsidies for workers aged between 60 and 64 years who are continuously employed by the same company or are re-employed by another company after the retirement age (age 60). The subsidies consist of "basic benefits for the extended

employment of the elderly' and 'benefits for the re-employment of the elderly.' From the viewpoint of income redistribution, these subsidies are paid to those employees whose wages from continuous work are 85% of their final monthly salary before the retirement age at their company (i.e., the salary at the age of 59).

The government expects that these benefits will increase the opportunities of aged workers to enter the labor force, because these subsidies will reduce the labor costs of companies that employ aged workers and provide an economic incentive to hire older workers. But, employment opportunities for these workers will depend on the overall economic condition of Japanese industries. During the recession following the collapse of the bubble economy in the late 1980s, the unemployment rate for male and female workers aged over 55 years increased faster than that of their younger counterparts (Table 2). Hence, we should investigate the effects of these subsidies on the demand for elderly workers, as well as on their participation in the labor force.

Table 2 Labor Force Participation (LFP) Rate, Share of Employees in the Labor Force, and Unemployment Rates by Age Group (%)

The labor participation of the elderly depends on economic factors and their individual attributes such as health status. Even when we control the effects of individual attributes, the eligibility for pension benefits or the expected value of lifetime pension benefits could induce the retirement of aged workers. Many empirical studies both in the United States and Japan support this view of the influence of pension benefits. The induced retirement effect of pension benefits seems to be stressed in the United States (Bosikin (1977), Venti and Wise (1985), Wise (1999) among others). But, many empirical studies in Japan found that the probability of retirement with respect to the amount of pension benefits is not so elastic that the induced retirement effect of pension benefit might be smaller than in other industrialized countries (Seike (1984), Takayama and Arita (1990), Ogawa (1998), Kaneko and Takahashi (1998), Oishi and Koshio (2000) and Iwamoto (2000)). Therefore, we can think that the Japanese elderly workers would not retire but would want to continue working if a job with labor conditions acceptable to them were offered. As a result, the labor force participation rate has been larger than in any other countries until recently (Figures 2-1 and 2-2.)

Figure 2-1. Labor Force Participation Rates for Men Aged 55-64 in 1998

Figure 2-2. Labor Force Participation Rates for Women Aged 55-64 in 1998

However, it is well known that inequality of income depends not only on the inheritance or wealth of the individuals but also on individual human capital. Because human capital is accumulated by human capital investment such as education and job training, even if they have the same educational attainment, individual income tends to be larger as working lives get longer. But, the

working life of the individual depends on individual choices of labor force participation and some stochastic aspects such as lay-offs caused by economic fluctuations, so inequalities in individual and household incomes tend to expand as an individual ages. Because individual consumption is related to household income proportionally according to the theory of consumption function, Jorgenson and Paxson (1998) first confirmed this by estimating variations of consumption classified by age group in the United States. In Japan, this was confirmed by Ohtake and Saito (1999) based on consumption data of "National Survey of Consumption and Savings" and by Ohtake and Saito (2000) and Iwamoto (2000) based on income data of "Income Redistribution Survey" and "Basic Survey of Household Living Conditions and Welfare." These results imply that the extended employment policy for elderly persons has a possibility of contributing to the expansion of income inequality induced by the aging of individuals. For the purpose of equity in income distribution, an income re-distribution policy should be designed to avoid this possibility.

Combining these facts of the 2000 pension reform, the employment policy for the elderly, and the current trend of income distribution, in order to achieve intergenerational equity and intragenerational equity in the social security system, the public pension system, the employment policy for the elderly, and the income re-distribution policy should be coordinated. Hence the purpose of this paper is two-fold. First, we provide the empirical evidence that supports the necessity for coordination within these components of the social security system, and we would like to discuss how to realize this coordination given the aging of Japanese Society.

2. The Decreasing Wage Rates of Aged Workers and the Level of Basic Benefits for Their Continuous Employment

One important function of the basic benefits for continuous employment is to maintain the income levels of aged workers because the wage profile tends to diminish as people age. The Japanese wage system is often referred to as a seniority wage system, under which salaries and positions rise with the length of service within a company. But, now that the economic growth has slowed, companies believe that middle-aged and older workers earn higher wages than younger workers who can adapt to the technological changes necessary for more efficient production. As a result, the wage profile of middle-aged and older workers becomes flatter and wage rates for their continuous employment tend to decrease during the final years of employment.

Hence, the basic benefits for the continuous employment of the elderly are designed to be paid to those people aged 60 to 64 years whose wages from continuous employment are under 85% of their final monthly salary at the age of 59 (See Figure 3). Because these benefits make take-home pay larger than the wage rate offered by the company, it plays an important role in maintaining the income level of the elderly who are ineligible to receive a pension until they are 65.

Figure 3. Basic Benefits for the Extended Employment of the Elderly

To calculate the average value of the basic benefits for continuous employment by sex, we must estimate the decreasing rate of wages earned by male and female workers in their early sixties. Using the "Basic Survey of Wage Structure" in 1994 and 1995, we can estimate the decreasing rate of the salaries of sixty workers aged between 60 and 64 years compared to those aged 59 years, the year before mandatory retirement. The reason why we use "Basic Survey of Wage Structure" in 1994 and 1995 is that Basic Benefits for the Extended Employment of the Elderly was introduced in 1995. We regressed the monthly salary by age group in 1994 to an age variable and the dummy variable for the mandatory retirement age to get the parameters for the wage profiles for male and female workers. According to the estimated parameters, we can obtain the estimated values of the monthly salary for male and female workers at the age of 59 in 1994. By comparing these values with monthly salaries of the 60 to 64-year-old group by length of service given by the "Basic Survey of Wage Structure" in 1995, we can then determine the decreasing rate of the monthly salary of the elderly who are continuously employed after the retirement age of 60. The outcomes are summarized in Table 3.

Table 3. Wage Rate (monthly salary) and the Decreasing Rate of Wages between Age 59 and Ages 60-64 years

According to Table 3, the shorter the length of service is of aged workers in a company, the higher the decreasing rate becomes. Especially for workers whose length of service is less than five years, the decreasing wage rate exceeds 15%. The ratio of workers whose wage rate is under 85% of the final wage rate at the age of 59 to the total number of workers aged between 60 and 64 years amounts to about 60% for males and 45% for females, respectively. The reason for the prevailing decrease in wage rates is that because many workers aged between 55 and 59 years are re-employed by the same company after mandatory retirement or by another company after a job search, their length of service is reduced to less than five years when they are continuously employed between the ages of 60 and 64 years.

Consequently, there is considerable room for applying the basic benefits for the extended employment of the elderly. In fact, the average decreasing rates of wages of male and female workers aged between 60 and 64 years over that of those aged 59 amounts to 21.9% and 20.9%, respectively. By applying these decreasing rates of male and female wages to the schedule for "basic benefits for extended employment" proposed by the Ministry of Labor, we can obtain the monthly amount of the benefits for male and female workers; that is, \18,048 and \9,534 respectively. The increasing rate of take-home pay by these amounts over wage rates offered by the company becomes 6.8% and 5.7%, respectively. In the next section, we consider the effects of these benefits on the labor demand for workers aged between 60 and 64 years.

3. The Effects of Basic Benefits for Extended Employment of the Elderly on Labor Demand

To estimate the wage elasticity of labor demand for aged workers, we used an estimation of the Trance Log production function of the Japanese manufacturing industry with three production factors: labor of workers aged over 55 years, labor of workers younger than 54, and real capital stock. The functional form of this production function is expressed as follows:

$$(1)\ y_s = a_s + \Sigma_{i=1}^{4} a_{si} \ln q_{si} + (1/2)\Sigma_{i=1}^{4}\Sigma_{j=1}^{4} b_{sij} \ln q_i \ln q_j + \Sigma_{i=1}^{4} b_{si\,t} \ln q_{si}t,$$

where y is the output of each firm measured by the annual amount of value added, q1 is number of workers younger than 54 years of age, q2 is number of workers aged between 55 and 59 years, q3 is number of workers older than 60, q4 is the amount of capital stock of each firm, t denotes time trend and s indicates the firm scale (1: workers less than 30, 2:30～99 workers, 3:100～299, 4:300～999, 5:1000+).

But, for the convenience of estimation, we estimated the production factor share functions that are derived by Eq.(1):

$$\begin{aligned} s_{54} &= a_1 + b_{11}*\ln q_1 + b_{12}*\ln q_2 + b_{13}*\ln q_3 + b_{14}*\ln q_4 + b_{1t}*t + u_t, \\ (2)\quad s_{55} &= a_2 + b_{12}*\ln q_1 + b_{22}*\ln q_2 + b_{23}*\ln q_3 + b_{24}*\ln q_4 + b_{2t}*t + u_t, \\ s_{60} &= a_3 + b_{13}*\ln q_1 + b_{23}*\ln q_2 + b_{33}*\ln q_3 + b_{34}*\ln q_4 + b_{3t}*t + u_t, \end{aligned}$$

where we have the following notations: s54: the share of total wage of workers younger than 54 years of age to the annual amount of value added for each firm, s55: the share of total wage of workers aged between 55 and 60 years to the annual amount of value added for each firm, s60: the share of total wage of workers older than 60 years of age to the annual amount of value added for each firm and u_{st}: the disturbance term. Each share of total wage of workers classified by age group is given by $s_i = w_i*q_i /y$, where w_i is average amount of monthly salary and wages for age group i (i=1; age group younger than 54 years of age, i=2: age group aged between 55 and 59 years, i=3: age group older than 60 years of age).

The data we use here are a set of pooled cross-section data for these three variables among 47 prefectures in 1984, 1988 and 1992. We obtained the number of workers classified by age group by multiplying the share of each age group to the total workers reported in 'the Survey of Working Status and Conditions of the Elderly Persons' on the number of workers reported in 'the Basic Statistics of Manufacturing Industry' for each prefecture in 1984, 1988 and 1992 respectively. The capital stock was obtained by calculating the average capital stock of the manufacturing industry in each prefecture

based on 'the Basic Statistics of Manufacturing Industry'' in 1984, 1988, and 1992 respectively. Because we used this kind of pooled cross-section data, we adopted the Generalized Method of Moment Estimator (GMM) for estimating Eq.(2) to deal with the heteroscedasticity of disturbance terms. The estimation results of this production function classified by firm size are summarized from Table 4-1 to Table 4-4.

Table 4-1 Estimation Result of Trance Log Production Function of the Japanese Manufacturing Industry (Firm size: number of workers is larger than 1000)

Table 4-2 Estimation Result of Trance Log Production Function of the Japanese Manufacturing Industry (Firm size: number of workers is between 300 and 999)

Table 4-3 Estimation Result of Trance Log Production Function of the Japanese Manufacturing Industry (Firm size: number of workers is between 100 and 299)

Table 4-4 Estimation Result of Trance Log Production Function of the Japanese Manufacturing Industry (Firm size: number of workers is between 30 and 99)

Using the estimated parameters in Eq.(2) and the average wage rate (monthly salary) for workers classified by age group, we can calculate the wage elasticity of labor demands for aged workers. Table 5 shows the own price elasticity of labor demand and of the demand for capital stock. According to Table 5, the wage elasticity of labor demand for elderly workers is largest for middle-scale firms with between 300 and 999 workers among all scales of firm. Its value is -0.975 and it is not elastic. But, this outcome implies that if 'the basic benefit for the extended employment' enables a firm to decrease the wage rate for elderly workers aged between 60 and 64 years by 5% or by 10% with take home pay kept constant, then labor demand would increase by 4.86% or 9.75%, respectively. If a firm with between 100 and 299 workers that has the second largest wage elasticity for elderly person's labor demand can decrease the wage rate by 5% or by 10% using this benefit, its labor demand for elderly workers increases by 4.74% or 9.49%, respectively.

Table 5 Own Price Elasticity of Demand for Production Factors

Because the share of elderly workers among the total number of the workers tends to be larger in middle-scale firms than in large-scale firms, which have a smaller wage elasticity, these results suggest that the set of decreased wage rate and 'the basic benefit for extended employment' with take-home pay for elderly workers kept constant could induce almost a proportional increase in the labor demand for workers aged between 60 and 64 years.

4. Effects of Basic Benefits for Extended Employment and Pension Benefits on Labor Supply of Elderly Persons

To estimate the wage elasticity of labor supply, we regressed the labor force participation rate of elderly workers for economic variables such as wage rate and employee pension benefits, as well as their individual attributes. Because the choice of labor force participation of elderly persons depends on the relationship between his/her reservation wage and amount of pension benefits, we have to take into account both of the sample selection bias of the wage rate in the labor market and of the endogenous relations among labor force participation rates, wage rates, and working hours. Hence, we use Heckman's two-stage estimation method here.

We can regard the market wage rate for the I-th individual, W_i (i=1,2,$\cdots$n), and a reservation wage rate, Wr_i (i=n+1,$\cdots$N), as a linear function of explanatory variables Xm_j and Xr_j (j=1,2,$\cdots$J), respectively. W and Wr are then specified as follows:

$$(2)\ W_i = \Sigma_{j=1}^{J} a_j Xm_{ij} + u_{1i}, \quad (i=1,2,\cdots n)$$

$$(3)\ Wr_i = \Sigma_{j=1}^{J} a_j Xr_{ij} + u_{2i}, \quad (i=n+1,..N)$$

where u_{1i} and u_{2i} are disturbance terms with a standard normal distribution. Then, we estimate a probit model of the labor force participation rate by maximizing the following likelihood function:

$$(4)\ L = \Pi_{i=1}^{N} \ln Pr\,(W_i > Wr_i\,)\ \Pi_{i=n+1}^{N} \ln Pr(\, W_i < Wr_i\,).$$

From this we can obtain the reciprocal of Mill's ratio, which is the λ variable. Adding this ratio to a wage rate function, we can correct for sample selection bias in the estimation of this function. Hence, the wage rate function we should estimate becomes:

$$(5)\ \log(W) = \Sigma_{j=1}^{J} b^j Xw_{ij} + \lambda_i + u_{3i},$$

where W is an observed wage rate in our sample, b_j is a set of parameters, Xw_{ij} is the j th explanatory variable of this wage function, λ_i is the reciprocal of Mill's ratio for the I-th individual, and u3i is a disturbance term with standard normal distribution. Finally, the estimated value of the wage rate from Eq.(5) is used to make a second stage for estimating the labor force participation rate function.

On the other hand, the working hours function is specified as follows:

$$(6)\ H = \Sigma_{j=1}^{J} h_j Xh_{ij} + W + u_{4i},$$

where H is observed working hours, h_j is the j th parameter, Xh_{ij} is the j th explanatory variable of a working hours function, and u_{4i} is a disturbance term with standard normal distribution. Because the expected mean of the disturbance term is zero with the reciprocal of Mill' s ratio added to Eq. (5), we can estimate Eqs. (5) and (6) using the conventional least-squares method.

The dependent variable in the labor force participation function is a choice variable: it is one if the observed sample indicates working status, otherwise it is zero. The explanatory variables of the labor force participation rate function are composed of economic variables and individual attributes. We select the following variables as economic variables: employees' pension insurance benefits (if the worker does not receive it, it is zero), corporate pension benefits and individual pension benefits, the dummy variables concerning the labor conditions of elderly persons, the dummy variable for the experience of mandatory retirement (it is one if he has experienced mandatory retirement, otherwise it is zero). In addition, the dummy variable of the individual attributes are the following: age, a dummy variable of health status (it is one if he is healthy, otherwise it is zero), the number of household members, and a dummy variable of his place of residence (it is one if he lives in the Tokyo metropolitan area, otherwise it is zero).

