Investigation of the Japanese Care Manager and Discussion on its Transferability into the Chinese Context

by

Jing Wang

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The University of Sheffield, UK

Faculty of Arts and Humanities

School of East Asian Studies

and

The Tohoku University, Japan

Graduate School of Law

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Declaration

I, the author, confirm that this Thesis is my own work. I am aware of the University's Guidance on the Use of Unfair Means (www.sheffield.ac.uk/ssid/unfair-means). This work has not been previously been presented for an award at this, or any other university.

Jing Wang

Abstract

Japan is on the frontline of ageing in East Asia. In this research, the Japanese elderly care delivery is examined, via analysing the role of care manager under the long-term care insurance system (LTCI). This thesis examines facility-based, agency-based and community centre-based care managers, via case studies conducted during my fieldwork in Japan. The investigations find functional and relational problems as a structural paradox in their work, and thus suggest possible improvements for the LTCI system. Following findings in the Japanese context, this research also broadens its insights into elderly care in China that is going through a process of similarly rapid increase in ageing population. In addition, this research is also a pilot trial, discussing the possibility of applying the mechanism of the Japanese care manager into the Chinese system. This thesis contributes to the research on care managers and elderly care in Japan and China, and fills the lack of research available in English. This research is also pioneering in academia in exploring the topic of the care manager in the Chinese context. Ageing is a worldwide issue; I hope this investigation can also share experiences for other nations in similar demographic transformations, from the lessons gained in Japan and China. In addition to the empirical explorations, this research also expands the analytic scope to a theoretical reflection of the care manager role and its transferability, by referring to policy diffusion theory, and the body theory from Michael Foucault, which complements the theoretical interpretation regarding research on the care manager and elderly care.

List of Abbreviations

ARAS	Annual Report on the Ageing Society (Cabinet Office, Japan)
CBLTC	Community-Based Long-Term Care
GBP	Pound Sterling
GDP	Gross Domestic Product
JNA	Japanese Nursing Association
JETRO	Japan External Trade Organization
LDP	Liberal Democratic Party
LTCI	Long Term Care Insurance
MHLW	Ministry of Health, Labour and Welfare
NGO	Non-Governmental Organization
NPO	Non-Profit Organization
OECD	Organisation for Economic Co-operation and Development
PhD	Doctor of Philosophy
PPP	Public-Private Partnership
QOL	Quality of Life
RMB	Ren Min Bi (official currency of the People's Republic of China)
UEBMI	Urban Employees Basic Medical Insurance
UN	United Nations
UNDESA	United Nations Department of Economic and Social Affairs
USD	US Dollar
WHO	World Health Organization

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Chapter One: Introduction

1.1 Introduction

Living with dignity at the end-of-life stage is a common pursuit for every human being; and dealing with the ageing population is a worldwide policy challenge for every nation. In Japan, people aged over 65 years occupy 28.8 per cent of the total population (ARAS; 2021). This research investigates the societal solutions provided in ageing Japanese society, via exploring a particular entity: the Japanese care manager, working as a key person in the long-term care insurance system (LTCI). Following the investigation into the Japanese context, this research also presents a discussion on the possibility of applying the care manager model into the Chinese socio-economic environment, resulting in a reflection on elderly care beyond a specific national context.

Tackling the issue of ageing requires proactive, comprehensive preparation. A sustainable system for elderly care delivery requires two essential factors: adequate financial resources and a sufficient number of qualified people to work within it. The financial sustainability comes from the LTCI, a hard structure built from a macro-level policy design. An efficient workforce forms the soft structure, indispensable at the micro-level, for ensuring the operation of the LTCI. My research focuses on the *care manager,* the key role in working in elderly care under the LTCI structure.

In Japan, the LTCI system started in 2000, having evolved from previous medical and social welfare systems. It is a universal system. and provides in-kind services for beneficiaries aged over 65, or who have been diagnosed with specific diseases aged over 40. The LTCI built up a macrostructure for the entire Japanese society, and opened up the privatisation of care provision in the market. The role of the Japanese care manager has its roots in the LTCI, bridging the insurance system and its beneficiaries. The care managers are mainly categorised into three types: i.e.,

agency-based, facility-based, and community centre-based care managers according to the type of affiliation. The case study chapters introduce these respective responsibilities in more detail.

The care manager is the top position in terms of career path in the care industry. This research explores specific roles and working circumstances in the context of the LTCI, to examine elderly-care delivery in Japan, exploring its dynamics, and then generating a discussion beyond a specific regional context. As a close neighbour, associating with Japan in various aspects in the long history, China is also going through a tremendous demographic transformation regarding its ageing population. Therefore, this research also structures the discussion on the lessons that can be learnt from Japan, and thus deepens insights in exploring the potential of establishing a similar care manager mechanism in Chinese society. China has so far only experienced the LTCI for a few years and in limited areas after adopting it since 2016. Japan and China also have significant socio-economic differences. Therefore, applying the Japanese care manager role into a Chinese context is not based from a comparative study, but instead an explorative approach has been taken, to discuss its potential to do so, examining the care manager's functionality in the system.

For a comprehensive understanding of the role of care manager and the entire elderly care system, I collected first-hand data through fieldwork and secondary data from literature. I stayed in Japan for one year, then travelled to China to investigate the situation from observations. The first-hand data formulate the major contents of the case studies in this thesis. The secondary data is from the literature studies, including academic publications, official documents, and industrial reports. Three case studies examine the facility-based, agency-based and community centre-based care manager roles in-depth, via participant or non-participant observations in their working environments. In addition to the first-hand observations, semi-structured interviews were held with care managers

outside of the workplace, and with people associating with them during their work. This first-hand data collection supplements the existing literature.

The Japanese care manager contributes significantly to running the LTCI system, and inevitably they encounter problems in their work. In summary, there are two layers of relationship in the role: the 'individual to institution' relationship, i.e., the care manager tackles relationships with the institutions within the LTCI regarding the municipality, their affiliating institution, and service providers; and the 'individual to individual' relationship, i.e., the care manager interacts with various older people for face-to-face counselling.

In the empirical findings, the functional problem was found in the 'individual to institution' relationship, whilst the relational problem was found in the 'individual to individual' relationship. The functional problem indicates the dilemma between individual and institution: i.e., the gap between what a care manager is supposed to do according to policy, and what they can actually do in reality. The relational problem indicates the dilemma between individual and individual, i.e., the gap between what a care manager is supposed to do for the beneficiary, and the reality of what they actually can do for the beneficiary. The 'nuts and bolts' of these dilemmas are explored in the case study chapters.

By discovering the strengths and weakness of the role of care manager in the LTCI system, we are able to form an overarching picture of the elderly care system in Japan, and make suggestions regarding the enhancement of service delivery for the whole social welfare system. By contrast, the Chinese LTCI has only been instituted in designated cities since 2016, and is not yet formed at a national scale. There is no care manager role currently. Operationally, everything is still in its initial stages; and as yet, there is not enough research available on the system. To understand circumstances first-hand, I travelled around several cities in China to witness the situation in person. In the same way as conducting the case studies in Japan, I visited facility-based institutions and community centres, and interviewed

staffs there, in order to form a relatively comprehensive understanding as to the possibility of applying the care manager model in China.

The discussion on transferring the mechanism of Japanese care manager into the Chinese context has been designed to be consistent with the logical sequence followed in investigating the care-manager role categories. Via examining the functionality of each type of Japanese care manager (i.e., facility-based, agency-based and community centre-based), the possibility of applying these roles into China is discussed according to the function of each type. Then the discussion follows the logic of whether it is possible to establish the care manager role, and how to establish it respectively in the contexts of facility-based, agency-based and community centre-based in China. This part of the analysis is presented in the independent chapter following the three Japanese case studies. As noted, this is not a comparative study, but rather a venture to locate a social mechanism from one domestic context into another, through which hypothesis there also arise reflections on the solution to the ageing population issue faced by all humankind.

The theoretical analysis on the research topic is conducted after the empirical conclusions. The functional problem and relational problems of a care manager's work stem from the paradoxical attributes embedded in their social identity—as both a scrutinizer and a service provider in the LTCI, fulfilling both sides of a naturally opposing process, which I have termed a 'structural paradox'. The dilemmas faced by a care manager pique my intellectual curiosity in areas such as individuality, institution, actor, agency and so forth. The care manager's work is guided by the structure (LTCI), and their work in turn influences the structure itself. A body of theorists shed light on the analytical framework of dualism between the individual and the institution. Among various prominent thinkers and perspectives, I adopt the 'theory of body' created by Michel Foucault (1978) in understanding the existence of care manager, i.e. the perspective of individual and institutional body of the care manager in the elderly care system. Foucault's *theory*

of the body forms his interpretation through '*Power-body*' conjunction to understand the body as a 'machine' (Foucault; 1978:139) that is an object of power to control and regulate through discipline, optimising its capabilities, exerting its forces, increasing its usefulness as well as its docility, and integrating into an efficient and economic system, which provides an intriguing explanation for me to explore the role of care manager.

In the discussion on transferring the Japanese care manager model into the Chinese system, I adopt the policy diffusion theory in analysing possible diffusion mechanisms between different socio-economic contexts. Different to policy transfer, policy diffusion contains the connotation of adjustment and transformation when applying a policy into a different social environment (Marsh. D and Sharman. J C; 2009). China initiated the LTCI in 2016, and has been testing the new modes in a few areas. Both central and local government are seeking efficient policy approaches for the large ageing population in the near future (Luo. X and Wang. R; 2021). It is certainly significant to learn and refer to the historic experiences of Japan, which has undergone a longer policy operation in LTCI for tackling the high ageing rate.

In contrast to research in the western world, policy diffusion research has not yet developed sufficiently in China and for Chinese issues (Wang. P Q and Lai. X J; 2013). Based on the literature review of policy diffusion from English literature and Chinese literature, I have created a theoretical framework for research on policy diffusion in China. In response to the research question about the transferability of the care manager model, this framework comprises two logic layers: (i) whether it is possible to transfer? And (ii) how to transfer if so? Regarding 'whether it is possible', I analyse the possibility from the perspective of transferring the functionality of three types of care managers in Japan, i.e., facility-based, agency-based and community-based, to conclude the answer respectively, based on empirical evidence. In regard to 'how to transfer', I make assumptions

based on the policy diffusion framework in China, and suggest possible approaches with expected benefits and difficulties, based on considering the specific political environment in China.

The reason for choosing the body theory and policy diffusion theory separately in the theoretical analysis section lies in the contents of the research questions. The research questions include two layers: the investigation of the care manager per se, and the discussion on the transferability of this social mechanism between two nations. The answers to the questions cross macro and microstructures, institution and individuality. There are fertile options of theories to comprehend the care manager. I venture the analysis from the 'power-body' context, partly due to my respect for Foucault's interpretation of 'power' his narrative, and how effectively this analysis allows understanding of the care manager's social and personal identity, which I will explain in the chapter of theoretical reflection. Aside from the focus on the care manager, another import purpose of the thesis is to investigate the possibility of applying such a mechanism into another social environment. Thereafter, I choose policy diffusion theory, which includes connotations of localisation and transformation of policy, to explore the possible paths of adopting and diffusing the care manager's role into the Chinese system.

In the book regarding palliative care *Being Mortal: Medicine and What Matter in The End,* Dr. Atul Gawande mentioned the philosopher Josiah Royce's opinion about 'care'. Josiah Royce stated people could not be happy if only being taken care of physically because life seems no meaning if there is no reason for it. Further, Dr. Atul Gawande pointed out the modern tendency of medicalizing too much on the physical safety and health measurement instead of focusing on the patient's preference and individuality. The definition and meaning of proper care have been widely discussed. Via conversations in my field work with many people working directly with the elderly, they all highlighted the importance of understanding the older people's previous life experiences. Taking care of a person at the last stage

of the life is not only about physical sustainability, it is also related to their life memories, such as the work they did, the memorable moments they had in life, the values they cherished, and so forth. Similar to making friends with a person, requiring comprehensive understandings of the person in front of one's eyes.

Since the humanitarian discussion is usually unfalsifiable unlike the unique result from scientific calculation, cautious reasoning is essential. The theories I choose for analysis and interpretation have pros and cons. Bridging the empirical findings and theoretical results is a challenge, yet a great opportunity to deeply understand the research target.

There are three dimensions in which this research tries to build an original contribution for academia. First of all, this research adds to the English-language literature regarding the research topic on the Japanese care manager. The English articles mainly focus on the LTCI, and less attention has been paid to the care manager. Although there is a small body of publications talking about the care manager, its contents are inconsistent regarding the subject, time, and location. Therefore, this research complements the research data in both languages for this topic.

Secondly, this research provides an overarching insight into elderly care delivery beyond one national context. Via examining the care manager role and its existence in the LTCI system, it enhances the depth of understanding of the Japanese LTCI system, and shares lessons to the Chinese society or nations with similar demographic transformations. Elderly care is an issue for human welfare, beyond one or specific regional contexts. Since China will move to an ageing society, making proactive plans by referring to helpful approaches of other nations is essential for Chinese society. At the same time, this is pilot research regarding the care manager in Chinese elderly care literature. The exploration of transferring a particular mechanism regarding policy design contributes to the originality of research.

Last but not least, this research enriches theoretical interpretation regarding the role of care manager and related welfare issues. In the current literature, welfare universities in Japan have conducted research on this topic from empirical angles without further theoretical reflection. Indeed, the role of care manager is a practical position, hence research questions have been usually directed towards an empirical tendency. However, as human beings, firstly, prior to their social identities, it is impossible to disregard personal traits in favour of exclusively considering work codes arising from the institution's requirement. In the eighth chapter, I adopt the 'body' theory and policy diffusion theory to interpret the care manager's existence and the transferability of care manager from Japanese system into Chinese society.

1.2 Research Background

Each family has elderly members that need care. Leo Tolstoy wrote, 'All happy families are alike; each unhappy family is unhappy in its way' in the novel *Anna Karenina* (Leo. T; 2016:3). Likewise, different nations might adopt various policies in dealing with the ever-increasing ageing population. It is possible to find common approaches regarding social policy design that enable the system to work sustainably and efficiently. This research focuses its attention on Japan and China. Japan has the highest ageing rate in the world, whilst China has the potential to surpass Japan regarding the number of aged people, due to its vast population. The lessons of these two nations are both worthy of consideration, if other countries are also to tackle ageing issues.

Taking care of the elderly is not only about caring for their physical condition. It entails a more profound understanding of the person. Older people come from various cultures, backgrounds, and different life stories, and thus, humanitarian consideration in the process of service delivery is significant. To attain this goal, as well as an adequate financial budget to sustain the system, sufficient and qualified labour is also essential for practical service delivery. Simply speaking, money and

people are indispensable elements for constructing a welfare system to respond to the ageing issue. This research revolves around the Japanese care manager, in order to look at the people working in the Japanese system, and further extend attention to China's situation.