The dependent variable of a wage rate function is an observed wage rate – the monthly wage divided by the monthly working hours. We use the following variables as explanatory variables for the wage rate function: age, a dummy variable for health status, a dummy variable for the experience of mandatory retirement, a dummy variable for extended employment for an older person, the number of job changes, and a dummy variable for place of residence. Because wage rates increase as the number of years worked in one firm increases, job changes lead to a decline in wage rate. To see such effects, we include the number of job changes in the wage rate function. The reason we use a dummy variable of extended employment is that there is a tendency for wage rates to decrease after an elderly worker accepts an extension of pre-retirement employment after reaching 60 years of age (see Kaneko (1998)).

The estimation result of a labor force participation rate function in which the wage rate takes an estimated value from Eq.(5) is presented in Table 6-1 and Table 6-2. According to the estimation result of the labor force participation rate function, the variables of employees' pension insurance benefits, corporate pension benefits, age, and experience of mandatory retirement has a negative sign respectively. In contrast, his/her health status, extended employment, and the place of his residence carry positive signs. The negative sign attached to pension benefits is consistent with the earlier estimation results of this variable in labor force participation functions in Japan (Tachibanaki and Shimono, 1984; Takayama, 1992; Seike, 1994; Kaneko and Kanamaru, 1997; Ogawa, 1998, among others).

Table 6-1 Estimation Result of Labor Force Participation Rate Function Based on Pooled Data (1988, 1992, 1996)

Table 6-2 Estimation Result of Labor Force Participation Rate Function in 1996

Using the estimated parameters in Eqs. (2) for males and females with the average monthly salary at the age of 60 years in 1995, the wage elasticity of the male and female labor supply with respect to the wage rate (monthly salary) is calculated as 0.114 and 0.117, respectively. This outcome implies that the male and female labor supply is inelastic with respect to wage rates.

Using the estimation results of this function, we can obtain the elasticity of retirement probability with regard to employees' pension insurance benefits and with respect to corporate and individual pension benefits. The former elasticity for males and females is -0.0307 and -0.0539, respectively, while the latter elasticity is -0.02483 and -0.02695, respectively (these elasticity values are evaluated for the average values of corresponding pension benefits). The minus sign indicates that the increase in these benefits decreases the labor force participation rate of middle-aged and older men. But, the magnitude of the elasticity of the labor force participation rate with respect to corporate pension benefits is much smaller than that with respect to employee pension insurance. This implies that a set of pension reforms composed of reducing future employee pension insurance benefits and increasing corporate pension benefits based on expanding pension portability would not cause a large decrease in the labor force participation rate of these workers. Furthermore, because the estimated parameter of the experience of mandatory retirement takes relatively large negative values among these explanatory variables, there is room for improving the labor force participation rate by coordinating extended employment policy and pension reform which are planned to reduce public pension benefits and to expand corporate pension schemes.

5. Expansion of Inequality of Income Distribution Induced by the Aging of Japanese Society

It is true that public redistributed income functions as a safety net to decrease inequalities among the total earnings of households, as we can see from the fact that the provision of the pension benefit supplements either the loss of or the decrease in labor income and self-employment income caused by retirement. From Table 7, we can compare the Gini coefficient of total earnings with that of public redistributed income. These two Gini coefficients were 0.37897 and 0.36406 in 1981 and 0.34448, 0.31654 in 1993, respectively. The Gini coefficient of public redistributed income has a lower value than the Gini coefficient of total earnings, although both of the Gini coefficients increased from 1981 in 1993. It is understood that the income distribution was equalized by public income re-distribution.

Table 7 Income Redistribution Effect (Gini coefficients)

However, public income re-distribution is achieved by taxation such as a progressive income tax and by social security. Social security comprises two kinds of income transfer: one is social insurance such as public pensions and unemployment insurance that are financed by social insurance contributions. The other is social assistance such as public assistance and child allowance that are financed by tax revenues. Hence it is necessary for us to decompose the factors of the Gini coefficient to examine the factors expanding inequalities of household income in detail. The method of decomposing the Gini coefficient that we use here is that provided by Lerman and Yitzhaki (1985, 1989, 1994). They pointed out that as the Gini coefficient could be expressed using the covariance of household income, this expression of the Gini coefficient becomes the weighted average of the covariance of each income source, if household income is composed of k income sources. Thus, we can obtain the following decomposition of the Gini coefficient for household income that accrues from k income sources.

(5)

$$GINI = \Sigma_{k=1}^{K} [cov(y_k,F(y))/cov(y_k,F(y_k))]*[2covcov(y_k,F(y_k))/m_k] [m_k/m],$$

$$= \Sigma_{k=1}^{K} R_k G_k S_k,$$

where y_k is a k-th income source of household income, $cov(y_k,F(y_k))$ is a covariance between the cumulative frequency of k-th income source and the amount of k-th income, $S_k = m_k/m$ is the ratio of k-th income source to the average household income, $R_k = cov(y_k,F(y))/cov(y_k,F(y_k))$ is the correlation coefficient between the amount of k-th income source and household income, and $G_k = 2cov * cov(y_k,F(y_k))/m_k$ is a relative Gini coefficient concerning the income distribution in the k-th income source. Moreover, the contribution level of the income distribution in k income source to household income's Gini coefficient is expressed by:

(6) $I_k = R_k G_k S_k / GINI.$

Following this method provided by Lerman and Yitzhaki (1985,1989,1994), we calculated the change in each component of decomposed Gini coefficient of public redistributed income from 1981 and 1993 (See Table 8). The reason why public redistributed income increases from 1981 in 1993, as well as household income, is that the percentage of total earnings to public re-distributed income is the largest income component of its Gini coefficient. Because the relative Gini coefficient of taxes is negative, taxes have the function of reducing inequalities in household income distribution.

Table 8. Factor Decomposition of the Gini Coefficient for Public Redistributed Income (All households, all age groups)

It can be judged whether the pension system contributes to income re-distribution by comparing the two relative Gini coefficients of pension benefit and social insurance contributions. There is a factor creating inequalities of income in public pension system because there is an earnings-related portion of the employee welfare pension. The amount of the benefit of the earnings-related portion in EPI depends on the gross wages and salaries the recipient earned before retirement and this leads to some inequality of income after retirement. Hence, the relative Gini coefficient of pension benefits takes a positive value. On the other hand, because social insurance contributions are levied on working generations who have earned income and are not levied on that pension recipients whose earned income is zero after retirement, the social insurance contribution plays a role in reducing inequalities of household income. Consequently, the relative Gini coefficient of public insurance contributions takes a negative value. According to Table 8, the net relative Gini coefficient calculated by subtracting the relative Gini coefficient of social insurance contributions from the relative Gini coefficient of pension benefit was 0.08790 (=0.41033-0.32243) in 1981 and 0.02520 (0.38742-0.36222) in 1993, respectively. The public pension system is expected to transfer income from working generations who have earned income to elderly persons who have retired and have relatively small incomes. But, the positive values of the net relative Gini coefficient imply that the public pension system does not play a satisfactory role in income redistribution because the public pension system in Japan has an earnings-related portion.

However, the supply of medical treatment (I4 and I5 in Table 8) has exerted a bigger influence as a factor of expanded inequality of public redistributed income since 1981. The reason for this is that the relative Gini coefficient of medical treatment is the biggest component of public redistributed income and its correlation coefficient with the distribution of public redistributed income is the largest after total earnings. The background to such a result seems to lie in the current health insurance and the health system for the elderly. Under the current systems, the co-payment is a fixed amount and its amount is very small compared to actual medical expenditure for a patient's medical treatment. Furthermore, the amount of co-payment is the same for rich and poor people.

The contribution of other social security transfers including public assistance and childcare allowance became negative in 1993 after being positive. This change implies that other social security transfers now have the effect of reducing inequalities of total earnings (R6 in Table 8). However, the magnitude of this effect is relatively small because the size of the contribution to the relative Gini coefficient of other social security transfers to public redistributed income is very small compared to taxes and social insurance contributions.

The result that the Gini coefficient of public redistributed income is smaller than that of household income (total earnings) implies that public redistribution through social security benefits financed by taxes and social insurance plays an important role in reducing income inequality among Japanese households. However, the pension benefits schemes and co-payment of medical treatment that is independent of actual medical costs, and patients income distribution have influences in expanding inequalities of public redistributed income. If we want to maintain public pensions and health insurance as a social insurance system, we have to give these two systems some re-distributional effect. Without a re-distributional effect, there would be no need to run these two systems as a social insurance, because to improve economic efficiency, the pension system and health care supply should be managed by a funded system like an individual account.

To investigate how such a problem is related to the expansion of inequalities brought about by aging, we made a decomposition of the factors of public redistributed income (See Table 9).

Table 9 Decomposition of the Factors of the Gini Coefficient for Public Redistributed Income Classified by Age Group

The contribution of total earnings to the Gini coefficient of public redistributed income shows how large increases are during working life and peaks by 50-59-year-old age group. However, this contribution begins to decrease in the 60-69-year-old age group, and the contribution decreases further in the age group of 70 years or more. Therefore, the inequality in public redistributed income does not expand by aging of household head so long as total earnings expands as householder's age rises.

The contribution of taxes is negative and this implies that taxes have the effect of reducing inequalities in total earnings. The absolute value of the contribution of taxes rises as householder's age increases because progressive tax rates are applied to wages and salaries that tends to rise below the age of 59 because we have a set of the long service pay and the wage profile (Ishikawa (1985)). However, the contribution of taxes decreases greatly among those in the age groups of 60 years old or more because the ratio of people who lose labor income due to retirement may increase. On the other hand, the contribution of social insurance contributions is negative and its absolute value is within a constant range instead being tied to the aging of householders. The reason for the latter is that the social insurance contributions are not as progressive as individual income tax, but are proportional. The contributions of pension benefits and medical treatment supply financed by government subsidy and health insurance increases greatly in the 60-69-year age group when the provision of a public pension and the application of the elderly person health system start. These contributions rise further by the age group of 70 years or more.

Furthermore, inequalities in individual and household incomes tend to expand as an individual ages, because of stochastic aspects of the distribution of human capital and economic fluctuations during a working life. After Jorgenson and Paxson (1998), in Japan, Ohtake and Saito (1999) found

out this fact by based on consumption data of "National Survey of Consumption and Savings". Furthemore, Ohtake and Saito (2000) and Iwamoto (2000) confirmed this fact by using household and individual income data of "Income Redistribution Survey" and "Basic Survey of Household Living Conditions and Welfare" respectively. Hence the Gini coefficient of public redistributed income rises as an individual ages, because this influences total earnings, one of the components of decomposition of the Gini coefficient.

When we consider this fact and that social security benefits tend to increase as an individual ages, being independent of household income, we can point out that the extended employment policy for elderly persons has the possibility of inducing some expansion of income inequality. To achieve intragenerational equity of income distribution, some income re-distribution policy should be designed to avoid this possibility.

6. Concluding Remarks

According to the estimation results of a trance log production function for the Japanese manufacturing industry and of the labor force participation rate function of elderly persons, the wage elasticity of labor demand for aged employees is not as inelastic as that of labor supply (work force participation). In particular, the elasticity of labor demand for elderly persons for small firm and for middle-scale firm is approximately one, which implies that one percentage decrease in wage rate brings about the same proportional increase in labor demand.

Because the basic benefits for continuous employment for the elderly are designed to increase take-home pay when the wage rate offered by a company for continuous work is less than 85% of the final monthly salary, this subsidy enables the company to reduce the wage rate without providing work incentives for aged employees. Under the severe economic constraints imposed by the recession following the bubble economy, companies are being urged to reduce labor costs, while they have to cope with controlling dismissals and maintaining the employment of aged workers under the Law on the Stabilization of Employment of Older People. Hence, 'the basic benefit for extended employment' plays an important role in increasing labor demand for workers aged between 60 and 64 years, because it enables a company to decrease the wage rate with take home pay being supplemented by this benefit. In addition, although the wage elasticity of labor demand of small and middle-scale companies is approximately one, while the wage elasticity of large-scale companies is smaller than one, the share of elderly workers to the total number of workers of middle-scale firms tends to be larger than that for large-scale firms. These results suggest that an employment policy that allows an opportunity for firms to decrease wage rates and provides 'the basic benefit for extended employment' could induce almost a proportional increase in labor demand for workers aged between 60 and 64 years.

On the other hand, according to the estimation result of the labor force participation rate function of elderly persons, the wage elasticity of the labor supply of elderly persons and their elasticity of labor supply with respect to public pension benefits and corporate and individual pension

benefits are inelastic. Hence, we can think that 'the basic benefit for extended employment' does not have as large effect on the labor supply of elderly persons than on the labor demand. Furthermore, while recent pension reforms that are planned to counterbalance the decrease in public pension benefits provided by the 2000 Pension reform by making much more use of corporate pension schemes such as new defined benefits and defined contribution schemes, the fact that the elasticity of the labor supply with respect to pension benefits is inelastic implies that these pension reforms could not bring about any substantial decrease in the labor supply of elderly persons. This would be useful for coordinating employment policy and pension reform.

However, the current social security system has a benefit structure that tends to expand inequalities in income distribution. In addition, the variation of income distribution becomes larger as the individual ages, because of stochastic aspects of human capital distribution and economic fluctuations. These facts imply that the aging of Japanese society would inevitably lead to an expansion of income inequalities without any appropriate income re-distribution policy being adopted. Extended employment of elderly persons might be good for their income security, but it also brings about the possibility of expanding income inequalities through the effect of aging on income distribution. Hence, to cope with the aging of Japanese society, it would be better for us to pay attention to interactions among pension reforms, employment policy for elderly persons, and income re-distribution policy, so that we can coordinate intergenerational equity and intragenerational equity in the social security system.

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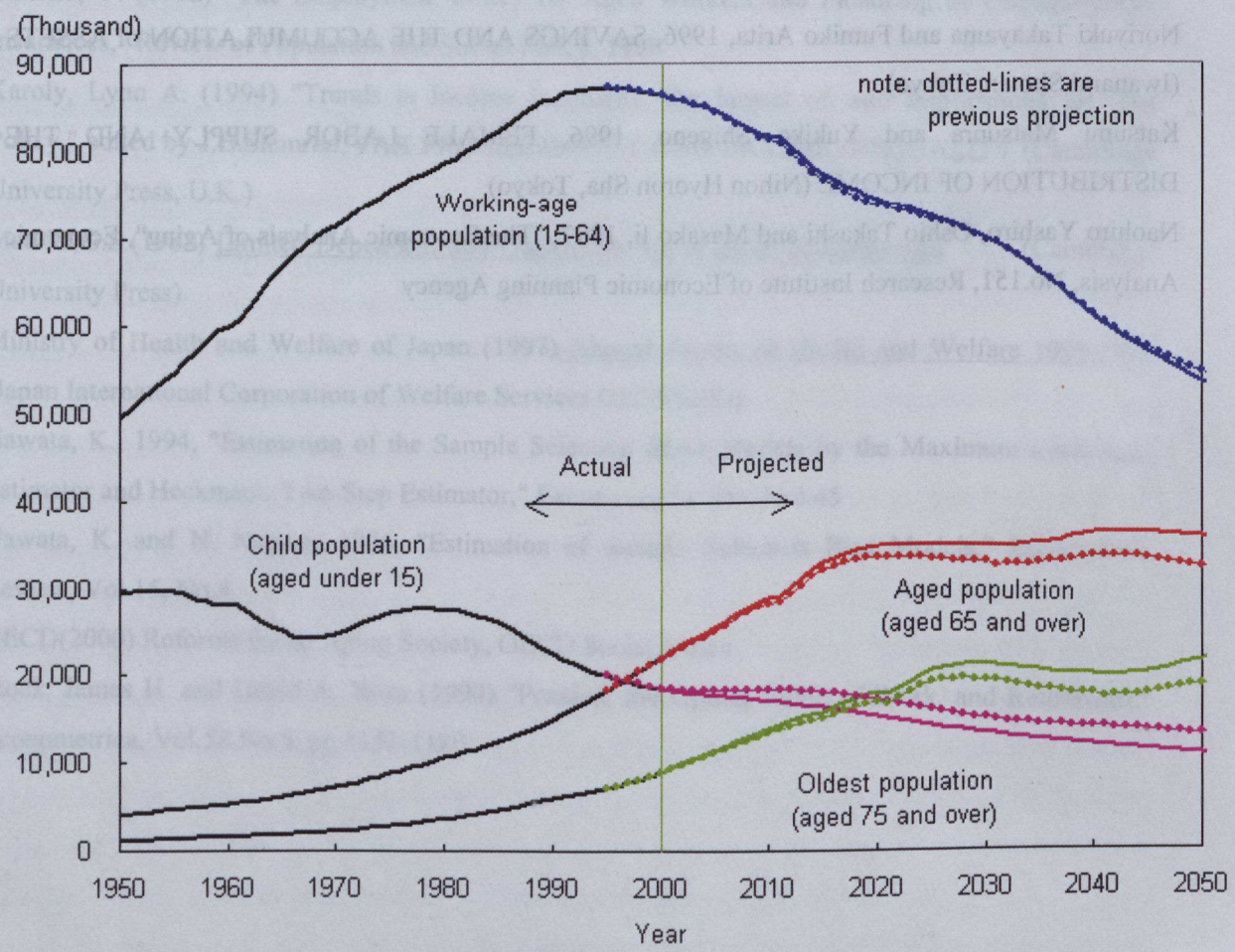
Table 1 Ratio of the Population Age 65 and Older in Major Countries

	Japan	U.S.	U.K.	Germany	France	Sweden
1950	4.9	8.3	10.7	9.7	11.4	10.3
1960	5.7	9.2	11.7	11.5	11.6	12.0
1970	7.1	9.8	12.9	13.7	12.9	13.7
1980	9.1	11.2	15.1	15.6	14.0	16.3
1990	12.0	12.4	15.7	15.0	14.0	17.8
1995	14.5	12.6	15.8	15.2	15.2	17.3
2000	17.2	12.4	15.8	15.9	16.2	16.7
2010	22.0	13.0	16.5	18.8	17.0	18.0
2020	26.9	16.3	19.1	20.0	20.8	21.0
2025	27.4	18.3	20.3	21.8	22.5	21.6
2030	28.0	20.0	21.9	24.9	23.9	22.4
2040	31.0	20.8	23.6	28.6	26.0	23.9
2050	32.3	21.2	23.2	29.2	26.4	23.2

Sources: For Japan, Statistics Bureau, Management and Coordination Agency, "National Census" for the years up to 1995, and National Institute of Population and Social Security Research, "Population Projections for Japan (estimated Jan. 1997)" for 2000 and thereafter. For other countries, United Nations, "World Population Prospects: The 1996 Revision"

Figure 1 Trends in the number of the major age composition, 1950-2050: Medium Variant



Source: Population Projection for Japan:2001-2050 (Jan 2002; National Institute of Population and Social Security Research) http://www.ipss.go.jp/English/ppfj02/f_3_e.html

Table 2 Labor Force Participation (LFP) Rate, Share of Employees in the Labor Force, and Unemployment Rates by Age Group(%)

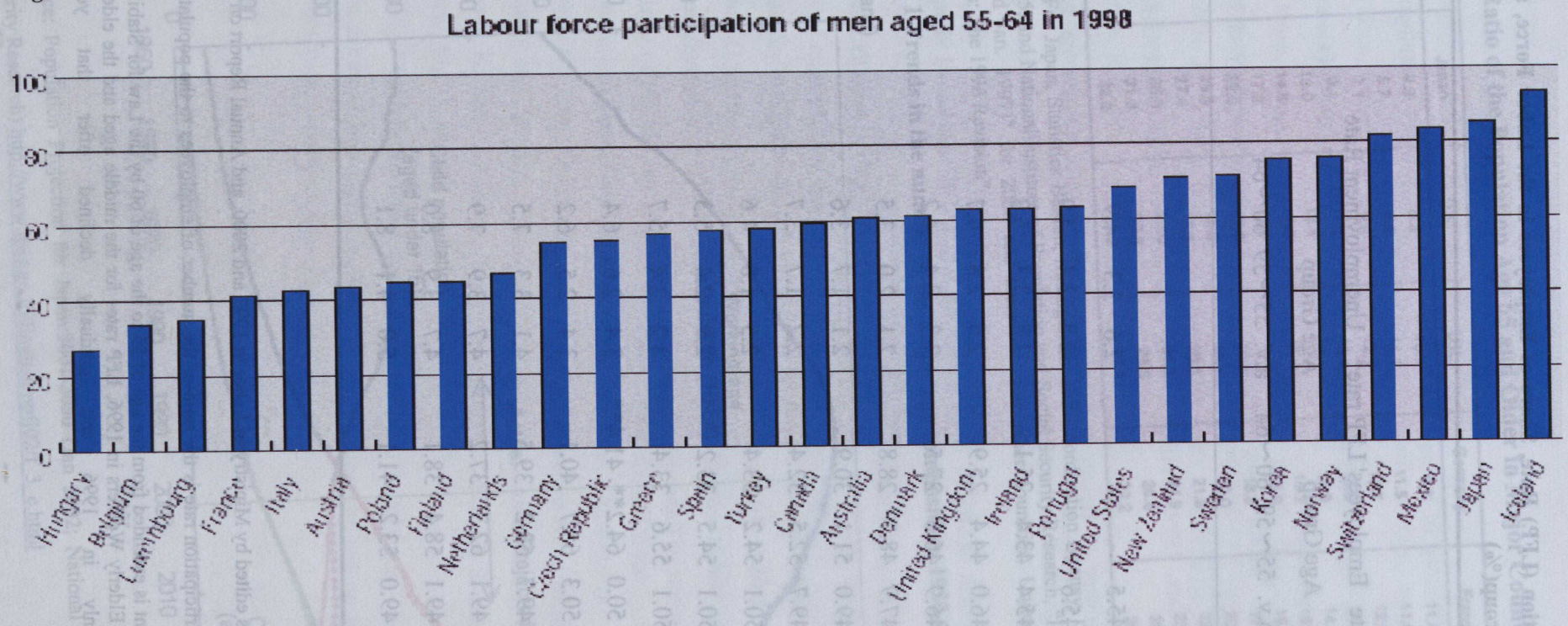
	Labor Force Participation Rate			Employees' LFP rate*			Unemployment Rate		
		Age Group			Age Group			Age Group	
Year	a.v.	55~59	60~64	a.v.	55~59	60~64	a.v.	55~59	60~64
1985	63.0	70.0	53.7	45.5	-	-	2.6	3.3	4.9
1986	62.8	69.7	53.8	45.6	-	-	2.8	3.4	4.9
1987	62.6	70.5	53.8	45.4	43.4	25.1	2.8	3.3	5.3
1988	62.6	70.7	53.8	46.0	44.4	25.9	2.5	2.8	4.7
1989	62.9	71.6	54.6	46.9	46.6	27.5	2.3	2.4	4.2
1990	63.3	72.7	55.5	47.9	48.7	28.8	2.1	2.0	3.5
1991	63.8	74.0	56.8	49.0	51.1	30.9	2.1	1.7	3.6
1992	64.0	74.2	57.2	49.7	52.5	32.4	2.2	1.7	3.7
1993	63.8	74.9	57.1	50.1	54.2	33.4	2.5	1.8	4.6
1994	63.6	74.8	56.6	50.1	54.5	33.2	2.9	2.4	5.3
1995	63.4	75.2	56.7	50.1	55.6	33.4	3.2	2.4	5.7
1996	63.5	75.9	56.2	50.0	64.2**	41.4**	3.4	2.6	6.4
1997	63.7	76.4	56.6	50.3	65.7	40.1	3.4	2.5	6.2
1998	63.3	76.4	56.9	49.7	63.2	39.5	4.1	3.3	7.5
1999	62.9	76.3	56.3	49.1	62.3	37.2	4.7	3.9	7.9
2000	62.4	76.1	55.5	49.1	58.4	38.1	4.7	3.9	8.0
2001	62.0	75.8	55.1	49.0	53.2	41.1	5.0	4.1	8.1

Source: White Paper on Labor Markets edited by Ministry of Labor in 1997 and 2000, and Annual Report on the Labour Force Survey 2001.

Note*: The employees' labor force participation rate is the ratio of the number of employees to the population classified by age group.

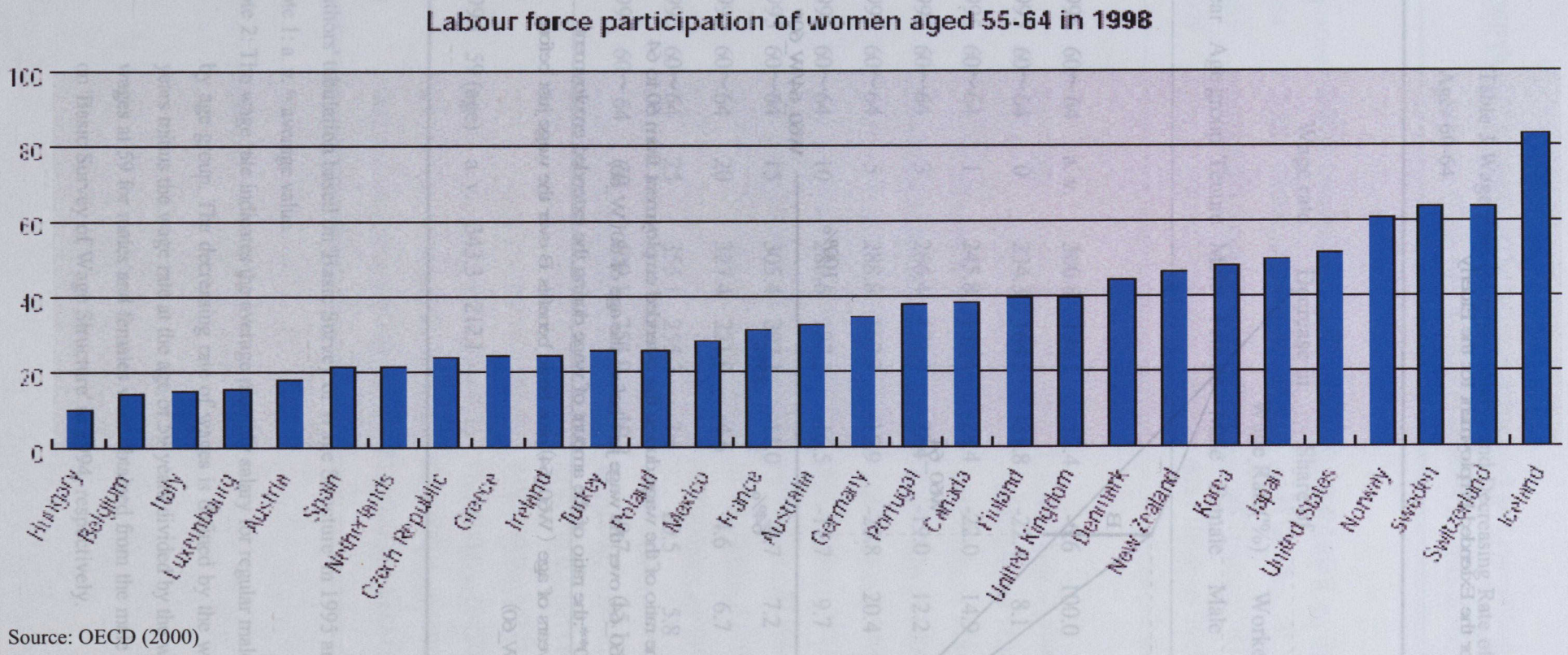
Note**: Since the mandatory retirement is extended from the age of 55 to the age of 60 by the Law for Stability of the Employment of the Elderly Workers in 1996, LFP rates for the middle aged and the elderly workers raised suddenly in 1996 and gradually declined after that year.

Figure 2-1



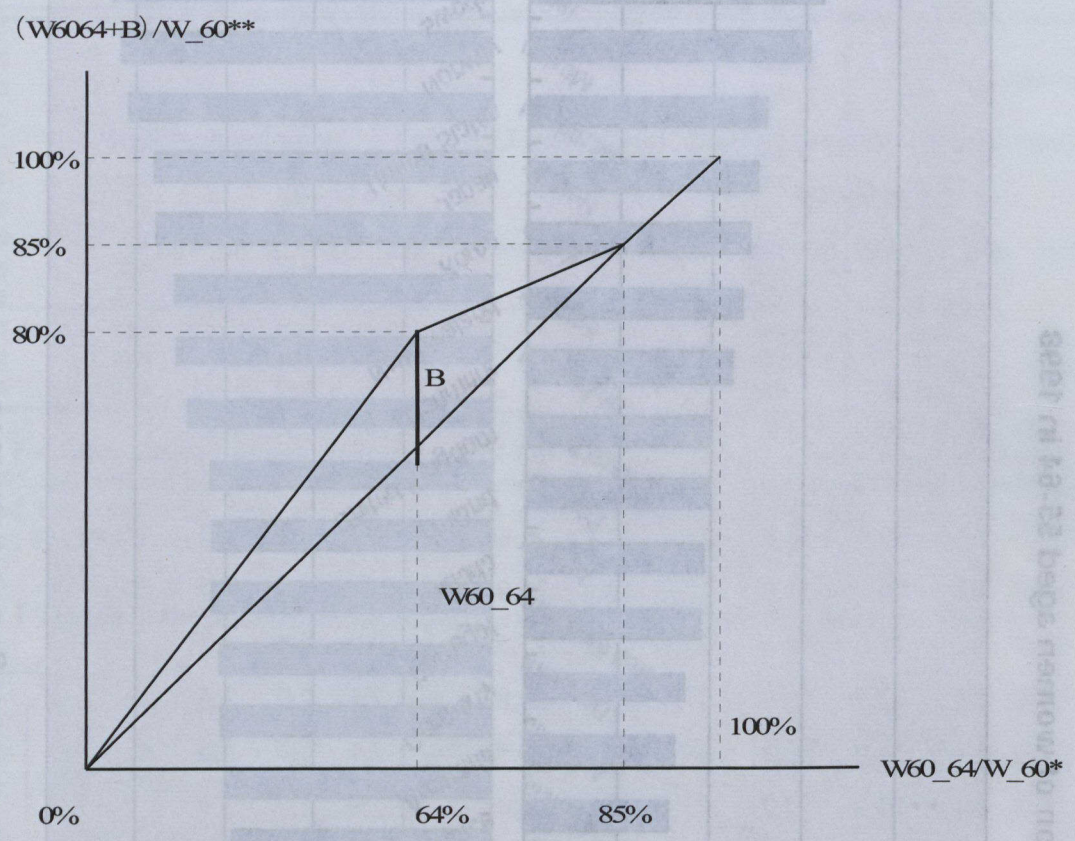
Source: OECD (2000)

Figure 2-2



Source: OECD (2000)

Figure 3 Basic Benefits for the Extended Employment for the Elderly



Note * W60_64/W_60: the ratio of the wage during the extended employment from 60 to 64 years of age (W60_64) over the wage just before the age of 60(W_60)

Note* (W6064+B) /W_60**:the ratio of the amount of wage during the extended employment from 60 to 64 years of age (W60_64) plus basic benefits B over the wage just before the age of 60(W_60)

Table 3 Wage Rate (Monthly Salary) and Decreasing Rate of Wages between Age 59 and Ages 60-64

			Wage rate		Decrease in Wage Rate(%)		Share of Workers(%)	
Year	Age group	Tenure	Male	Female	Male	Female	Male	Female
1995	60～64	a. v.	300.8	198.1	-12.4	-6.6	100.0	100.0
1995	60～64	0	234.3	164.5	-31.8	-22.4	8.1	4.6
1995	60～64	1	245.8	165.4	-28.4	-22.0	14.9	9.8
1995	60～64	3	266.4	171.9	-22.4	-19.0	12.2	8.8
1995	60～64	5	288.8	167.9	-15.9	-20.8	20.4	19.9
1995	60～64	10	286.6	187.3	-16.5	-11.7	9.7	17.9
1995	60～64	15	305.4	202.1	-11.0	-4.7	7.2	14.5
1995	60～64	20	327.4	221.9	-4.6	4.6	6.7	11.0
1995	60～64	25	355.1	255.7	3.4	20.5	5.8	7.3
1995	60～64	30	409.1	253.9	19.2	19.7	15.1	6.2
1994	59 (age)	a. v.	343.3	212.1				

Authors' tabulation based on 'Basic Survey of Wage Structure' in 1995 and 1994.