The Japanese care manager works as the frontline dynamic in the LTCI system. They are rooted within LTCI, since they receive training and regulation from LTCI and are paid through this system. In Japan, for people who work in the elderly care system, the LTCI already has formed a complete career path from temporary home-helper to the most senior position as a care manager. The care manager acts as a bridge to connect the LTCI system and the beneficiary. They work as scrutinizers within the system to confirm whether the services have been adequately planned and provided. But, on the other hand, they are asked to put the beneficiary as the first priority to increase the quality of service. These two sides sometimes contradict practical operations, as they naturally oppose each other regarding benefits.

Most care managers have worked as care workers earlier in their career. Examining care managers rather than care workers helps to grasp the holistic structure of the LTCI system, since the care manager performs a comprehensive role. Japanese LTCI has been in place for over two decades, and has accumulated plenty of experience and lessons. In contrast, in China there is no complete career system in the care market yet, since the Chinese LTCI was instituted in 2016 and has been only established in a limited number of cities. This situation provoked me to wonder whether it is possible to apply the mechanism of Japanese care manager into the Chinese context, developing a relatively matured career structure for elderly care alongside the development of the LTCI as a whole system package in China in the future.

Japan has the fastest aged population in the world, with the expectation that people aged over 65 will exceed 30% by 2025 (Cabinet Office; 2016). This

demographic change has a significant impact on society at all levels, necessitating appropriate responses in a wide variety of areas (Matanle; 2017). The Japanese LTCI, established in 2000, aimed to accomplish social transformation under these demographic shifts and in the context of long-term economic stagnation after the economic collapse.[1]

The Japanese government achieved universal insurance in the 1960s and made a significant contribution to national health. Following expanding medical costs due to 'social hospitalisation'[2] and increase in the elderly population, after adopting the 'gold plan' in the 1990s, with the collapse of LDP[3] dominance, an insurance system independent from the medical system became necessary, and then LTCI was introduced, which was funded by both insurance and tax. In addition, it has spurred a quasi-market for elderly care in Japan, since every service rate was fixed and for-profit organizations were encouraged to enter into this market.

LTCI covers all disabled and frail people over 40 years of age without exceptions (Tamiya N, et al; 2002), integrating provisions for community-based, home-based and institutional care services (Sato. M, et al; 2006). It provides seven levels of services according to the conditions of a beneficiary. For example, at level 1 and level 2 of 'assistance required' (*yōshien*), beneficiaries can access the home-based care services, while at level 1 to level 5 of 'care required' (*yōkaigo*), they are eligible to use both home-based care and institutional services. Financial sustainability has been guaranteed by utilizing a co-payment approach.

Another important feature of Japanese LTCI is its human capital. Forming a complete career path regarding the workforce and setting up job roles from the

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[1] Economic Collapse: from 1986 to 1991, Japanese real estate and stock market inflated and the economic bubble burst(バブル景気) burst in early 1992.

[2] In the early 1970s, patients were admitted for hospitalization without much medical justification. The LDP abolished co-payment in medical care in Japanese economic boom. Medical costs soared and services towards elderly people developed slowly.

[3] LDP: Liberal Democratic Party, 自由民主党, conservative political party in Japan.

care worker to the care manager has enabled people in this industry to have explicit career goals, and helped the educational system establish sufficient straightforward training courses for preparing qualified people for service delivery. The term ‘care manager’ is, in fact, not new. It existed in various nations before the Japanese LTCI system was established. The care manager has also been named a ‘case manager’ since the 1970s; this position was defined under the development of community-based care provisions. At first, there was no social structure in charge of home-based and community-based care services. As a result, the case management based on this condition was developed, and thereby the role of case manager appeared during the process. Japan introduced the concept of the case manager from the US, and the Japanese government changed the definition from 'case' to 'care', as they thought the term 'case' was too detached to express the warm spirit embedded in care provision. Instead, they chose to adopt the term 'care' as more appropriate in this context.

Although there are mechanisms of case manager or care manager in different nations, ‘care manager’ in Japan is a unique structural design linked closely to the long-term care insurance system itself, with features significantly different from other national contexts. For example, the care manager and other types of care staff are rooted in the LTCI, and are paid according to a national-wide fee structure that is adjusted every three years (Rhee. C. J, et al; 2015). Most care managers work have worked as care workers previously. After working at the first site for over five years, they have to pass a municipal standardized exam and undertake a training program to get licensed as a care manager.

In contrast to Japan, which has a longer practical experience in operating the elderly care system, China’s LTCI is still in its primary trial stages. The majority of the ‘baby boom’ generation in China, similar to the era of ‘*Dankai Sedai’* in Japan, will become old and surpass Japan shortly regarding the number of people aged over 65 years by 2030. By 2050, it is estimated that the 65 years or more senior

will reach 358 million, approximately 26% of the total population (Feng. Z L; 2019). Dealing with the upcoming vast ageing population is becoming an urgent policy agenda for Chinese society.

In contrast to Japan, that moved into an ageing society after unprecedented economic growth since the 1960s, enabling every family to attain an averagely wealthy life, the GDP per capita in China was 10434.78 dollars in 2020, which is below the globally average 10918.723 dollars according to the world bank data[4].

Despite economic achievement after the reform and opening-up policy[5], the enormous ageing population and soaring ageing rate are bringing about great structural challenges for Chinese society. Becoming old without sufficient financial preparation is popularly termed '*Wèi fù xiān lǎo*' in the Chinese language. '*Wèi fù*' represents 'not reached the wealthy level of life' whilst *'xiān lǎo'* means 'get ageing first'; put simply, this phrase means 'getting old before getting rich'. This phenomenon poses challenges in various aspects of policy design and social preparation.

It is well known that China has practiced the one-child policy since 1980, and repealed this policy on the first day of 2016 (Feng, W., et al; 2016)—which means this strict population regulation has worked for 35 years nationally. In current society, after a long-term practice of the one-child policy, it is normal that the only child of a family lives distant from their birth home. Many young people born in metropolitan cities from economically developed families live in foreign countries for study or work. Young people from rural areas or less economically developed

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[4] The Word Bank Data on GDP per capita 2020
https://data.worldbank.org/indicator/NY.GDP.PCAP.CD?name_desc=false

[5] Reform and opening-up policy, 改革开放，known as Chinese economic reform; the concept was initiated in 1978 and practically started in 1992 under President Deng Xiaoping's guidance. Chinese economy was able to soar from this policy that in 2014 became the world largest economy by GDP, and accordingly transformations happened in various social aspects in past 30 years.

families move to metropolitan regions and thus, are still distant from their parents (Feng, W., et al; 2016). The empty nest elderly person (*kōngcháolǎorén)*[6] is becoming a normal social phenomenon in China. Massive migration in the background of the one-child policy has caused family-based caregiving capabilities to shrink drastically.

China is also seeking an appropriate approach to tackle the forthcoming ageing population. Based on the concrete economic and administrative features in different provinces, China adopted the LTCI in limited areas in 2016. Its practical operation has only gone through several years, and it is at a trial stage. Apart from the hard structure design that has built up a stable financial source for sustaining the welfare system, the soft structure (i.e., the people) is essential to ground the policy into daily life. This research consequently focuses on the people who contribute to the structure. As a key character, the Japanese care manager mirrors the pros and cons of the LTCI system. Discovering the practicalities of their work naturally leads us to understanding the whole system. Additionally, the discussion on its transferability into China will provides angles for Chinese elderly care. The hard and soft structures formulate a complete picture of elderly care in each nation.