Note 1: a. v. = average value.

Note 2: The wage rate indicates the average monthly salary for regular male and female workers classified by age group. The decreasing rate of wages is defined by the wage rate of those aged 60 - 64 years minus the wage rate at the age of 59 years divided by the wage at the age of 59 years. The wages at 59 for males and females were obtained from the male and female wage profile based on 'Basic Survey of Wage Structure' in 1994, respectively.

Table 4-1 Estimation Result of Trance Log Production Function of the Japanese Manufacturing Industry (Firm size: number of workers is larger than 1000)

Equation	SSE	MSE	Root MSE	R-Square	Adj R-Sq	Durbin Watson
S54	5.89270	0.06138	0.24775	0.0299	-0.0105	1.829
S55	0.01449	0.0001509	0.01229	0.2572	0.2263	1.757
S60	0.0002544	2.64959E-6	0.0016278	0.0285	-0.0120	1.804

Parameter	Estimate	Std Err	'T'Ratio	Prob>|T|
A1	1.384057	0.50372	2.75	0.0072
A2	0.160824	0.03310	4.86	0.0001
A3	0.00690245	0.0052297	1.32	0.1900
B11	-0.00454704	0.06955	-0.07	0.9480
B22	0.013525	0.0019086	7.09	0.0001
B33	0.000049258	0.00001849	2.66	0.0091
B12	-0.020119	0.0052818	-3.81	0.0002
B13	0.00070896	0.0007264	0.98	0.3315
B14	-0.063316	0.03017	-2.10	0.0385
B23	-0.00013643	0.0001208	-1.13	0.2614
B24	-0.00347750	0.0027818	-1.25	0.2143
B34	-0.00075549	0.0002758	-2.74	0.0074
B1T	0.00302805	0.0048367	0.63	0.5328
B2T	0.00020660	0.0003222	0.64	0.5229
B3T	0.000034257	0.00004215	0.81	0.4184

Author's estimation

Table 4-2 Estimation Result of Trance Log Production Function of the Japanese Manufacturing Industry (Firm size: number of workers is between 300 and 999)

Equation	SSE	MSE	Root MSE	R-Square	Adj R-Sq	DurbinWatson
S54	1.27677	0.0081323	0.09018	0.3537	0.3372	2.008
S55	0.00758	0.00004828	0.0069484	0.6138	0.6040	1.808
S60	0.00152	9.67677E-6	0.0031108	0.0982	0.0752	1.857

Parameter	Estimate	Std Err	'T' Ratio	Prob>|T|
A1	1.282790	0.45899	2.79	0.0058
A2	0.116699	0.02434	4.79	0.0001
A3	0.010800	0.0056016	1.93	0.0557
B11	0.080749	0.06864	1.18	0.2412
B22	0.012743	0.0013976	9.12	0.0001
B33	0.00011938	0.00002155	5.54	0.0001
B12	-0.011879	0.0042767	-2.78	0.0061
B13	0.00034082	0.0007597	0.45	0.6543
B14	-0.112734	0.01487	-7.58	0.0001
B23	-0.00004609	0.0001043	-0.44	0.6591
B24	-0.00524943	0.0012535	-4.19	0.0001
B34	-0.00079185	0.0003658	-2.16	0.0319
B1T	0.00534266	0.0017442	3.06	0.0026
B2T	0.00049309	0.0001227	4.02	0.0001
B3T	-0.00001573	0.00004666	-0.34	0.7366

Author's estimation

Table 4-3 Estimation Result of Trance Log Production Function of the Japanese Manufacturing Industry (Firm size: number of workers is between 100 and 299)

Equation	SSE	MSE	Root MSE	R-Square	Adj R-Sq	Durbin Watson
S54	0.49330	0.0027104	0.05206	0.5891	0.5800	1.434
S55	0.00799	0.00004388	0.0066244	0.7952	0.7907	1.771
S60	0.01202	0.00006604	0.0081263	0.0874	0.0674	1.754

Parameter	Estimate	Std Err	'T' Ratio	Prob>|T|
A1	1.872884	0.24144	7.76	0.0001
A2	0.202882	0.02306	8.80	0.0001
A3	0.039487	0.01505	2.62	0.0094
B11	-0.00448619	0.04884	-0.09	0.9269
B22	0.025113	0.0017271	14.54	0.0001
B33	0.00044136	0.00008364	5.28	0.0001
B12	-0.022064	0.0044601	-4.95	0.0001
B13	-0.00099882	0.0007474	-1.34	0.1831
B14	-0.127490	0.01212	-10.52	0.0001
B23	-0.00059248	0.0001971	-3.01	0.0030
B24	-0.010780	0.0016163	-6.67	0.0001
B34	-0.00209579	0.0013373	-1.57	0.1188
B1T	0.00346959	0.0013128	2.64	0.0089
B2T	0.00045659	0.0001698	2.69	0.0078
B3T	-0.00005644	0.0001308	-0.43	0.6667

Author's estimation

Table 4-4 Estimation Result of Trance Log Production Function of the Japanese Manufacturing Industry (Firm size: number of workers is between 30 and 99)

Equation	SSE	MSE	Root MSE	R-Square	Adj R-Sq	DurbinWatson
S54	0.35664	0.0019488	0.04415	0.5443	0.5343	1.871
S55	0.00538	0.00002939	0.0054213	0.8424	0.8390	1.842
S60	0.01544	0.0000844	0.0091868	0.0278	0.0065	1.476

Parameter	Estimate	Std Err	'T'Ratio	Prob>|T|
A1	2.506557	0.28472	8.80	0.0001
A2	0.445272	0.03561	12.50	0.0001
A3	0.036693	0.02565	1.43	0.1543
B11	-0.213712	0.06735	-3.17	0.0018
B22	0.026217	0.0021159	12.39	0.0001
B33	0.00161850	0.0005123	3.16	0.0019
B12	-0.079568	0.0088511	-8.99	0.0001
B13	0.00358158	0.0005698	6.29	0.0001
B14	-0.121985	0.01506	-8.10	0.0001
B23	-0.00082552	0.0001619	-5.10	0.0001
B24	-0.014140	0.0019748	-7.16	0.0001
B34	-0.00310805	0.0026457	-1.17	0.2416
B1T	0.00360502	0.0013361	2.70	0.0076
B2T	0.00064692	0.0001636	3.95	0.0001
B3T	-0.00018568	0.0002575	-0.72	0.4718

Author's estimation

Table 5 Own Price Elasticity of Demand for Production Factors

Scale of Firms (Number of Workers)	EP54	EP55	EP60	EPKK
1000+	-0.73047	-0.11588	-0.91541	-0.20203
300～999	-0.41864	-0.63109	-0.97510	-0.19999
100～299	-0.64739	-0.31817	-0.94927	-0.17513
30～99	-1.19512	-0.56189	-0.91874	-0.21291

Author's estimation

Note: EP54, EP55, and EP60 indicates the wage elasticity of the labor demand for the workers younger than 55 years, the workers aged between 55 and 59 years, and the workers older than 60 years, respectively. EPKK is the elasticity of demand for capital stock with respect to an interest rate.

Table 6-1 Estimation Result of Labor Force Participation Rate Function Based on Pooled Data (1988, 1992, 1996)

work |	dF/dx	Std. Err.	z	P>|z|	x-bar	[95% C.I.]	
age6064*	.0850419	.0089807	9.46	0.000	.574767	.06744	.102644
rlwage~t	.0900851	.0155648	5.79	0.000	6.88477	.059579	.120592
rPhonra	-.0180931	.0006285	-28.67	0.000	7.34945	-.019325	-.016861
rPpub	-.0162824	.0006552	-24.76	0.000	4.00027	-.017567	-.014998
rPkojin	-.0130376	.0012369	-10.54	0.000	.662135	-.015462	-.010613
rpropin0	-.0001989	.0001538	-1.29	0.196	1.40996	-.0005	.000102
healtD*	-.2983034	.0091548	-31.23	0.000	.316138	-.316247	-.28036
famsiz	.0409966	.0027988	14.64	0.000	3.19076	.035511	.046482
other*	-.4053805	.0114951	-32.09	0.000	.323969	-.42791	-.382851
bteine*	-.142814	.0103414	-13.65	0.000	.49741	-.163083	-.122545
tokyo*	.0455395	.0166664	2.70	0.007	.086306	.012874	.078205
fem~6064*	.004854	.0149643	0.32	0.746	.202279	-.024475	.034184
femrlw~t	.0007826	.0197114	0.04	0.968	2.4073	-.037851	.039416
femrPh~a	-.0062505	.0014615	-4.28	0.000	1.40777	-.009115	-.003386
femrPpub	-.0134013	.0015087	-8.89	0.000	.840482	-.016358	-.010444
femrPk~n	-.0025469	.0037333	-0.68	0.495	.088677	-.009864	.00477
femrpr~0	.0000512	.0002805	0.18	0.855	.331036	-.000499	.000601
femhea~D*	.0321405	.0153794	2.07	0.038	.123596	.001997	.062284
femfam~z	-.0221369	.0043309	-5.11	0.000	1.07425	-.030625	-.013648
femother*	.1087826	.0179842	5.88	0.000	.221711	.073534	.144031
fembte~e*	.0038342	.0168445	0.23	0.820	.113611	-.02918	.036849
femtokyo*	-.0029807	.0263825	-0.11	0.910	.033934	-.054689	.048728
female*	-.071123	.1378819	-0.52	0.605	.350404	-.341367	.199121
dum92*	.1235692	.0121197	10.00	0.000	.357199	.099815	.147323
dum96*	.1021988	.0126443	7.94	0.000	.31792	.077416	.126981

obs. P .5580278, pred. P .5765527 (at x-bar)
Pseudo R2 = 0.1944, Log likelihood = -13344.912
Number of obs = 24135

Author's estimation based on 'Survey of Working Status and Conditions of Elderly Persons' in 1988, 1992, 1996.

Note: Profit estimates, (*) dF/dx is for discrete change of dummy variable from 0 to 1
z and P>|z| are the test of the underlying coefficient being 0.

Table 6-2 Estimation Result of Labor Force Participation Rate Function in 1996

work	dF/dx	Std. Err.	z	P>|z|	x-bar	[95% C.I.]	
age6064*	.027741	.0168582	1.65	0.100	.552587	-.005301	.060782
rlwage~t	.0657973	.0300268	2.19	0.028	6.67134	.006946	.124649
rPkosei	-.0241152	.0011881	-20.14	0.000	7.30014	-.026444	-.021787
rPpub	-.0184535	.0012081	-15.19	0.000	3.76221	-.020821	-.016086
rPkojin	-.0126368	.0020889	-6.05	0.000	.825892	-.016731	-.008543
rpropin0	-.0030573	.0006956	-4.39	0.000	1.20556	-.004421	-.001694
healtD*	-.3148956	.0163249	-18.37	0.000	.311873	-.346892	-.282899
famsiz	.0458535	.0055108	8.31	0.000	3.05891	.035052	.056654
other*	-.4043398	.0231968	-15.82	0.000	.303141	-.449805	-.358875
bteine*	-.1199893	.0185994	-6.40	0.000	.496025	-.156444	-.083535
tokyo*	.0534621	.0296532	1.77	0.076	.095008	-.004657	.111581
fem~6064*	.0179573	.0279179	0.64	0.521	.200443	-.036761	.072675
femrlw~t	.0520934	.0640097	0.81	0.416	2.33235	-.073363	.17755
femrPk~i	-.0030723	.0027034	-1.14	0.256	1.52109	-.008371	.002226
femrPpub	-.0122096	.0027383	-4.46	0.000	.888317	-.017577	-.006843
femrPk~n	.0017555	.0068098	0.26	0.797	.089562	-.011592	.015102
femrpr~0	-.0080981	.0026513	-3.05	0.002	.23583	-.013295	-.002902
femhea~D*	.0215696	.0281412	0.76	0.446	.118337	-.033586	.076725
femfam~z	-.0184863	.0083549	-2.21	0.027	1.03806	-.034862	-.002111
femother*	.118235	.0343236	3.34	0.001	.226248	.050962	.185508
fembte~e*	-.0366723	.0325224	-1.13	0.257	.117685	-.100415	.027071
femtokyo*	-.0016432	.0485516	-0.03	0.973	.039489	-.096803	.093516
female*	-.4237779	.3727378	-1.03	0.304	.351623	-1.15433	.306775

obs. P .5551935, pred. P .578609 (at x-bar)
Pseudo R2 = 0.2158, Log likelihood = -4133.9101
Number of obs = 7673

Author's estimation based on 'Survey of Working Status and Conditions of Elderly Persons' in 1996.

Note: Profit estimates

(*) dF/dx is for discrete change of dummy variable from 0 to 1.
z and P>|z| are the test of the underlying coefficient being 0.

Table 7 Income Redistribution Effect (Gini Coefficients)

	Initial income	Income after redistribution		Income after redistribution through taxation		Income after redistribution through the social security systems	
	Gini coefficient	Gini coefficient	Improved by (percentage)	Gini coefficient	Improved by (percentage)	Gini coefficient	Improved by (percentage)
1981	0.3491	0.3143	10.0%	0.3301	5.4%	0.3317	5.0%
1984	0.3975	0.3426	13.8%	0.3824	3.8%	0.3584	9.8%
1987	0.4049	0.3382	16.5%	0.3879	4.2%	0.3564	12.0%
1990	0.4334	0.3643	15.9%	0.4207	2.9%	0.3791	12.5%
1993	0.4394	0.3645	17.0%	0.4255	3.2%	0.3812	13.2%
1996	0.4412	0.3606	18.3%	0.4338	1.7%	0.3721	15.7%

Source: "Survey on the Redistribution of Income (Fiscal 1996)" by the Research Section, Policy Planning and Evaluation Division, Minister's Secretariat, Ministry of Health and Welfare

Notes: 1. Initial income = Compensation of employees + business income + agricultural income + property income + home work income + miscellaneous income + benefits privately received (remittances, corporate pensions, retiring benefits, and life insurance money)
2. Income after redistribution = Initial income – taxes – social insurance premiums + social security benefits + medical expenses
3. Income after redistribution through taxation = Initial income – taxes
4. Income after redistribution through the social security systems = Initial income – social insurance premiums + social security benefits + medical expenses
5. Improved by (percentage) = (Gini coefficient of the initial income – Gini coefficient of the income after redistribution)/Gini coefficient of the initial income x 100
6. Taxes: among direct taxes, income tax, individual inhabitant tax, property tax (excluding tax on real estates used for business), and tax on automobiles and light cars (excluding those used for business)
7. Social insurance premiums: premiums paid under the employees' insurance, national health insurance and national pension systems (contributory plan).
8. Social security benefits: benefits such as pensions paid in cash under the social security systems
9. Medical expenses: cash value calculated for medical benefits paid in kind

Table 8 Decomposition of the Factors of the Gini Coefficient for Public Redistributed Income (All Households and All Age Groups)

YEAR		R1	R2	R3	R4	R5	R6
GINI		0.93474	-0.80770	-0.68794	0.10871	0.41612	0.045542
1981	0.31654	G1	G2	G3	G4	G5	G6
		0.34475	-0.60008	-0.32243	0.41033	0.68974	0.49889
		S1	S2	S3	S4	S5	S6
		1.04305	-0.10354	-0.068607	0.17421	0.12325	0.11753
		I1	I2	I3	I4	I5	I6
		1.06188	-0.15854	-0.048076	0.024550	0.11175	0.0084362

YEAR		R1	R2	R3	R4	R5	R6
GINI		0.95126	-0.80572	-0.77442	0.025784	0.41146	-.0097958
1993	0.36406	G1	G2	G3	G4	G5	G6
		0.38029	-0.59403	-0.36222	0.38742	0.66970	0.63967
		S1	S2	S3	S4	S5	S6
		1.11510	-0.11850	-0.083016	0.27112	0.13958	0.078275
		I1	I2	I3	I4	I5	I6
		1.10802	-0.15579	-0.063964	.0074391	0.10565	-0.0013472

ΔYEAR	GINI	DGINI	TDGINI	DTGINI		
1993-1981	0.36406	0.047525	0.047497	.000027542		
	DS1	DS2	DS3	DS4	DS5	DS6
	0.072052	-0.014964	-0.014409	0.096919	0.016330	-0.039257
	DR1	DR2	DR3	DR4	DR5	DR6
	0.016525	.0019746	-0.086480	-0.082929	-.0046603	-0.055338
	DG1	DG2	DG3	DG4	DG5	DG6
	0.035534	.0060570	-0.039794	-0.022906	-0.020038	0.14078

Author's Tabulation based on 'Income Redistribution Survey' in 1981 and 1993.