1.3 Logical and Structural Sequence

Japan has a longer social experience regarding ageing issues, whilst China is facing a forthcoming intense ageing rate. By examining the cases in Japan and China, this research also discusses the solution for a rapidly ageing population worldwide. In spite of many criticisms towards the Japanese long-term elderly-care insurance system, due to the severe austerity budget of the central government, LTCI provides for an undeniably large elderly population in Japan, and has supported

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[6] *Kōngcháolǎorén*,空巢老人:the word 巢 usually describes bird nest;空巢 means a nest without bird literally, in this context, it represents the one-child generation move out distant from their family and left the empty house without people living in.

the operation of this mechanism smoothly since its establishment in 2000. Therefore, the Japanese LTCI system and its practice are worthy of exploration as a reference for China and other ageing nations.

The logical structure of this thesis is divided into three major steps. The first step starts with secondary data. It examines the previous literature and builds the overall understanding of this research. From literature review, the situation of current research and what has been missed in the research can be confirmed as research gaps, which helps to establish the research questions in this thesis. The second step is to form interpretations from the first-hand data collection. This part is an empirical study, and the investigations in Japan and China were conducted in my fieldwork. Three case studies examine the Japanese care managers in three types of affiliations. The research findings indicate the practical situation and problems in the care manager's work and further provides insights into the operation of the whole LTCI system. After investigating the situations in Japan, I also visited several cities in China to collect the first-hand information regarding my research question. Since there is no care manager in Chinese LTCI system yet. The fieldwork focused on the current reality of elderly care and people who work in the system. Based on the present information, it is a tentative discussion on the possibility of establishing a mechanism as the care manager in Chinese system. After the empirical studies in Japan and China, last but not least, the last part of this thesis develops theoretical understandings towards the care manager and the topic of *care* by referring to the *theory of body* in the interpretation of the existence of care manager as well as the issue of proper *care* for humankind.

In light of the logical sequence, the first chapter provides a brief introduction to the overall structure of this thesis, entailing the abstract, brief introduction, research background, logical and structural sequence and research questions, methodology and contributions.

The second chapter examines the literature on elderly care in Japan and China, and

also works as the detailed introduction. First of all, existing literature in regard to the Japanese LTCI and care manager role has been reviewed, revealing gaps and inconsistencies in the current literature in academia. The literature reviews are divided into LTCI and care manager respectively in the second chapter. The review for Chinese elderly care has been conducted after reviewing the Japanese part. For this section, I chose publications in terms of Chinese elderly care and topics on care workers or similar relevant roles in the care industry. Although care workers or other types of staff in elderly care are not care managers, the studies on them can share insights regarding the workforce in LTCI and foster the discussion on the potential to have the care manager in the Chinese market. Through this chapter, I depict the general picture of the elderly systems in Japan and China.

The third chapter mainly introduces the research questions and methodology. Except for the secondary data collected from literature reviews, this chapter presents the whole process of how the fieldwork was completed in Japan and China. Since interviews were conducted not only with Japanese care managers but also included other people who closely relate to the care manager in work, this chapter details the people interviewed.

The fourth to sixth chapters are case studies of the Japanese care manager. These three chapters are case studies of care managers affiliated with three types of agencies: facility-based, agency-based and community-based. The fourth chapter focuses on care managers who work as facility-based. Facility-based means the older people live in a residential facility for a period, or until the end of their life, such as the social welfare corporation (*shakai fukushi hōjin*). Social welfare corporations provide long-term accommodation for elderly people facing the last stage of their life. The fourth chapter comprises a case study of one facility-based care manager and a set of interviews with other facility-based care managers. The sixth chapter investigates a care manager who works in a home-based care provision agency (*kyotaku kaigo shien jigyosho*), known as an agency-based care

manager. This type of agency does not accommodate the elderly directly, but is a workplace for the care manager who visits the elderly to provide home-based services. The fifth chapter also contains two parts: the first part is the case study of an agency-based care manager, and the second part is interviews with similar agency-based care managers. The sixth chapter focuses on the community centre-based care manager, again covering a case study and interviews. From the fifth to seventh chapters, apart from the interviews with the care managers, I also undertook interviews with people closely associated with a care manager, this aims to formulate relatively complete perspectives of the care manager's existence. By examining the reality of work, and challenges faced by the three types of care managers, this research establishes a vivid understanding of Japanese LTCI and the whole system working for elderly care.

The seventh chapter shifts research attention to the Chinese social context. I also did fieldwork in China to collect first-hand data and build up at-site insights. Since there is no home-based care provision agency thus far, I visited facility-based institutions and community centres, and interviewed people working there. The first-hand information accompanied with examining the existing literature helped me to grasp the situation in China, and thus promote the discussion on the potential for establishing the mechanism of care manager in the Chinese environment. Maags. C (2020) argued there is great difference regarding the LTCI design among East Asia. Japan and China also have significant difference in its socio-political structures. Moreover, China has just adopted LTCI in a short-term within limited geographic areas. Therefore, the eighth chapter is not comparative research, but rather a discussion on exploring the possibility of applying care managers, a social mechanism into another socio-economic structure, based on examining its functionality within its original structure. Based on the insights into the functions fulfilled from facility-based, agency-based and centre-based care managers, the eighth chapter analyses the possibility, by thinking about how these functions can be attained in the corresponding Chinese institutions, alongside

consideration of circumstances in the fieldwork and literature studies.

The eighth chapter is the theoretical analysis on the research questions. I use body theory and policy diffusion theory to answer the two major questions in this thesis: the role of Japanese care manager in the LTCI, and its transferability into Chinese society. Body theory provides an interpretation for the existence of the care manager role, exploring the interactive dynamic between institution and individuality, and incorporating Foucault's theory into a sociological interpretation. Policy diffusion theory reveals the diffusion mechanism of a policy or social mechanism, which pave the basement to analyse the possibility of adopting and diffusing the care manager's role into Chinese elderly care.

The final chapter is the conclusion. The first part of this chapter is a summary of empirical findings. The second part is theoretical reflection. Since time and resources were rather limited for a PhD candidate, particularly when the fieldwork has to be undertaken in a foreign country, the time cost in building the network and accessing the related people were big challenges in my fieldwork. This research can only present a portion of the data, and a personal angle of interpretation regarding the research topic—it cannot represent the whole picture. The topic of elderly care is a never-end research issues and thus I would like to focus on it in future career, and hopefully to understand it with more academic competency under practical resources.

Structure of the Thesis
Chapter One: Introduction *Abstract, Background, Logic, Research question, Methodology and Contributions*
Chapter Two: Literature on Elderly Care in Japan and China *Literature regarding elderly care in Japan and China, Research gaps*

Chapter Three: Research Question and Methodology
Chapter Four: Facility-based Japanese Care Manager *Case Study, Interviews*
Chapter Five: Agency-based Japanese Care Manager *Case Study, Interviews*
Chapter Six: Community Centre-based Japanese Direct Care Manager *Case Study, Interviews*
Chapter Seven: Discussion on transferability of Japanese care manager into the Chinese context *Chinese Situation, Fieldwork in China, Discussion of the Possibilities*
Chapter Eights: Theoretical Analysis on the Research Questions *Care manager, whether it is possible to transfer, and how to transfer*
Chapter Nine: Conclusion *Empirical and theoretical summarization*

1.4 Research Question, Methodology and Research Contribution

Research questions, methods adopted and empirical findings have been indicated in corresponding chapters. This 1.4. section summarizes and organizes them concisely.

With regard to the research question, it contains three dimensions of questions according to the logical sequence noted in previous section.