Note 1: R_k is the correlation coefficient between the amounts of k-th income source and the household income, G_k is a relative Gini coefficient concerning the income distribution in k-th income source, $S_k(=m/m_k)$ is the ratio of average income classified by income source to average household income.

Note 2: The number of suffix k indicates each of the following income sources. 1: Total Earnings=Wages and Salaries + Self-employment Profit Income + Self-employment Farming Income + Cash Property Income + the Other Income, 2: Taxes, 3: Social Insurance Contribution, 4: Pension Benefits, 5: Medical Treatment Supply, 6: the Other Social Security Income Transfer including Public Assistance.

Note3: DS, DR, and DG indicate the differentials of S,R,G between 1981 and 1993, respectively.

Table 9 Decomposition of the Factors of the Gini Coefficient for Public Redistributed Income Classified by Age Group (All Households)

Age Group	GINI	R1	R2	R3	R4	R5	R6
20～29	0.30898	0.95648	-0.81957	-0.79813	0.042707	0.27812	0.024990
		G1	G2	G3	G4	G5	G6
		0.30003	-0.38948	-0.29402	0.50623	0.68490	0.74566
		S1	S2	S3	S4	S5	S6
		1.09750	-0.083830	-0.094821	0.43180	0.16863	0.084494
		I1	I2	I3	I4	I5	I6
		1.01935	-0.086606	-0.072016	0.03021	0.10396	.0050957
Age Group	GINI	R1	R2	R3	R4	R5	R6
30～39	0.26595	0.96310	-0.80440	-0.73856	0.062595	0.37953	-0.038410
		G1	G2	G3	G4	G5	G6
		0.2709	-0.47268	-0.25715	0.35050	0.62703	0.67052
		S1	S2	S3	S4	S5	S6
		1.10408	-0.089688	-0.091626	0.19496	0.11108	0.054784
		I1	I2	I3	I4	I5	I6
		1.08349	-0.12822	-0.065431	0.016084	0.099391	-.0053054
Age Group	GINI	R1	R2	R3	R4	R5	R6
40～49	0.29178	0.95327	-0.81291	-0.73424	0.10699	0.37402	-0.010408
		G1	G2	G3	G4	G5	G6
		0.30293	-0.52489	-0.26086	0.40171	0.67637	0.67117
		S1	S2	S3	S4	S5	S6
		1.11760	-0.11468	-0.086996	0.16236	0.11163	0.081441
		I1	I2	I3	I4	I5	I6
		1.10607	-0.16771	-0.057107	0.023914	0.096779	-.0019498
Age Group	GINI	R1	R2	R3	R4	R5	R6
50～59	0.33662	0.95924	-0.81171	-0.78044	0.053693	0.38266	-0.015471
		G1	G2	G3	G4	G5	G6
		0.35362	-0.55689	-0.30738	0.40426	0.65565	0.55915
		S1	S2	S3	S4	S5	S6
		1.13844	-0.12984	-0.089393	0.14513	0.11239	0.087856
		I1	I2	I3	I4	I5	I6
		1.14720	-0.17436	-0.063705	.0093584	0.083768	-.0022577

Table 9 Decomposition of the Factors of the Gini Coefficient for Public Redistributed Income Classified by Age Group (All Households): *Continued*

Age Group	GINI	R1	R2	R3	R4	R5	R6
60～69	0.40029	0.88542	-0.77417	-0.69827	0.14352	0.50558	.0032667
		G1	G2	G3	G4	G5	G6
		0.45755	-0.65866	-0.44281	0.35464	0.67985	0.58801
		S1	S2	S3	S4	S5	S6
		1.02332	-0.12201	-0.067584	0.31820	0.15250	0.11182
		I1	I2	I3	I4	I5	I6
		1.03569	-0.15542	-0.052204	0.040459	0.13095	.00053660
Age Group	GINI	R1	R2	R3	R4	R5	R6
70 +	0.46677	0.71212	-0.68051	-0.72415	0.33062	0.57383	-.0039964
		G1	G2	G3	G4	G5	G6
		0.53264	-0.74123	-0.56553	0.36574	0.65523	0.45493
		S1	S2	S3	S4	S5	S6
		0.14287	-0.12938	-0.059946	0.33782	0.21924	0.10670
		I1	I2	I3	I4	I5	I6
		0.92872	-0.13982	-0.052594	0.087513	0.17660	-.00041560

Author's tabulation based on 'Income Redistribution Survey' in 1981 and 1993.

Note 1: R_k is the correlation coefficient between the amounts of k-th income source and the household income, G_k is a relative Gini coefficient concerning the income distribution in k-th income source, $S_k(=m/m_k)$ is the ratio of average income classified by income source to average household income.

Note 2: The number of suffix k indicates each of the following income sources. 1: Total Earnings=Wages and Salaries + Self-employment Profit Income + Self-employment Farming Income + Cash Property Income + the Other Income, 2: Taxes, 3: Social Insurance Contribution, 4: Pension Benefits, 5: Medical Treatment Supply, 6: the Other Social Security Income Transfer including Public Assistance.

Note 3: DS, DR, and DG indicate the differentials of S,R,G between 1981 and 1993, respectively.

Canadian Social Policy and Ageing

by

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Canadian Social Policy and Ageing

Introduction

This paper begins with a brief introduction to ageing in Canada, providing a demographic and cultural context before proceeding to further discussion. As a Western capitalist society with an emphasis on autonomy and independence for the individual, myths persist that elderly persons are, by and large, frail, lonely and isolated, and put into long-term care institutions where possible. Empirical research during the last three decades has demonstrated that seniors, despite gradually declining physical health, tend to cope, and are embedded within the community in social networks, preferring 'intimacy at a distance' to living with family members. Families, furthermore, are the first resort for care when health deteriorates providing an estimated 75-80% of all personal care. In other words, the focus on individualism does not mean that seniors are isolated or alone, or that they are abandoned when their health fails.

The paper goes on to discuss selected issues in contemporary Canada that relate to an ageing population. One refers to a tendency in our modern capitalist society, to value others for their productive roles and/or for their wealth, so seniors tend to be devalued. Their exclusion from paid labour leaves them without any socially defined, contributing roles within society. Theirs is a role of exclusion. This is becoming increasingly important as disability free years in old age increase. Governments view volunteerism as one mechanism that allows them to capitalize both on the resources represented by seniors, as well as providing meaningful roles for elderly persons. The next issue discussed refers to 'ageing in place', the expressed preference of the vast majority of individuals, including seniors. This broad topic encompasses sufficient economic means, adequate health care, adequate housing, and other environmental issues. This section focusses largely on the built environment as permitting ageing in place and some programs that would allow seniors to do so, including supportive housing. Still related to aging in place, the next section argues for a considerable expansion of community home care in Canada . Despite health reform at the present time in Canada, there are few signs that the Canadian health care system is becoming more appropriate for its ageing citizens. Indeed, there are indicators to suggest the opposite. The last issue deals with diversity, focussing on subcultural differences. Diversity, while a catch word in many documents, is not well understood and mechanisms for ensuring needs are met within a heterogenous elderly population has not yet been resolved.

The intent of this paper is to provide an overview of ageing in Canada, that draws on existing research knowledge. Where the research contradicts commonly accepted stereotypes about the elderly, this information is provided. Where we do not yet have answers or solutions to problems, this is made explicit. Where we know the solution, but have not seen a willingness to implement, this is also indicated. After describing the current situation of seniors in Canada, this paper focuses on a selected number of issues with which Canadian social gerontology is currently grappling. The answers are more apparent for some than for others, but for none is the future certain. Even in areas where the optimal solutions may be known (such as, for example, in health care), it is not at all clear that the political will exists to ensure the necessary change. Throughout the discussion, areas of contention requiring change are highlighted. This should not be interpreted to mean that seniors in Canada generally are dissatisfied or receive less assistance than is found elsewhere. Rather, while Canada has an enviable quality of life and has many social policies that commend it for seniors, including long established health and welfare measures, there are, nevertheless, numerous issues related to ageing that still require attention. That is, societal assistance for seniors can be improved everywhere - Canada is no exception.

Canadian Demographics

Seniors (those age 65 and over) are one of the fastest growing population groups in Canada, comprising 12% of the total population in the late 1990s compared with 10% in 1981 and 5% in 1921 (Statistics Canada, 1999). They are projected to comprise 23% of the population by 2041 when the baby boom generation (born between 1946 and 1965) begins reaching age 65. Among seniors, those aged 85 and over are the fastest growing age group, almost doubling their numbers between 1981 and 1998. The majority (57%) of seniors are women with this proportion increasing the older one becomes (70% of those aged 85 and older are female). Over one quarter (27%) are immigrants. Most (93%) live at home in a private household and most (68%) live in households headed by a senior. Ninety percent of these senior homeowners have paid off their mortgage. Most (57%) live with their spouse; 7% live with members of their extended family; 29% live on their own; and 7% live in a long-term care institution.

The current cohort of seniors has relatively low levels of formal education with only 8% having a university degree, 25% attending but not graduating from high school; and 37% with less than a Grade 9 education. Partly because of this, over half (53%) are able to perform only simple reading tasks such as locating one piece of information in a text. Few senior households are connected to the internet with only 4% of households headed by a senior linking in compared with 15% of younger adult households. Most Canadian seniors are retired, but 6% are working in the paid labour force. Approximately one quarter (23%)* though, participate in formal volunteer activities. Even more (80%) make at least one donation to a charity, more than any other age group. Television viewing is a favourite activity among seniors with people age 60 and over watching, on average, 4.9 hours per day, almost two hours more than those between ages 18-59. News and public affairs account for the largest share of television viewing, over two hours per day. Canadian seniors are almost as active as younger age groups with 50% engaged in regular physical activity and 12% occasionally taking part in such activity.

In 1997, 19% of Canadian seniors had incomes below Statistics Canada's low income cutoff. This was a drop from 1980 when it was 34%. Among unattached seniors, women are much more likely to have low income, with 49% in the low income category. While most seniors report their overall health is relatively good, 82% of those living at home have been diagnosed with at least one chronic condition, with arthritis and rheumatism the most common chronic health problem; 28% of these seniors report some level of restriction in their activities because of a long-term health problem; and 25% of seniors living at home have a long-term disability or handicap. Seniors are heavy users of hospitals, with three times more hospitalizations than people aged 45-64. The majority of seniors (84%) take some form of prescription or over-the-counter medication. Pain relievers are the most commonly used drug.

That is, Canadian seniors, by and large, are married and living with their spouse or they live on their own. Few live with children or with other family members. Most are not working in paid labour; a quarter are engaged in formal volunteer activities. The poverty rate is decreasing** but among unattached seniors, women are particularly vulnerable. Canadian seniors view their overall health as good given their age but are heavy users of hospitals and of medications.

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* Figures just released reveal this has dropped to 18% (consistent with a drop in volunteering generally).

** Poverty rates are effected by the definitions used. The official definition changed during the time period discussed here, contributing to the decrease.

The Cultural Context of Living in Canada

Canada is a capitalist society with a long and strong democratic tradition. Although often compared with the United States as less individualistic and materialistic, it would unquestioningly be grouped with other Western countries in comparison with more collectivist, holistic values of many Asian countries. The norms, as reflected in the statistics revealed in the preceding section, are for seniors not to live with their children. Once their spouse dies, they tend to live alone. The emphasis on autonomy and independence of the individual in Western capitalist society, together with a youth focus, has lead to concerns that Western countries such as Canada, devalue their senior citizens and evidence ageist attitudes. Seniors, no longer primarily employed in paid labour and with visible signs of declining physical prowess, it is believed, are largely alienated from their families, especially from their children and excluded from mainstream society (Wernick, 1995; Turner, 1995).

It is true that most seniors in Canada are not employed in paid labour and ageist attitudes are evident, for example in media portrayals of elderly individuals, among school age children, and among health care professionals (Achenbaum, 1995). There are major problems for older workers who become unemployed due to ageist attitudes among employers (McDonald & Wanner, 1984). However, this does not mean that they are, by and large, lonely, isolated and put in long-term care institutions whenever possible. Indeed, research that began in the 1970s and continued in the 1980s in both Canada and the United States documented the types, the extent, and the sources of support for elderly individuals. Despite widespread belief at the time that the nuclear family abandoned their elders to long-term institutional care, and that seniors were isolated especially from their families, social gerontology established the falsity of these assumptions and debunked the myth of the abandoned elder in North America (Antonucci, 1985; Chappell, 1990; 1992). The phrase 'intimacy at a distance' conveys the fact that seniors, as well as their children, prefer not to live with one another, but rather prefer to live independently while maintaining close and intimate ties with one another. Most seniors are embedded in social networks and most live near at least one child.*

When their health deteriorates, whether physical, mental**, or some combination of the two, it is the informal network of family and friends who tend to provide care; who are the first resort of care. Caregiving from kin and friends is the primary source of assistance for seniors in contemporary Western society. In the 1980s, it was established that 90% of non-institutionalized Canadian seniors, receiving any assistance, do so from informal networks. A review by Kane (1990) of all scientific studies throughout the Western industrialized world established that the informal network provides the vast majority of care, estimated at between 75% and 85% of all personal care to seniors, irrespective of whether or not the country has universal health care. That is, the family has traditionally provided and continues to be the major source of interpersonal support. When health fails, it is the family who comes to the aid of the elderly member.

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* It can be noted that while the higher prevalence of seniors living with their children in some Asian countries has often been interpreted as an indication of closer familial bonds than in North America, this interpretation has been criticized as wrong. Ikels (1990) for example argues it is more often the result of children living with their parents (not parents living with their children) and is out of economic necessity.

** While prevalence of cognitive impairment increases with age, it is not a necessary consequence of ageing. The Canadian Study of Health and Aging estimates Canada's prevalence rate for dementia among seniors at 8% (comparable to other Western societies); a clear minority of seniors.

The notion of the modified extended family (Litwak, 1960) with an emphasis on mutual aide and close personal ties among kin is more characteristic of present day Canadian society than the isolated nuclear family. Present day Canadian day society is characterized by a continuation of the extended family, strength of intergenerational relations, the continuity of responsible filial behaviour, and a frequency of contact between the generations. That is, a focus on individualism and on youth has not translated into a society of isolated and alone seniors.