The first dimension begins from the Japanese side:

i. *What is the role of care manager in the Japanese LTCI?*

ii. *What is their contribution, and challenges in their work?*

iii. *Examining through the lens of the care manager, how does elderly care delivery work in Japan?*

The focus then shifts to China:

i. *What is the condition of the Chinese LTCI?*

ii. *Is it possible to have a care manager role, like Japan's, in the current social-economic structure?*

After answering all these questions with empirical findings, research questions deepen into a theoretical discussion of the care manager role:

i. *How may we see the role of care manager inside the social structure?*

From exploring care manager's role in elderly care,

ii. *What is proper elderly care?*

There follows a piece of reflective writing, after the theoretical analysis based on empirical findings.

The research consists of firsthand data collected from fieldwork during a one-year stay in Japan, and several weeks' stay in China. The secondary data are from reading literature, reports and official documents. The investigations of the three types of Japanese care managers have been done via case studies respectively. After staying in Japan, I travelled to the cities in China, and visited several agencies in an intensive trip. I personally contacted and interviewed the people who work in the agencies for my research questions. The time spent in China is much shorter than the time in Japan, however, I have attempted to associate with as many people whom I could access, in order to understand and master the situation firsthand.

There are three aspects that I wish to contribute regarding my research topic during this PhD:

(i) To fill in the language gaps in articles, because there are only a few articles about Japanese care managers in the English language. Even among literature in the Japanese language, the major part of these focus on the LTCI system itself. They examine the elderly care delivery in the LTCI from various angles, but seldom pay special attention to the care manager. Hence, this research can also complement research data in both English and Japanese academic spheres.

(ii) Secondly, there is no research to consider and reflect the care manager and possible applicability in China. This research is a pilot trial to explore the possibility of establishing the social mechanism of care manager into the Chinese socio-economic context. The long-term care insurance system has been initiated for a short period in China. Consequently, there are only a few publications in academia, and almost none of them mention care managers. This is original research on this topic, and enriches the literature about the Chinese elderly care system. As well as its academic contribution, the research can also provide practical reflections to the policymakers in the future implementation and development of the system.

(iii) Last but not least, in contrast to most previous research regarding elderly care finishing at empirical data conclusion, this research tries to expand the theoretical comprehension of the research target. Although theoretical interpretation may not bring direct practical impact, the reflective process itself is intrinsically meaningful for the doctoral process. The issue of *care* challenges the ability of every government in constructing an adequate macro-level social structure, but it is not enough to only build up an external structure without proper micro-level operations. *Care* for a human being needs the basic conditions, i.e. the insurance or money to cover his/her physical services; at the same time *care* is also a closely interactive process between the care giver and care receiver. Therefore, the

existential attributes of a care manager entail the macro-level operator for the system and also the micro-level communicator for the old people. What is proper *care* for a person at the last stage of life is an issue worthy of considerations from both care providers and receivers, and hence to extend my reflection on human being's *life* and *care* in the more general approach, indicated in the last chapter.

Chapter Two: Introduction and Literature on Elderly Care in Japan and China

2.1 Chapter Introduction

This chapter aims to establish an overview of elderly care in Japan and China through a literature review, according to the logical sequence of research questions listed in the first chapter; it organises the information arising from the literature, and formulates an overarching understanding of long-term care insurance (the LTCI) and the workforces in Japan and China, laying the groundwork for the fundamental comprehension of this research.

This chapter comprises four areas: literature on the situation of elderly care in Japan; literature on the Japanese care manager role; literature regarding elderly care in China; and the literature on human resources working within elderly care provision in China. The first two sections explain how elderly care developed in Japan from pre-LTCI to post-LTCI, and investigate the role of the care manager, a role essential for the LTCI's function. This attention to the LTCI system provides a macro-level understanding of the social background to the development of the LTCI in the Japanese socio-economic context. The focus on the care manager provides a micro-level perspective, looking at people who work in LTCI; there is also a brief consideration of the dynamics between macro- and micro-levels. The latter two sections aim outlining the general condition of elderly care from macro and micro perspectives in China, pivotal in analysing questions regarding the feasibility of transferring the mechanism of the Japanese care manager into the Chinese socio-economic context. These four areas of literature together provide an overview of the research: what has been done, and what has not been done in relation to the research topic of this thesis.

First, a review of research on Japanese elderly care will be conducted, incorporating three layers of content: firstly, an exploration of the historic

necessity for the LTCI system being established in Japanese society; secondly, the operation, services and service providers in the LTCI, understanding elderly care in Japan after it instituted the LTCI; and thirdly, an examination of the effect and contributions of the LTCI, to gain insight into possible system improvements. This overarching overview of the LTCI system builds a fundamental understanding of how care managers function in this system.

Following the macro review of the LTCI system, the next section offers a review of the studies on the role of the Japanese care manager in academia. Unlike the many publications on the LTCI, there is little literature focusing solely on the care manager role. A small number of articles have investigated the care manager role from different angles, locations and times, deepening understanding towards the care manager's role and development within the LTCI – yet there has not been enough dedicated research for a systematic review.

After reviewing studies concerning the Japanese angle, the next section shifts attention to China. China instituted the LTCI system in 2016, in designated areas; however, the literature from 2016 is insufficient to understand the whole development of elderly care in China. Therefore, this chapter also reviews pre-LTCI publications, to fully understand the situation across multiple decades. It is impossible to do an exact comparison with Japan, since these two countries have vast differences regarding socio-economic environments; however, a fundamental understanding of each context is beneficial in answering the research question, in regard to the transferability of the role of care manager into a Chinese context.

From macro-overview to micro-insight, unlike Japan, in China there is no such mechanism as the care manager in the system yet. Consequently, the literature review is conducted towards people who work in care industry more generally. In China, human capital in elderly care provision has not yet formed a complete career path. In previous decades, the majority of labour resources for this field were those less educated, or migrant workers living in an urbanised context. The

situation is gradually transforming, in light of various policies on standardising the quality of care workers. However, it will take time to form a complete career path in the care industry. A literature review on Chinese care workers would benefit our understanding of the macro policy system, as well as the micro detail of human resources in elderly care in China, and become a supportive reference for a discussion on the applicability of the Japanese care manager role into the Chinese system.

In conducting this review of literature regarding elderly care in Japan and China, some research gaps have been found. The research questions for this study were decided according to these gaps – in order to explore the field further, identify necessary areas for study, and to establish the originality of this research. The research questions and methods will be indicated in detail in the next chapter.

2.2 Literature on Elderly Care in Japan

2.2.1 Historical rationale of the LTCI

Japan has the fastest aging population in the world. The percentage of elderly people rose to 27.7 per cent in 2017, with the expectation that 1 in 2.6 people will be over 65 years of age, and 1 in 3.9 will be 75 years old or more by 2065 (Cabinet Office; 2017). The total number of elderly people is ever increasing; the spatial distribution of elderly groups varies in different areas. Matanle. P (2017) claims that unlike metropolitan areas, the ageing issues in rural Japan has existed for over half a century, but did not receive as much attention as in big cities. Japan's demographic characteristics necessitate building up a system to tackle a large elderly population.

The formation of any social policy includes the rationale behind it; any analysis of such rationale would consist of various aspects of a society: the social needs for formulating it, the political structure to promote it, and the economic situation to ground it. Moreover, cultural and collective cognition will shape policy. Therefore,

enlarging the range of aspects to look at a comprehensive social situation is important in understanding a social system or policy. This section will provide a perspective from the historical development of health and social care in Japan to examine the rationale behind the birth of the LTCI.