Most elderly individuals have fairly extensive social contacts with little evidence that advancing years reduce the need for affiliation or its lessened importance in people's lives. Lack of role involvement tends to refer to the lack of involvement in paid labour when one is elderly and lack of social contacts tends to refer to those who are old elderly, in poor health, and are frail, a minority of seniors. We know that in Canada, like other industrialized countries, women tend to be more involved in kin relations than men. Rosenthal's (1985; 1987) research on the kin-keeping role (the role assumed by a family member who expends effort to keep family members in touch with one another) and the comforter role (the role taken by a family member who provides emotional support to other family members) confirms the predominance of women in these activities. Women are more likely to use interpersonal and emotional skills in their interaction, whereas men are more likely to orient their behaviour to an instrumental style of interaction. Certainly, among those who are elderly today, most are or have been immersed in marriages and have children.

Canadian seniors have active lives. The most frequently reported leisure activities include socializing with friends and relatives, watching television, gardening, reading newspapers, and sitting and thinking. The majority do not become involved in seniors' organizations even when they know about them, and despite their presence in virtually all Canadian cities. Women, those in good health, those with access to transportation, those who have been joiners throughout life, those who belong to the lower middle and middle classes, and those with strong attachment to neighbourhood and community are most likely to become involved in seniors' organizations (McPherson, 1998). Not surprisingly, given the diversity among the senior population, leisure patterns are also diverse. However, leisure involvements in old age tend to be similar to those established in the younger years. Typically, it is declining health that will lead to a drastic decrease in leisure activity (Cousins & Keating, 1995).

Of course, Canada's elderly population in the future will be different in significant ways from those who are elderly today. We know that the baby boom generation has much more formal education, increased divorce rates, fewer children, more women working in paid labour, and much greater geographic mobility, than was true in the past. One of the most visible distinguishing features of present day society is its advanced technological capability which extends options available to individuals and families. Without question, ageing will be a different experience for the baby boom generation. Nevertheless, no evidence exists to support predictions that the baby boom generation will shirk their responsibility of family care towards their elderly members. To the contrary, the baby boom generation, who are now in middle age and are the family caregivers for many seniors in Canadian society, are demonstrating the strength of the Canadian family. Despite additional and competing demands in their lives, they make great personal sacrifice in order to care for their elderly loved ones. The evidence (Keating et al., 1999) suggests that these ties will endure into the future.

Because seniors in Canadian society are not isolated and abandoned and because they are generally integrated within social networks and engage in a variety of activities, does not mean things cannot improve. Indeed, social gerontologists argue that there are both longstanding and new issues that require urgent social policy attention. In addition, and

importantly, the fact that most seniors cope with the declines that come with ageing does not mean that all seniors are without need. Rather, the minority who are frail, who live in poverty, and/or are isolated or lonely must not be forgotten when the general portrait of Canadian seniors is revealed. This will become clearer in the following sections as contemporary issues are raised.

Current Issues - A Meaningful Life

The vast majority of Canadian seniors are retired; they do not work in the paid labour force. Those who do, primarily do so on a part-time basis. While this can be viewed as 'free' time, a well-deserved 'rest' from a life of hard work, and a 'reward' for their contributions to society, a capitalist society like Canada tends to view lack of participation in productive roles as non-contributing to society and worse, as an economic drain. Furthermore, seniors' exclusion from paid labour has not been replaced with societally defined and sanctioned roles. This is becoming more of an issue as disability free years within old age increase. The latest figures show approximately a third of the added years that people are now enjoying are disability free (Olshanky, 1998). This is not to argue that all seniors should necessarily have role involvements that are different from those in which they are now engaged. But many seniors represent resources that often remain untapped at the present time. Not only do many seniors wish to contribute to society, they believe that such involvement is essential to a meaningful old age, through a sense of worth and usefulness (Centre on Aging, 1998). In addition, the federal government is now recognizing the potential of volunteerism to provide meaningful roles while also providing a mechanism for harnessing the resources which seniors represent, and seniors themselves are asking for more meaningful involvements. In other words, the idea of giving back to society is intertwined with the concept of meaningful volunteerism. As expressed by Hadley (1998):

> 'The Troisième Age of human development is a time when we can give back to society the lessons, the wisdom and resources that we have derived throughout our long and productive lives... This Troisième Age is a special period when we can deepen our wisdom and personal sense of spiritual identity. Whatever emphasis each of us might place in this stage of life, our full engagement implies an enhancement of the common good.' (Hadley 1998, "Volunteering and Healthy Aging: What We Know" 1999).

As noted earlier, only about a quarter of seniors are involved in formal volunteering. The 1997 National Survey on Giving, Volunteering, and Participating (NSGVP) reveal that, while formal volunteer rates among youths have doubled since the survey in 1987 (from 17% to 34%), volunteer rates among older adults (65+) remain relatively stable at 23%. However, these seniors devote more of their time to volunteering than do other age groups (202 hours/year compared with the next largest category, 160 hours for those 55-64 years of age to a low of 125 hours among those 15-24 years of age) (Statistics Canada 1998; Brennan, 1989).*

Volunteering in the new millennium differs significantly from the past. During the past century, Canada evolved into a welfare state with societal institutions in psychiatric care, criminal justice, services for the developmentally handicapped, economic security and

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* Interestingly, understanding volunteering among seniors (or younger adults for that matter) has not captured the interest of researchers. In contrast, the area now being referred to as informal volunteering (support and caregiving) has a long history of academic research, though it is not considered part of the volunteering literature (Chappell, 1999).

healthcare. Professional human service workers (in the helping professions including social work, physiotherapy, occupational therapy, speech therapy, psychology, psychometry, child development, and community development) largely displaced lay persons, including volunteers, by the end of the century. An implicit message was that trained professionals were better, more competent than volunteers. Government support of community, non-profit volunteer organizations was not strong. Indeed, changing fiscal policies meant less generous funding to voluntary organizations when it was available at all.

Society at the millennium is significantly different in other ways as well, including the women's movement that supports the founding of new service oriented organizations such rape crisis centres, shelters for battered women, and women's reproductive health services that rely heavily on volunteers for direct service work. Democratic decision-making, involvement of service users, and relatively non-hierarchical structures are characteristic of these organizations. New ways of thinking emphasize the importance of understanding how social identities are influenced by social structural variables such as class, gender, and race. There is heightened awareness of the consequences of political and economic culture for lived lives (Gordon & Neal, 1997).

These societal changes are especially important because, with health reform of the 1990s, governments in the latter part of the 20th century started devolving responsibility back to the community and its not-for-profit sector after largely taking over their traditional areas of involvement (Gordon & Neal, 1997). The current devolution of service programs, programs previously provided by government, to the voluntary sector has enormously increased the pressure and opportunities for this sector. Governmental reform has meant that administrative and financial responsibility for the social net for vulnerable persons and groups now falls to the community. However, aside from a declared interest and minor sums being provided to national volunteer and philanthropic organizations, it is not clear that the government is going to provide substantial support to this area.

There is major concern that the infrastructure necessary in order to undertake this task has been allowed to deteriorate during the building of the welfare state to the point where it is no longer adequate. That is, with governments now embracing partnerships and promoting community agencies that have been starved for resources for several decades, the community infrastructure necessary for the new collaboration may well be insufficient to carry this new role. The infrastructure requires resources for rebuilding but there is no indication at present that substantial resources are going to be put into this sector.

Two issues require attention. One is governmental support in the form of resources (funds but also training sessions in building and maintaining community infrastructure) and the opportunity for seniors themselves to assist in creating volunteer opportunities which they themselves consider meaningful. 'Meaningful' for many includes feeling that they are making a significant contribution. Despite a national network of volunteer organizations, many of these agencies focus on listing redundant and repetitive tasks such as receptionist, stuffing envelopes, pouring tea, etc., which may suit some elderly individuals but are not preferred by others. What is meaningful will vary; for some it will include utilizing past professional expertise when they were in paid labour; for others, it will not. And there is resistance from some quarters. Integrating meaningful volunteer roles includes evolving volunteer roles within employment organizations. This requires the involvement of both management and unions, and a detailing of appropriate roles so volunteers are not exploited and employee job security is not threatened. Another difficult issue being raised in Canada but not yet resolved refers to liability, particularly where volunteers are working with children or with vulnerable populations such as cognitively impaired or demented elderly populations.

The topic of volunteerism and seniors' active contribution to mainstream society relates to the issue of public and private responsibility. Despite a philosophy that generally

invites community participation and citizen empowerment, Canada, like other industrialized nations, has not found a means in order to ensure that this happens. Indeed, with technological advance and the increase in specialized knowledge, it is difficult to know how volunteers can have appropriate knowledge for much of the civic work that they may be interested in or asked to do. Findings to date about citizen participation, for example, in health care, are pessimistic. Research in Norway, the United States, and Sweden all reveal that regionalization of health care has resulted in domination by local professionals and bureaucrats without evidence of major impact by citizens (Church & Barker, 1998). Similarly, O'Neill (1992), studied the role of citizen participation in Quebec and concluded that the community was not empowered to significantly influence the system. This author suggests that both the highly technical and complex issues they were confronted with, as well as the techno-professional culture to which they did not belong, inhibited this from happening. To ensure community empowerment, boards must have autonomous sources of power, such as having a majority so they can carry the vote.

Canadians, though, wish to maintain their social democratic model of operating. Peters (1995) analysed 18 opinion polls between 1980-1995 and several focus group discussions held across the country in 1995. She concluded that Canadians do not believe the government's role in social policy should be minimized. Rather, social policy, including health care, is at the forefront of defining the Canadian identity. Sennett (2001) argues that a major challenge for governments is ensuring authentic public participation. Although having a voice and having a choice are unchallenged expectations in a democratic society, there is little consensus about what the terms actually mean (Abelson & Lomas, 1996) and even less on how to achieve it. Many would agree that involvement and consultation are not synonymous with public participation and that Canada's electoral system does not ensure that all voices are heard. Mechanisms for those voices to be heard are lacking.

Future generations of elderly may demand a greater voice than those who are elderly today. There is evidence that Canadian citizens are becoming increasingly politically savvy (Nevitte, 2000), with greater knowledge and attentiveness to politically relevant information, with more education and more knowledge about where to gain independent political information. Canadians, therefore, are more autonomous in their political thinking and have become much harsher in their evaluations of politicians and governments. Simultaneously, the majority of Canadians are not deeply dissatisfied with the way democracy works in Canada, nor are they disaffected from democratic principles generally. A major challenge for governments today is to find ways to capitalize on and utilize the resource that these energies symbolize; define new ways of working with citizens who are substantially different from in the past. This includes opportunities for those seniors who wish to be involved in meaningful ways.

Current Issues - Ageing in Place

The concept of home is closely linked to that of families and entails a commonsensical understanding but defies precise scientific definition. Often home is associated with security, with comfort and familiarity, with caring, commitment, privacy, closeness between members, and with helpfulness (Dupuis & Thorns, 1996; Namazi et al., 1989). For older people in particular, home means a place where they have control and where they can express their individuality (Rutman & Freedman, 1988). Canadian seniors, like seniors in most industrialized countries, express a preference for staying in their home, for 'ageing in place'.

This does not mean that they wish to live in only one house for their entire lives, but rather that as they settle into a place in their later middle years and early old age, they do not wish to be uprooted to a place where they cannot take their personal belongings that have history and meaning attached to them, from a space that has become familiar and easy to

manoeuver, from a location which they know well and from which they can meet their needs and be put in an environment which is unfamiliar, distant from family and friends, and/or institutional-like. For some, this is the large family home; for others it is the small one story home they moved to with their spouse after the children left home; for others it is an apartment; for others it is sheltered housing. Ageing in place demands intersectoral participation because it requires sufficient income for the individual to live there, a built environment that will permit them to remain in their own homes, often times an appropriate geographical environment, and appropriate health care that will allow them to remain there.

As noted earlier on, a disproportionate percentage of elderly women who are not married are living in poverty. This restricts their options for living independently and ageing in place especially when their physical health begins to decline. These needs can be met either through increased income (raising the Old Age Pension or through means tested programs such as the Guaranteed Income Supplement) and through in kind supports. A type of housing that is receiving attention in Canada at the present time is known as assisted living (also known as supportive housing) whereby individuals live in apartments that provide at minimum, a general on-site manager who checks on them and is available for more than physical maintenance of the building, a personal alarm system in case an emergency arises, and congregate meals for those who wish to partake.

Despite support in the country, supportive housing has been slow to develop. Many of those available at the present time are provided by the private sector and are, therefore, out of the reach of many seniors, especially those who live below the poverty line. Some provinces (such as B.C.) are currently assessing the feasibility of building publicly supported assisted living but those plans have yet to materialize. While every major city in Canada now has a network of seniors centres and numerous senior activities, they are designed primarily for the well elderly. Assisted living is for those whose health has begun to deteriorate. Alberta's lodges are similar in many ways to supportive housing or could be considered a type of supportive housing where individuals have their own living space, but share space for meals and recreation. In addition, the Abbeyfield concept begun originally in Great Britain is now available in Canada. These are often large, older homes in residential neighbourhoods where six to ten residents live with a housekeeper. They have their own rooms with a bath, but share chores like cooking.

In addition, both the federal and provincial governments provide a variety of assistance to older homeowners through grants, loans, and tax rebates. Policies range from tax relief, to rent subsidies, to support for reverse mortgages. These policies are important because many older adults have difficulty maintaining their homes, a phenomenon sometimes referred to as 'house rich, cash poor.' Sometimes grants are available to improve deteriorated housing or to make the house accessible to wheelchairs through low interest and often forgiveable loans for those who have low income. In some provinces, shelter allowances subsidize individuals, not the housing project. Housing policies often make it possible for older individuals, especially those in rural areas, to remain in their own communities (Joseph & Martin-Matthews, 1993).

Current Issues - Home Care

Health care is especially important for those ageing in place, given that physical health problems increase as we age, especially among the old elderly. Importantly, seniors suffer primarily from chronic conditions and not acute illnesses. Yet Canada's universal Medicare system is focussed on physician care and hospital care oriented toward acute illnesses. The Canadian health care system, in other words, is both medicalized and institutionalized, the two most expensive forms of health care. Neglected within the system are community-based programs, alternative non-medical forms of care and long-term care. Virtually all visions of

health reform in the 1990s called for an expansion of home care as a type of health care that would be less expensive than medical care delivered in hospitals and as care that would be more appropriate. This argument has been made especially for an ageing population (Segall & Chappell, 2000; Chappell, 1993). However, Canada has never had and does not have universal or comprehensive coverage for non-hospital, non-physician related services.

All provinces provide some home care services (in British Columbia they are referred to as home support services) but the specific services that are available, whether they charge a user fee and whether they are based on ability to pay, varies from province to province and indeed from jurisdiction to jurisdiction within one province. At the current time, home care is provided in a decentralized system with a lack of national coordination and lack of universal access, although Canada's recent National Forum on Health (1998) recommended that home care be added to medical care so that it could become nationally available and universally accessible. Recent reforms that have been taking place within the health care system, though, suggest that traditional home care services that had been provided as the mainstay for long-term chronic care in the community* are being dismantled, they are not being supported and expanded.

Attempts to redistribute health care dollars from expensive acute care hospitals to less expensive home care are typified by the Capital Health Region of the province of British Columbia. Penning et al. (1998) examined official government expenditure data on health services for the eight year period from 1988-89 to 1995-96, revealing gradual declines in the proportion of the health care budget assigned to medical and hospital services. There were increases in the proportion of the budget allocated to community and other health care services including continuing care. Within continuing care, the proportion of the budget that is expended on home care services, that is, non-nursing services only, increased in the early years but declined in later years. Similarly, the number of clients served and the number of hours of services provided to home care clients increased in the early part of the period but declined more recently.

In contrast, the intensity of services provided to those receiving services increased; that is, fewer people are receiving services but those who are receiving services are receiving more hours of service. In addition, those receiving services are in greater need as measured by level of care. These data suggest there has been a reduction rather than an expansion of community-based home care services and that health reform is resulting in a redirection of services away from clients who are less needy (and who may have greatest potential for prevention), who require non-medical or supportive services, towards clients who require more intensive and medically-focussed needs. Community home care is providing more medical support and less social care. This is precisely the experience in the United States when diagnostic related groups (DRGs) became used as a funding formula for acute care hospitals. The new formula resulted in earlier discharges from hospital and an increased demand in home care for intensive post-acute care, with a restriction of the social services available through home care (Estes & Wood, 1986). Medical support is provided for the medical needs of hospital discharges. Community services have become tailored to support the medical needs of the hospital and now offer fewer and fewer services that will facilitate health maintenance and disease prevention. Home care is becoming a medical support system rather than expanding the domain of non-medical care.

These shifts followed bed and hospital closures in many provinces (especially in Saskatchewan for closure of entire hospitals), limits to new admissions and postgraduate training in medical schools, differential fees in some provinces to encourage physicians to

* This is not to suggest that they have ever been adequate.

settle in under- serviced areas, aggregate caps on physician salaries through negotiation with provincial medical associations, and decreasing or lack of increase to hospital budgets (Chappell, 1993). More recent reforms have included regionalization in most provinces (with Ontario being the major exception) because it is believed to offer both integration of services and allows for decision making at the local level. It is too early yet to know the result of this restructuring, but Sullivan and Scattolon (1995) argue that regional boards with no budget or policy setting authority will be unsuccessful at ensuring consumer participation. Another question for Canada, a geographically expansive country with a relatively small population, is whether regional populations contain too few people to effect economies of scale or the coordination of services. Furthermore, at the present time, payment for physicians and for drugs (Pharmacare) lies outside of the regional health authorities and, therefore, do not allow for true integration.

A current focus attracting much attention is the primary care organization. Marriott and Mable (1998) note that primary care has been defined as essential health care that is universally accessible to individuals and families by means acceptable to them and through their full participation. Primary care is usually considered the first level of contact with the national health care system for individuals and families and should be delivered as close to home as possible. It includes health promotion, illness prevention, curative, supportive, and rehabilitative services. Key elements of a primary care model include:

- The development of general practitioners working in a group environment (this could include a network of solo practices).
- The development of multidisciplinary teams, including general practitioners as well as others such as nurse practitioners, counsellors, and nutritionists.
- Patient registration and rostering, whereby the organization is responsible for specific individuals rather than a geographic area.
- Funding on a population or a capitation basis (that is, a set amount of dollars is provided per person).
- Core services, including health promotion, sickness prevention, diagnosis and treatment of illness, urgent care, 24 hour accessibility, and management of chronic illness.
- High quality specific information of records that will allow for greater certainty for costing and benefit analysis and better analysis of benefits.

Primary care is still more an idea than a reality in Canada; hospitals are still largely funded on a global budget basis and allocation to physicians and other fee-for-service providers, such as walk-in clinics and physiotherapists, is based on a market allocation model (practitioners are paid for their services to clients who choose who they see). Reimbursement follows as a function of the volume and mix of services delivered. Physicians are still, by and large, paid on a fee-for-service system. The changes taking place in hospitals are leaning to more and more outpatient surgeries. New technologies and drugs allow this shift in practice with a patient discharged immediately into the home. Deber et al. (1998) report as much as 70-80% of surgeries are now being performed on an outpatient basis in some hospitals in Toronto.

Despite the rhetoric, there are few examples that health promotion and disease prevention are yet being considered as serious mandates for the formal health care system.

While there are examples of particular facets of health promotion programs such as self help education, social support groups, educational and information programs, one could not say that a population-based health promotion approach has been adopted by the health care system. Indeed, reform has been focussing on decreasing or refusing increases to hospital budgets; caps on physician salaries; graduating fewer physicians; encouraging outpatient surgeries and post-intensive care at home rather than in the hospital; and more recently, regionalization. One of the reasons why it is believed health care systems hesitate to embrace the health promotion perspective in practice is because they do not know where to begin and end. That is, it seems to encompass everything. There are isolated examples of attempts to experiment with the most appropriate role for a regional health authority in a population-based health promotion approach, but the starting questions are not receiving serious attention - should they try to do this? Should they facilitate grassroots community groups in doing this? Should they simply focus on providing illness care and not even attempt health promotion and disease prevention? These questions are not being asked at present.

There has been striking consistency across the country in the vision of a more cost effective and appropriate health care system. It is to include a broadening of the definition of health beyond biomedical boundaries, have less emphasis on institutional care, more emphasis on home care, more emphasis on health promotion and disease prevention, care closer to home, more evidence-based decision making, and alternate payment for physicians away from fee-for-service. It is believed all of this can be achieved without added dollars (except in the initial transition period) and through restructuring and redistribution. This vision would provide a health care system appropriate for an ageing society. Reform to date, however, does not suggest this is likely to happen in the forseeable future. Indeed, rather than embracing and implementing the recommendations of the National Forum on Health, the Prime Minister has recently announced the establishment of a new Commission (The Romanow Commission) to examine the health care system for the new century.

Current Issues - Diversity

Seniors represent a heterogenous group along a multitude of dimensions. It is important, especially when viewing aggregate statistics, to remember that diversity characterizes seniors. Not only does the term 'seniors' or 'elderly persons' span over three decades in terms of ages, it encompasses the rich, the middle class and the poor, the well and the ill, the educated and the not so educated, the happy and the sad, and a spectrum of subcultural groups. In this section, subcultural diversity is elaborated. There is a paucity of research in this area in Canada although the issue of ethnic or racial subgroups is receiving some attention and the delivery of culturally appropriate health care services has been of concern for some time.

The term 'cultural competence' has been used to refer to 'a set of congruent behaviours, attitudes, and policies that come together in a system, agency or among professionals and enables that system, agency, or those professionals to work effectively in cross-cultural situations', (Cross et al., 1989). It refers to more than cultural awareness or sensitivity, including not only cultural knowledge and respect for different cultural perspectives, but also having skills and being able to use them effectively in cross-cultural situations. Brach and Fraser (2000) argue that it includes an ongoing commitment or institutionalization of appropriate practice and policies for diverse populations. It refers to a continuum recognizing that responses to cultural diversity can vary in effectiveness.

After reviewing available literature, Brach and Fraser (2000) derive nine major cultural competency techniques that can be utilized with diverse populations, but hasten to add that the research does not tell us whether or not or in which situations these techniques are most likely to be effective. They include: interpreter services; recruitment and retention of

staff from the subculture involved; training to increase knowledge skills and awareness of the subculture; coordinating with traditional healers from that subculture; use of community health workers; culturally competent health promotion; including family and/or community members; immersion in another culture; and administrative and organizational accommodation. A major barrier to the delivery of culturally appropriate services, and of the implementation of many of the techniques listed here, is the small numbers of several different subcultural groups in one geographic area who seek health care services. This makes the provision of 'culturally competent' services, for example the hiring and training of staff in one subculture, highly costly.

In Canada, one of the most striking examples of a subcultural group that reflects dramatic poor health and disadvantageous social conditions is aboriginal peoples (including North American Indians, First Nations people) registered under the Indian Act, North American Indians not registered under the Indian Act, Métis people, and Inuit people. Canada's Royal Commission on aboriginal people (1996) documents the social and health situation of these individuals dramatically illustrating the inter-relationship between the two:

- The life expectancy of registered Indians is 7-8 years shorter than that of non-aboriginal Canadians (statistics are not available for other groups of aboriginal peoples).
- Unemployment rates, low educational attainment, and welfare dependency are higher in First Nations communities.
- The incidence of violence, physical and sexual abuse, and suicide is higher in aboriginal communities.
- Aboriginal people are increasingly effected by conditions such as cancer and heart disease.
- Children in aboriginal communities have higher rates of accidental death and injury than other Canadian children.
- Many aboriginal communities have higher rates of infectious diseases such as tuberculosis and AIDS than non-aboriginal Canadians.

The leading causes of death among First Nations infants - respiratory ailments, infectious and parasitic diseases, and accidents - are indicators of inadequate housing, sanitary conditions, and access to medical facilities. Death rates among adults from infectious and parasitic diseases are consistently above national levels, reflecting differences in lifestyle and living conditions.

One difficulty when studying the area of cultural minorities is that many of these groups are also economically disadvantaged so that it is difficult, if not impossible, to determine the extent to which cultural uniqueness or economic disadvantage is operative. The National Forum on Health's working group concluded that the consequences of hardships among aboriginal peoples are similar to those experienced by others in the same circumstances. That is, Canadians who experience inadequate income, dependency on welfare, substandard living conditions, stresses, physical violence, sexual abuse, and substance abuse suffer worse health. Zong and Li (1994) studied 118 countries around the world and concluded that economic conditions and nutritional levels, not cultural influence

implied in 'race', were responsible for differences between countries in life expectancy and infant mortality rates.

The relationships between socioeconomic status, specifically poverty, and ill health are well-known and well-documented (Wilkinson, 1996; Hay, 1994). Similarly, the social gradient in health has also been well-documented and is receiving widespread acceptance. The social gradient refers to the fact that those with less socioeconomic resources than others have more ill health; those on the second highest rung of society are in better health than those on the third highest rung, but less healthy than those on the highest rung. This refers not simply to having more income or education, but to the distribution of inequality in a society. In other words, inequality per se is bad for health, irrespective of the absolute income level or material standards of living. As has been obvious throughout this paper, many of the seniors who require assistance are those who are living at or near the poverty line. Those in poor health with higher income, have the means to be able to receive needed care. The issue of affordable health care, two-tier health care, is dealt with in the companion paper by Evans and Barer so is not pursued here.

Research on aging among other subcultural groups in Canadian society is scant at best, and much of the research in this area from the United States focusses on blacks and hispanics, two groups which are not prominent in Canadian society. Research which is available suggests the common assumption that cultural minorities utilize fewer health care services is not warranted, at least among some groups. It is commonly believed that subcultural minorities have extensive social network that provide needed care and, due to preference as well as system barriers, do not use established services to a large extent. However, a representative sample of (N=870) Chinese seniors in greater Vancouver and greater Victoria (Chappell & Lai, 1998), reveals that they utilize formal health care services to the same extent as do seniors in general, even when controlling for a number of health variables. Furthermore, they overwhelmingly embrace and believe in the effectiveness of Western medicine. Among this cohort of seniors, a minority understand English well so they see practitioners who have Chinese staff.

That research also suggests the falsity of the assumptions that seniors within subcultural groups extensively use traditional or alternative medicines, and that such use is instead of the use of Western medicine. Rather, Chinese elderly in Vancouver and Victoria use traditional Chinese medicines in addition to Western medicine, not as a substitute. Those who use traditional medicines the most are those who also embrace traditional ancestor worship. Despite the fact that the use of alternative medicines and therapies is associated with subcultural groups, mainstream 'white' society also has their folk remedies and beliefs (such as the health benefits of chicken soup and the illness effects of staying in wet clothing). While data are starting to be collected in national health promotion surveys, we do not know whether subcultural groups differ substantially from the host society in this regard.

The issue of long-term institutional care targeted to subcultural groups lacks consensus in Canada. Even where there are sufficient numbers to warrant dedicated nursing homes, or wings of homes, there are differing views as to the appropriate course of action. In the province of Manitoba for example, such targeting is considered responsiveness to subcultural need where specialized food, language, furniture, timetabling, activities, etc. can be provided. In contrast, the province of British Columbia has responded to such requests as unacceptable because they are discriminatory (a nursing home for Chinese seniors for example would exclude non-Chinese seniors and would therefore be discriminatory).

There are many other areas of diversity that are equally relevant to an aging society. One area of diversity that has received little attention in the gerontological literature is that of geographical differences. Canada not only has vast geographic expanse, but also tremendous diversity of terrain (mountains, lakes, inlets, islands, coast plains) and as well, extremes of

temperature (from places such as Winnipeg that have such cold, snow and ice conditions that seniors can be housebound for months to Victoria, where winters can pass without a snowfall). Physical access, both due to social support and to needed services, includes not only travel time and costs, but physical barriers within the environment. Lin and Allan (2000) have demonstrated the impact of both distance to and terrain barriers on hospital care. This area has particular salience for a country like Canada, and requires much more research.

Another area of diversity relates to remote, rural and urban place of residence. Formal services have historically been concentrated in urban areas and seniors tend to migrate from remote areas to small rural towns but those towns are still lacking in services. Canada's vast geographic expanse poses particular challenges in this regard. Some provinces such as Newfoundland present unique settlement patterns, where the majority of their senior citizens live in small towns of 100 or less (the majority of whom are often elderly), scattered at substantial distances from one another in a harsh climate and in rugged terrain. Self care and informal social support are the backbone of care in these communities, with mobile health clinics visiting occasionally.

Diversity alerts us to the fact that social policy for an ageing society must be sufficiently flexible to permit responsiveness to differing situations. This has been the idea behind the 'closer to home' concept within health reform. Efforts to bring health care closer to the local community though (as elaborated in the preceding section), highlight the dangers of this approach and are a reminder that these are complex problems without obvious or simple solutions.

Conclusions

An ageing population has implications for virtually all of social policy; only a selection of examples have been discussed in this paper. Canada's elderly population today consists of individuals who have spent most of their adult years within marriages and most have living children, with at least one nearby geographically. Canadian seniors are, by and large, retired and most are not living in poverty although about half of unmarried elderly women do live in poverty. Seniors view their health as good for their age, but they are heavy users of health care services and of medications. Being without defined productive roles, economic circumstance and health care are both relevant for life during old age in Canada and have implications for social policy.

Despite the lack of productive roles and the presence of ageism within society, seniors are nevertheless embedded within active social networks and are strongly supported by their own family members. They do, furthermore, cope quite well despite declining physical health, which tends of occur on a more or less gradual basis. However, the lack of replacement roles for discontinued involvement in paid labour within capitalist Canada, does leave many seniors without the option of meaningful participation in which they could define themselves as contributing in a worthwhile manner to society. Recently, governments, especially the federal government, has acknowledged volunteering as a mechanism to both provide such opportunity to seniors and to capitalize on seniors as an untapped resource. Social policy and programs that would facilitate and support meaningful volunteering, however, have not yet been launched, partly because many of the difficulties in doing so have not been resolved. These barriers include introduction to the workplace without threatening job security and implementation of options without exploiting seniors themselves.

Seniors, like younger adults, overwhelmingly prefer ageing in place. This concept informed the next two issues discussed, supportive housing and home care. The built environment is an essential component to ageing in place, one that can mean the difference between independence or the lack thereof. The option of choice for many whose health has declined, is known as supportive housing. This is not a new concept but it has not been

available in Canada. Even at the present time in which there is widespread support for this notion, few such options are available through public provision. This means that for those who are most in need of supportive housing (those without economic means), it is least available.

Health care in the community and in the home is critically important if those with failing health are to age in place. Without entering the debate about cost effectiveness (not the topic of this paper), home care has been presented as an optimal service for an ageing society, a program of services that has been widely endorsed both within Canada and elsewhere. Unfortunately, health reform that is taking place at the current time in Canada does not suggest an expansion of an appropriate and adequate home care system for an ageing society. To the contrary, reforms to date suggest a transformation of a previously existing chronic care community system into a medical support system for intensive post-acute hospital care. The desirability and appropriateness of an expanded home care system for seniors, however does not seem to be in question.

The final issue discussed here related to diversity, with a particular emphasis on subcultural or ethnic diversity. This represents another social policy issue which has been acknowledged within Canada and for which there is much concern and the solutions have yet to be formulated. Available research suggests that some of the assumptions about subcultural groups are not accurate and that we require valid knowledge as a starting point for dealing with many of these issues. How best to provide health care, for example, for different subcultural groups, is a challenge with which Canadians are still struggling.

The issues that have been raised in this paper are all salient at the present time in Canada; they refer to currently acknowledged difficulties for seniors but difficulties that do not have obvious solutions, or, where the solution is known, do not have obvious paths of implementation. The extent to which satisfactory answers will be found within social policy and program delivery remains unknown at this time.