Japan launched universal insurance after World War II, medical and elderly care were not separate systems in Japan. Two pillars supported national health and elderly care of the Japanese people after World War II: a universal health care system established in 1961 for all Japanese people, and the long-term care insurance system (LTCI) adopted since 2000 (Tamiya. N, et al; 2011) towards elderly people. Japanese universal insurance has significantly contributed to national health improvement, despite the fragmented plan in recent decades (Ikegami. N, et al; 2011). The first legislation of social health insurance came in 1922, and by 1961, almost everyone was insured (Ikegami. N, et al; 2011). Since then, the contribution and the problem that occurred from universal insurance became important driving factors for the formation of the LTCI (Sato. M; 2010).

The *Lancet* journal released a series of articles that discussed the Japanese universal health care for its 50th anniversary, including the reviews of universal health care and the LTCI together. Ikeda. N, et al (2011) addressed the improvement of national health condition in Japan after World War II. From the 1950s to the early 1960s, the rate of stroke-related mortality vastly decreased, and the mortality rate continuously dropped after implementing a preventative community public health policy in the mid-1960s, in the framework of national health insurance. Other major challenges for Japanese society included a rapidly ageing population and expanding resource disparities. Ikegami. N, et al (2011) also accentuated the significance of universal health insurance in supporting national health and taking care of vulnerable people, including the elderly group, before the establishment of the LTCI.

Tsutsui. T and Muramatsu. N (2005) pointed out the characteristics of the health

care system in Japan were those of the 'pluralistic universal', and 'egalitarianism'—since in the framework of health insurance, all Japanese people were involved, regardless of the type of the affiliation. The standardised fee schedule provided care services at the same price. Therefore, long-term care was a service provided by the 'tax-based' social system, which did not share enough consideration to people who earned a lower income or suffered from a lack of assistance from family members.

Before enacting the LTCI in 2000, there were mainly two public schemes that provided elderly care in Japan: The Act on Social Welfare Services for the Elderly, through which public welfare services were offered, and the Health and Medical Service Act for the Aged, which provided medical services. In 1963, the Welfare Act for Elders (*rōjin fukushihō*) was enacted, which aimed to initiate a welfare programme for the elderly, after it became clear that people who had been through prolonged wartime poverty lacked resources to support the elderly group (Ikegami. N 2012; Campbell. J. C, et al, 2007). The Act promulgated several fundamental principles of conducting elderly welfare, and according to the newly established law, Japan began to initiate nursing homes as institutionalised accommodation for elderly people who were physically and mentally frail. Moreover, a home-helper system and community centres were established for those elderly people who stayed at home.

After enacting this new law, the second benchmark in Japanese welfare history was the 'start-up of advanced welfare state policies in Japan (*fukushi gannen*)' in 1973. Healthcare became free without co-payment. The LDP government revised the Elderly Welfare Law, increased health insurance benefits (Ikegami. N, et al; 2011). Free medical care opened up for those aged 70 years or more, and those with disabilities aged 65 or more (Ikegami. N; 2012). The provision of elderly care developed under rapid economic growth (*kōdoseichōki*) after World War II. An expansive welfare policy was adopted as Japan went through high economic

development. These were detailed in the research from Tamiya. N, et al (2011): The Liberal Democratic Party abolished co-payment in medical care and hospital stays in the early 1970s against the background of an economic boom, which caused so-called 'social hospitalisation', where patients were admitted for hospitalisation without much medical justification. Medical costs soared and (except for hospitalisation) other services towards elderly people developed slowly. Simultaneously, families sent their elderly relatives to hospital as a quasi-nursing home solution when they could not take care of them at home. The shortage of service assessment for frail elderly people as well as poor households was also stated by Tamiya. N, et al (2011).

This situation lasted until the first oil shock in 1973; then consumption tax was introduced as a solution (Ikegmi. N, 2012; Takeshi. H, 2012) to drastically increasing medical expenditure. Also, whilst hospitalisation serving as accommodation expanded rapidly (for either medical or 'social reasons' (Ikegami. N; 2012)), other institutional services grew very slowly, as home-based help was offered only with strict restrictions to those with low incomes or living alone (Takeshi. H, 2012; Sato. M, 2006).

In 1986, the Health and Medical Services for the Aged Law was revised to subsidise medical bills, triggering possible implications for setting up the LTCI in the future. One type of intermediate facility, called '*Choukan Shisetsu*', established bridging services between nursing homes and home-based care, and at the same time, a health care facility called '*Rōjin Hoken Shisetsu*' was built up (Itō. M, 2007; Furuya.K, 2003). In 1988, the Ministry of Health and Welfare established the Department of Health and Welfare to formulate a proper response to the expanding elderly population, starting the 'Golden Plan' the following year, to deal with financial deficiencies occurring due to social hospitalisation (Nishikawa. M; 2011). The Golden Plan (*Kōreisha Hoken Fukushi Suishin Jukkanen Senryaku*) was initiated in 1989 (Ikegami. N; 2012), followed by the 'New Golden Plan' in 1994. The LTCI has

been seen as a policy extension of these two plans (Kawamura. M; 2014), partly because of a massive increase in the number of people who work in the care system, as well as the number of care centres established (Ikegami. N; 2012), which, to some extent, laid the infrastructural basis for the LTCI.

At the same time, both national and local government found elderly care to be a financial burden (Maddrell. D; 1996) after the economic bubble collapsed, and felt the urge to transform the role of government in elderly care from that of direct service provider to indirect (Suda. Y; 2011). This led to establishing a market environment, and introducing the private sector to share the burden (Shimizutani. S and Suzuki. W, 2007; Suda. Y, 2011).

Social transformation also happened during the implementation of the two Golden Plans, with two aspects impacting the capability of service provision: the amount of care workers and institutions, and the increasing variety of provision. After the new Golden Plan, the government had almost achieved their elderly care goals. Home help dramatically increased to 170,000 people (Ihara. K; 2012)—compared to 100,000 written in the Gold Plan—whilst day care centres increased to over 17000 locations—compared to 1615 locations at the beginning (Ihara. K, 2012; Ikegami. N, 2012). There were also significant improvements, both in number and quality, in terms of other types of long-term care infrastructure, such as short-stay agencies, home-visit agencies and so on.

The progress in care infrastructure influenced the formation of the LTCI policy, and the shift that happened in the societal context also significantly impacted elderly care policymaking. Aside from the perspective of the limitations of national health insurance, there is a range of literature discussing what drove the formulation of the LTCI. From a political-economic standpoint, the Ministry of Health and Welfare established the Department of Health and Welfare, intending to formulate a proper response to the expanding elderly population and start the Golden Plan the following year, to deal with financial deficiencies that occurred due to social

hospitalisation in 1988 (Nishikawa. M; 2011). The reasons behind this innovation also included the collapse of the economic bubble, that impacted financial systems significantly after the recession; therefore, both national and local government considered elderly care to be a financial burden (Maddrell. D; 1996). This perspective transformed the role of government in elderly care from a direct service provider to an indirect one (Suda. Y; 2011), and accordingly built up a the pre-LTCI structure market environment to successfully promote the LTCI, subsequently introducing private sectors involvement in service provision (Shimizutani. S and Suzuki. W, 2007; Suda. Y, 2011).

In addition to the literature that pointed out political and economic reasons, Ihara. K (2012) addressed the social transformation that occurred during the conduction of both 'Golden Plans', promoting the formation of the LTCI. The infrastructural map of elderly care formed gradually, and influenced two main aspects: one being the capability of service provision presented by care workers and institutions; the other is the variety of forms for provision, which were not just limited to agency-based structures, but a combination of home-based and community collaborations.

The macro structural shifts, such as the improvement in care infrastructure also influenced the progression in formulating the LTCI. The rapid shift of people's opinions towards elderly care impacted policy decisions at the same time. In the literature concerning societal shifts in the context of family structures and gender status that happened in Japan, Lynch. J (2006) states the importance of the social value and religious orientations deeply rooted in family structures, which influenced the view of family members in looking at elderly care. In Japan, a traditional family used to be a large structure, with multiple generations living together. Taking care of old people in a family was seen as the responsibility of the elder son's wife, i.e., the daughter-in-law, in traditional primogeniture structures (Tanaka. K and Iwasawa. M; 2010). In the process of modernisation, the big family became the nuclear family. In the meantime (Lynch. J; 2006), women's social status

rose after the equal entitlement of education and employment rights (Tanaka. K and Iwasawa. M; 2010).

Women played the central role in taking care of the elderly in a family before the 1980s (Broadbent. K; 2014), since Japanese men were usually the breadwinners, and the common phenomenon '*nenkōjōreitsu'*[7] also restricted women from a life-time employment positions, encouraging women instead to be dependents at home (Tamiya. N et al, 2002; Michihiko. T, 2009). 'The hell of care' (*kaigo jigoku*) was a phrase which described the stressful life of a Japanese woman in providing long-term care at home. This cultural concept was used to appeal for a reduction of the care burden on daughters-in-law through social activities.

On the other hand, the government propagated 'family values' by incentivising women to get involved in care provision (Lynch. J; 2006). However, with rapid economic development, social conditions changed accordingly. More and more women tried to confirm their social identities within the labour market, and the rate of female labour in Japan rose sharply from 1990, after the enactment of the Equal Opportunity Employment Act. The traditional value of filial piety was also challenged by the shift in gender discourse in Japan (Hashimoto. A and Ikels. C; 2005). Several aspects of societal change urged people to re-conceptualise filial piety: the collapse of the large family and its change to a nuclear structure; the gradually decreasing fertility rate; and the increasing status of women due to equal working rights.

People's changes in thinking and viewing the issue of elderly care also influenced the related policymaker and political framework. In a political context, the shift of power dynamics between parties also significantly impacted the decision for the LTCI (Eto. M, 2001; Hieda. T, 2012). In 1993, the LDP lost their long-term dominant

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[7] *Nenkōjōreitsu*,年功序列, represents the seniority-wage system in Japan, differed from payment based on labour-productivity, seniority has been valued more.

position and formed a coalition with other parties (Eto. M; 2001). In the old political framework, before the collapse of the LDP, an individual vote was necessary. Thereafter, it became challenging to promote the national scale of a welfare programme if this contradicted certain people's and groups' benefits. After losing the ruling position of the LDP, the new coalition government finally submitted the bill for the LTCI to the diet in 1996, which also aimed to solve financial austerity after the economic bubble collapsed (Hieda. T; 2012). In 1997, the LTCI law was enacted, and in 2000, the LTCI was finally initiated in practical operation.

The literature mentioned above listed the historical rationale for the LTCI, including financial considerations, transformations in long-term care infrastructure, market incentives, gender discourse and political background. A new social policy, adopted on a universal scale, is usually created and influenced by multiple factors.

If inclusively examining the historical rationale of the Japanese LTCI after World War II, the transformations that occurred in political, economic and societal aspects must be all considered. Provision of elderly care developed against the background of rapid economic growth after World War II; however, before the LTCI enactment, a large part of the care provision burden was moved into medical care. It was more expensive to receive elderly care than to apply for hospital-based care for disabled elderly or elderly people who could not access care from a family member. Entering into hospital for 'social reasons' caused massive financial inefficiencies, and reduced efficiency of medical aid provided to old people who became acutely ill.

Additionally, economic austerity derived from the ever-increasing domestic budget and the international political-economic environment. The first 'oil shock' and bubble collapse after high economic growth forced the government to reconsider its role in planning the welfare system. At the same time, gender

perspectives and cultural values gradually shifted with post-modernisation, leading people to expect new forms of social structures with a more integrated approach. Despite this new social system, contradicting traditional values, the dramatic power transition from the LDP to the coalition government shifted the balance of power, removing political obstacles and making the LTCI a reality.

As a consequence, the LTCI started to be implemented in 2000. It aimed to build two essential structures for dealing with the ageing population in Japan: a structure capable of guaranteeing stable financial operations covering the economic costs, and a sustainable structure capable of providing efficient services from care staff. Money and people are inseparable aspects in the design of the elderly care mechanism.

2.2.2 LTCI Operations, Services, and Providers Discussion

2.2.2.1 LTCI Operations

The LTCI has now initiated building a proper social system for the expanding elderly population in Japan, aiming to provide social help for all elderly people, regardless of physical disability or household situation (Igarashi. A, et al; 2014). The LTCI has operated for over 20 years so far, and has been through several amendments and innovations, either in regulation or service provision. It also has been through various ups and downs according to the development of society. This section will examine the literature related to its development after the establishment of the LTCI, to build a clearer picture.

Beneficiaries aged at or over 65 years old are entitled to receive care provision from the LTCI, divided into two main genres: 'assistance required' (*yōshien*) and 'care required' (*yōkaigo*). There are two levels of services in 'assistance required' and five levels of services in 'care required', categorised by the physical and mental condition of the beneficiary (Tamiya. et al; 2002). In the initial implementation stage of the LTCI, the government adopted a computer-aided initial assessment

(74-item questionnaire) as a national model to assess the eligibility of elderly (Tsutsui. T and Muramatsu. N; 2005). The result would then be reviewed by a Care Need Certification Board (*kaigo nintei shinsai kai)*. When elderly people require care provision, they first must visit a municipal office or community centre to apply for the assessment. After initiating the application procedure, the beneficiary's eligibility will be assessed according to conditions of physical health and family assistance, under standardised criteria (Imai. H, et al; 2008). In the evaluation process, a care manager would be assigned to the specific beneficiary, using the assessment questionnaire; the computer programme would then classify the level of assistance required. The Certification Board then makes a final judgment based on the computer evaluation and a report from the beneficiary's physician (Imai. H et al. 2008; Tsutsui. T and Muramatsu. N; 2005).

The LTCI offers care benefits rather than cash, compared to other LTCI systems in the world (Ikegami. N; 1997). The service provided by the LTCI is nationally standardised, incorporating care provision from the home, community and institutions, as well as medical assistance (Sato. M et al; 2006). Services can be divided into two main genres: long-term care and preventive care (Imai. H, et al; 2008). The LTCI incorporates a wide range of home-based and institution-based care benefits, such as housekeeping, personal care, visiting nurse care and rehabilitation. It also covers the free hire of assistive devices for use by disabled or frail beneficiaries.

Institution-based care provision comprises three categories: the *special nursing home* (*tokubetsu yōgo*) established for end-of-life care (Campbell. J. C and Ikegami. N; 2000); the *long-term care health facility* (*kaigo rōjin hoken shisetsu*) providing rehabilitative service or care for a transitional period for the elderly, to make the transition from the hospital back into the community; and *chronic hospitalised care* (*ryōyokei iryō shisetsu*).

Community-based care was introduced in 2006, composed of home visits at night,

day-care for dementia patients, dementia group homes and multiple function home-based care. There are also other forms of institutions that provide private nursing care. However, the LTCI does not cover all types of needs from the elderly, forcing many clients to purchase additional services at their own expense.