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Work and Family

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Mr. Woo was born in Malaysia and grew up in Singapore. He was educated at Lester B. Pearson College, Wheaton College, the University of Cambridge, and the University of London. He came to Canada in 1988 and has been with the Foundation since 1996. Mr. Woo previously worked as a consultant on international marine issues and as an economist for the Monetary Authority of Singapore, the Government of Singapore Investment Corporation, and the Institute of Southeast Asian Studies.

Lead Presenter: Nobuko Nagase

Nobuko Nagase, PhD, is an Associate Professor of Graduate School of Humanities and Sciences at Ochanomizu University. She teaches and researches in the areas of labor and social policy. Much of her work focuses on the analysis of patterns of labor supply behavior of Japanese women, child-care support programs and social policy. She received her doctorate in labor economics from Tokyo University in 1995. Dr. Nagase's recent and forthcoming publications include papers on women and the pension system, analysis of supply of child-care facilities, and the estimation of child cost. She is a member on the Specialist Sub-Committee under the Council for Gender Equality in the Cabinet Office.

Lead Presenter: Linda Duxbury

Linda Duxbury is a Professor at the School of Business, Carleton University. She received a B.A.Sc. and M.A.Sc. in Chemical Engineering and a Ph.D. in Management Sciences from the University of Waterloo. Within the past decade she has completed majors study on (1) Balancing Work and Family in the Public and Private Sectors, (2) HR and Work-family Issues in the Small Business Sector (3) Balancing Work and Family in Saskatchewan, (4) Management Support - What is it and Why does it Matter? (5) Career Development in the Public Sector and (6) Career Development in the High Tech Sector. Dr. Duxbury has also (and is currently) conducted research which evaluates the organizational and individual impacts of E-mail, portable offices, cellular telephones, telework, compressed work week, flextime, shiftwork, regular part-time work and on-site day care programs, change management and studying what makes a "supportive" manager.

Dr. Duxbury has published widely in both the academic and practitioner literatures in the area of work-family conflict, supportive work environments, stress, telework, and supportive management. She has also given over 150 plenary talks on these issues to both public and private sector audiences.

Within the business school at Carleton, Dr. Duxbury teaches the third and fourth year courses in Systems Analysis as well as the masters course in Management of Technology and the Ph.D course in Managing Change.

Dr. Duxbury is also an accomplished trainer and speaker in the area of supportive work environments, gender and communication and the communication process.
Dr. Duxbury held the Imperial Life Chair in Women and Management from 1992 to 1996 and is current Director of Research for the Carleton Centre for Research and Education on Women and Work. She sits on Carleton University Board of Governors and was appointed in 1999 to the Fryer Commission on Labour-Management Relations in the Federal Government. In May, 2000 Dr. Duxbury was awarded the Public Service Citation from the Association of Public Service Executives for her work on supportive work environments.

Discussant: Ito Peng
Ito Peng is an Associate Professor at the School of Policy Studies, Kwansei Gakuin University. She received a B.Sc. from University of Toronto, B.S.W and M.A. in social welfare policy from McMaster University, and Ph.D. in Social Policy and Administration from London School of Economics. Dr. Peng's research focuses on: 1) comparative welfare states, and particularly comparisons of welfare states in East Asia with the European and North American welfare states; comparison on family policies; and 3) gender and welfare states.
Her current research involves: 1) a comparison Japanese, Taiwan, and Korean welfare states; 2) effect of the marketization of care in Japan since the introduction of the long term care insurance scheme; and 3) gender, demographic changes and welfare state restructuring in Japan.
Dr. Peng has published widely in both academic and policy literatures in the area of comparative welfare states, gender and family policies in Japan, and has given numerous lectures and plenary talks on these topics. She has worked with the Canadian and Japanese governments on social policy issues. Dr. Peng is also a member of the experts committee on European and East Asian Social Policy Research Group for the World Bank, and the Committee on Gender and Social Safety Net for UN ESCAP.

Discussant: Michael MacKinnon
Michael MacKinnon is an Associate with the Policy Research Initiative within the Privy Council Office of the Government of Canada. Over the past two years at the PRI he has worked on issues such as population health, rural community development, social cohesion and public service renewal. Prior to joining the PRI, Mr. Mackinnon worked in a wide range of government departments, including Health Canada's National Health Research and Development Program.
Mr. MacKinnon is a graduate of Carleton University, with a Master of Arts degree in both Soviet and East European Studies and Public Administration, and has been an officer in the Cadet Instructors' Branch of the Canadian Forces Reserves for the past twelve years.

Health Domain

Chairperson: Shuzo Nishimura

Shuzo Nishimura is a professor in the Faculty of Economics at Kyoto University. He conducts research in the area of aging society and its influence on economic. He has published books on the economics of medical care, medical insurance and welfare.

Lead Presenter: Robert G. Evans

Robert G. Evans is a professor with the Department of Economics, and a member of the faculty of the Centre for Health Services and Policy Research, at UBC. He is a Fellow of the Canadian Institute for Advanced Research and was director of the Institute's Program in Population Health from 1987 to 1997. From 1985 to 1997 he held a National Health Research Scientist award at UBC, and has received a CIHR Senior Investigator award for the period 2001-05. Major publications include Strained Mercy: The Economics of Canadian Health Care (1984), and Why Are Some People Healthy and Others Not? The Determinants of Health of Populations (1994) [senior editor].

Dr. Evans' studies of health care systems and policies have led to a number of invitations to provide policy advice to the Canadian federal and provincial governments. He has also been a consultant and lecturer on health care issues to a number of governments and other public agencies in the United States, Europe, Asia and the South Pacific. Dr. Evans was a member of the British Columbia Royal Commission on Health Care and Costs in 1990-91, and of the National Forum on Health, chaired by the Prime Minister of Canada, from 1994 to 1997. He is an honorary Life Member of the Canadian College of Health Services Executives and of the Canadian Health Economics Research Association, and is a member of the National Academy of Social Insurance (United States), and has recently been elected a Fellow of the Royal Society of Canada. Dr. Evans received his undergraduate degree in Political Economy from the University of Toronto in 1964, and a Ph.D. in Economics from Harvard University in 1970.

Lead Presenter: Hiroya Ogata

Hiroya Ogata is a professor in the Graduate School of Medicine (Master Course in Medical Management and Administration) at Kyushu University. Prior to this he was, Director of the Department of Empirical Social Security Research at the National Institute of Population and Social Security Research in Tokyo. Hiroya Ogata has served the Japanese government in many capacities, including as: Director of the Department of Hospital Administration for the Federation of National Government Employees' Mutual Aid Associations; Planning Director of the Nursing Division in the Health Policy Bureau at the Ministry of Health and Welfare; and First Secretary of the Permanent Mission of Japan for the International Organizations in Geneva. Hiroya Ogata was educated at the University of Tokyo, receiving a B.A. in Urban Engineering in 1975, a B.A. in Economics in 1977, and a B.A. in Business Management in 1978. His research interests are in social security policy in general, and health policy, health economics and hospital management in particular. He has published a number of books and articles on these issues.

Discussant: Carmen Connelly

Carmen Connolly was appointed to the position of Director, Canadian Population Health Initiative at the Canadian Institute for Health Information in June 1999.

MS Connolly was born in Maniwaki, Quebec and graduated with a B. Sc. (Dietetics) from the University of Ottawa in 1973. She completed a dietetic internship at St. Michael's Hospital in Toronto and worked as a clinical dietitian in Ottawa prior to serving with the Canadian University Services Overseas (CUSO) in Togo, West Africa. Upon returning to Canada, Carmen obtained a Post-Graduate Diploma in Public Health from the School of Hygiene, University of Toronto (1976) and an MA in Adult Education from the Ontario Institute for Studies in Education, University of Toronto (1980).

Ms. Connolly has extensive experience in policy development, program management and strategic planning and has held a number of progressively senior positions in the health care, academic and governments sectors.

She has worked in public with the North York Public Health Department (1977-1980) and the City of Toronto Department of Public Health (1981-1985, 1987-1989) as a consultant and co-ordinator of nutrition and prenatal programs. From 1985-1987 Ms. Connolly held an appointment at the University of Toronto as an Assistant Professor and Co-ordinator of the M. H. Sc. Program in Community Nutrition.

In 1989, Ms. Connolly moved to Ottawa, Ontario to join Health Canada, Health Promotion Directorate where she managed national programs and policy development in nutrition until 1994. Building on this experience, she then joined the Secretariat of the Prime Minster's National Forum on Health where she served as Senior Policy Analyst, Determinants of Health. In 1997, Ms Connolly returned to Health Canada as Manager, Canadian Population Health Initiative and then as A/Director General for the Major Projects Directorate. She remained at Health Canada until she assumed her current appointment.

In addition, Ms. Connolly has volunteered on several national, provincial and regional Boards and Committees such as the Canadian Cancer Society, the Heart and Stroke Foundation of Ontario, Ryerson, and the Sandy Hill Community Health Centre.

In her capacity as Director, Canadian Population Health Initiative (CPHI) at CIHI, Ms. Connolly's principal responsibilities relate to ensuring that CPHI carries out its core functions:

- Generate new knowledge on he determinants of heath;
- Contribute the development of a population health information system and infrastructure;
- Analyze and synthesize population health research findings and promote the transfer of knowledge to policy/decision makers; and,
- Develop and disseminate reports for decision- makers and the public on the policy implications of population health research findings and changing patterns of population health.

Discussant: Nobuyuki Izumida

Mr. Nobuyuki IZUMIDA is research fellow in the National Institute of Population and Social Security Research, Japan. He majors in health Economics and related studies. His current interest is utilization of claim data from the medical institutions in Japan. He was at the University of York as a Visiting Scholar from December 1999 to March 2000.

Aging Domain

Chairperson: Koichi Hiraoka

Koichi Hiraoka is a professor at Ochanomizu University in Tokyo. He received his PhD from Tokyo University. His research interests are sociology, social policy theories, and social welfare theories. He has conducted international comparative social policy research.

Lead Presenter: Yoshihiro Kaneko

Dr. Yoshihiro Kaneko received his doctorate in economics from Hitotsubashi University in November 1993. In 1996, he joined the Department of Empirical Social Security Research at the National Institute of Population and Social Security Research, Tokyo, as a Senior Research Fellow. Dr. Kaneko co-authored a book, entitled, "Economic Analysis on Pension Systems: Towards the Actuarially Fair Pension System," for which he was awarded the 1996 Yomiuri Newspaper and Japan Institute of Labor's prize for the best book on labour issues.

Lead Presenter: Neena Chappell

Dr. Chappell is a Professor in the Department of Sociology at the University of Victoria. In 1992, she became the first Director of the Centre on Aging. Over the past seven years Dr. Chappell has developed the Centre into a world-class research facility that is accessible to the community-at-large. Her previous experience as Founding Director of the Centre on Aging at the University of Manitoba helped define her commitment to research of the highest calibre in aging.

Dr. Chappell's critical research and writing on aging in our society are motivated by a strong commitment to improving the quality of life of seniors and the calibre of care they receive. Her current research focuses on respite care for caregivers, care for people with dementia, drug policies, aging and ethnicity, quality of community-based home and residential care and the Canadian health care system. Dr. Chappell has written more than 200 academic articles and reports, authored books and spoken extensively on health, health care policy, and formal and informal caregiving that has relevance to seniors. She is an Editorial Board Member of the Journal of Aging and Ethnicity, Canadian Journal of Sociology, Journal of Aging Studies, Journal of Applied Gerontology, Social Sciences, Journal of Gerontology and The Gerontologist and has sat on many boards and committees. She was an executive member of the Canadian Institutes of Health Research Task Force and its interim governing council. She is currently a member of Health Canada's Science Advisory Board and is a fellow of the Royal Society of Canada.

Discussant: Michiko Mukuno

Michiko Mukuno is director of the Department of Research and Planning and Coordination, and of the Department of Empirical Social Security Research, at the National Institute of Population and Social Security Research. Prior to this, she was a professor at Japan College of Social Work, teaching on social security in general. While she worked for the Ministry of Health and Welfare, she wrote and edited the 1998 White Paper 'Considering the Society with Fewer Children'. Her current research is focused on gender and social security, and social service and informal care.

Discussant: Sherri Torjman

Sherri Torjman is Vice-President of the Caledon Institute of Social Policy. She is the recipient of the 2000 PRS Knowledge Broker Policy Research Award. She has written in the areas of social spending, the interaction of the welfare and the tax systems, social program reform, social services, health care and fiscal arrangements. She is the author of many Caledon reports including Strategies for a Caring Society; Civil Society: Reclaiming Our Humanity; Sustainable Social Policy; The Key to Kyoto: Social Dimensions of Climate Change; and Partnerships: The Good, The Bad and The Uncertain. Ms. Torjman has co-authored many Caledon reports including How Finance Re-Formed Social Policy; Opening the Books on Social Spending; and Lest We Forget: Why Canada Needs Strong Social Programs. She has taught a course in social policy at the McGill University School of Social Work.

Ms. Torjman has written the welfare series of reports for the National Council of Welfare, including Welfare in Canada: The Tangled Safety Net; Welfare Reform; and Welfare Incomes 1989, 1990, 1991, 1992, 1993 and 1994. She also has authored four books on disability-related policy: Income Insecurity: The Disability Income System in Canada; Poor Places: Disability-Related Housing and Support Services; Nothing Personal: The Need for Personal Supports; and Direct Dollars: A Study of Individualized Funding.

Sherri Torjman worked for the House of Commons Committee on the Disabled and the Handicapped, the House of Commons Special Committee on Child Care and the Royal Commission on New Reproductive Technologies. She is a former Director of The Trillium Foundation.

Cross-Cutting Themes and Issues for Further Collaborative Research

Chairperson: Noriyuki Takayama

Noriyuki Takayama is a professor in the Institute of Economics at Hitotsubashi University. He conducts theoretical and econometric research on pensions and decreasing birth rates. He recently began a research project into the coordination of interests between generations. He has been active in a number of committees, including the Council on Population Issues and the Council on Pensions.

Lead discussant: Michèle Stanton-Jean

Michèle Stanton-Jean, was appointed Special Advisor to the Minister of Foreign Affairs (Health and Social Affairs) assigned to the Canadian Permanent Mission to the European Commission in Brussels in July 1998. She held that position until August 2000. In September 2000 she was appointed Advisor in Programs Development, Montreal University, Faculty of Higher Education. Previously, from 1993 to July 1998, Michèle S. Jean was Deputy Minister of Health Canada.

Mrs. Jean started her career as a journalist in Quebec City. She then completed a B.A. and an M.A. in History and an M.Ed. in Adult Education, all at Montreal University. In 1995, she was awarded an Honorary LL.D. from Concordia University.

From 1980 to 1982, she chaired the Quebec Inquiry Commission on Vocational and Socio-Cultural Training for Adults. She then served as a consultant for the International Institute for Educational Planning (IIEP) in Paris. In 1984, she was appointed Assistant Deputy Minister and Director General of the Professional Training Division in the Quebec Department of Manpower and Income Security. In 1988, she became Executive Director of Employment Services in the federal Department of Employment and Immigration and was named Associate Deputy Minister of that department in 1990. In 1992, she was appointed Under Secretary of State.

One of the ten Quebec "Women of the Year" in 1979, she was named "Career Woman of the Year" by Montreal's O'Sullivan College in 1981. She is the author of several books and publications including " L'Histoire des femmes au Québec de la Nouvelle-France à nos jours", written with three other historians.

Mrs. Jean has participated in several international meetings and working groups on labour market training, adult education, health and aging in Argentina, France, China, Europe and Canada.

Lead discussant: On-Kwok Lai

On-Kwok Lai is a professor in the School of Policy Studies at Kwansei Gakuin University. He currently holds both an honorary research fellowship at the Centre of Urban Planning and environmental Management and an honorary professorship in Social Administration & Social Work at the University of Hong Kong. He completed his Dr.rer.pol. at the University of Bremen, under a DAAD Fellowship in Germany. He has taught in Hong Kong and New Zealand. His research interests are in the area of comparative urban and environmental affairs.