Home-based elderly care has three main categories: *housework assistance*, *housework*, and *various care* (which includes making meals and personal care). Each type of service has a corresponding rate. Beneficiaries purchase one or multiple allocations of care through the day / week, decided after the care manager's assessment. Most care services are fitted into a fixed-fee schedule decided within central government.

Care providers receive payment for care services directly from the LTCI. *Assistance required* beneficiaries generally can still function independently to some degree, and only need support in daily activities—whilst *care required* beneficiaries (from care levels 1 to 5) are those requiring partial to total care to sustain primary daily functions (Imai. H, et al; 2008). The *assistance required* beneficiaries can only receive care services in home-visit form.

The ceiling for service at each level ranges from USD400 to USD2900 every month, according to Igarashi. A, et al (2014) and Tamiya. N, et al (2011). Campbell. J. C and Ikegami. N (2000) state that beneficiaries have to pay excess costs if services surpass the ceiling figure. As a social insurance system, comprising pay-as-you-go as well as open-ended financing, LTCI has been funded through three channels: tax, premiums and co-payments (Campbell. J. C et al; 2015). The tax revenue funds 50 per cent, of which 25 per cent of revenue is from national government. The remaining 25 per cent is split into 12.5 per cent from prefectural government, and 12.5 per cent from local municipalities. Premiums are paid by people aged 40 years old or over. In terms of co-payments, beneficiaries are required to pay 10 per cent of the total cost of care service they use. This proportion has been adjusted every three years, since massive fiscal pressure has occurred during the

implementation/delivery of LTCI.

The LTCI system has been in practical operation for 22 years, since 2000. The policy itself has changed according to social conditions over time; it has been through various challenges in different periods. The biggest concern has been its financial sustainability, due to an expenditure explosion causing the cost to double beyond original estimates in the first five years. At the same time, real household incomes decreased 8.7 per cent between 2001 to 2009, against a background of stagnated economic development (Tokunaga. M, et al; 2015). Regional differences, sharp increases in service demand, and inconsistency in applying certification procedures have been challenges for the LCTI since its inception.

Consequently, in post-2005 and 2006, the LTCI has undergone a reform that removed the cost of payment for accommodation and meals in institution-based care provision and also set up strict restrictions on the application of housekeeping care (Tokunaga. M, et al; 2015). A subsidy policy was adopted to support the elderly whose annual household was lower than a given standard (Sato. M, et al; 2006); this was abolished in the 2005 reform. Aside from removing specific benefits, this reform initiated innovative policies to sustain the LTCI's operations, such as encouraging older but still healthy volunteers to support older and frail people.

In the modifications of the LTCI, aside from removing means testing, the *assistance required* level of care service was redefined, and decreased into a preventive-oriented service package, whilst the monthly rate was fixed. After these 2005 amendments, the LTCI's expenditure dropped for the first time. The speed of increase in the number of beneficiaries slowed down, and accordingly, service provision decreased. The growth of expenditure stabilised after this reform.

2.2.2.2 LTCI Services

LTCI promoted the socialisation of elderly care. In particular, after the 2005

reforms, community-based care was underlined as a strategy to enhance preventive care—aligned with the understanding of the gradual physical decline of the elderly, and implementing early intervention to support the elderly in sustaining their independence, delivering greater benefit than care after this stage.

Community care and prevention-led services were classified as *assistance required* care level, supporting the daily functions of the elderly, helping them to maintain physical condition as long as possible. Home-based care, community-based care and institutional care were categorised as *care required* level (Olivares-Tirado. P, et al; 2011).

The LTCI provides no cash benefits, only service provision, and operates on a 'pay-as-you-go' principle. Providers come from both for-profit and non-profit sectors (Olivares-Tirado. P and Tamiya. N, 2014; Olivares-Tirado. P, et al; 2011). Service prices are fixed on a national scale, and also standardised within regions. The competitiveness of places rely on consumer preferences and quality of service provided (Tsutsui. T and Muramatsu. N 2005; Campbell. C. J et al, 2010; Olivares-Tirado. P and Tamiya. N, 2014; Olivares-Tirado. P, et al; 2011).

Categorising care service from a functional perspective, the LTCI provides care-based services and prevention-oriented services (Shimizutani, S; 2014). To further classify the services from an industrial perspective, they contain home-based care, community-based care, and institution-based care. In terms of the financial attributes of the agency, the LTCI also introduced for-profit sectors to cover home-based and community-based care, and as a consequence, shaped the whole market into a quasi-market mechanism. For-profit sectors elevate competition in service provision, as well as filling a service gap that cannot be supplied through the public system.

Aside from the institutional care (end-of-life care, hospital-to-community transition, and chronic-care hospitalisation) other medical care is offered through

national insurance (Shimizutani, S; 2014). Institutional care provided through social welfare incorporation (*shakai fukushi hōjin)* is more popular than home-based services and community-based services (Ikegami. N, et al; 2012), since the institutional care offers 24 hours of non-stop service, greatly reducing the care burden of the family caregiver. Since a massive amount of people require nursing home services, these institutions always have a very long waiting list.

As a consequence, two other types of institutional care have appeared: the *specified facility* (*tokutei shisetsu*) and the *group home* (*gurūpu hōmu).* The specified facility is furnished to a higher standard, similar to a nursing home. Group homes aim to provide accommodation for the elderly with dementia (Ikegami. N, et al; 2012). These two types of institutions developed rapidly, as they do not need construction subsidies, and set their pricing independently (Ikegami. N, et al; 2012).

While for-profit organisations have been allowed to provide community-based services, institutional service provision was only legitimised by medical corporations and social welfare corporations. The ownership and management of special nursing home care are controlled by social welfare corporations (*shakai fukushi hōjin*), while healthcare facilities are restricted to medical corporations (*iryō hōjin*) (Ikegami. N, et al; 2012). Other specific facilities that provide residential care services (such as group homes, social welfare corporations and medical corporations) are privileged over other for-profit providers. Therefore, Kubo. M (2014) argues that institutional care has not shifted so much, despite government encouragement of market competition.

Community-based care service was inaugurated in 2006. Post-reform, service providers were required to publicise their programme and quality of service to support beneficiary decision-making (Yoshioka Y. et al, 2010; Feng. M et al, 2017). The reason for shifting the focus on community care lies in the increasing cost of home-based care provision. The cost of home-based care occupied more than half

of the total cost (Shimizutani, S; 2014). Therefore, the government has tended to find regional support by reducing costs, through introducing community-based care provision.

Community care covers services such as night home-visits, daily care for elderly people with dementia, group homes[8], home-visit services on a small scale, and some specific service items from private nursing homes or long-term welfare agencies (Shimizutani, S; 2014). In 2012, the government established a five-year plan, Promotion of Measures Against Dementia. In 2014, the Ministry of Health, Labour and Welfare published a White Paper indicating that the LTCI's goal is to comprehensively extend the healthy life of the elderly. Two paths of approaches were suggested to attain this: to enhance the existing functions in the comprehensive community-based care system; and to promote collaboration between care provision and medical treatment.

Home-based care provision covers the following ten features: (Shimizutani, S; 2014)

1. *Housekeeping*
2. *Home-visiting nurse*
3. *Bathing support*
4. *Home-based rehabilitation*
5. *Elderly care from the for-profit sector*
6. *Supportive device leasing (mobility/safety items)*
7. *Home-based-care-management counselling*
8. *Purchase device and renovation of home for elderly-friendly*
9. *Respite stay out-of-home*

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[8] Group home,グループホーム is small facility or unit house, accommodating the beneficiary with dementia, usually between 5 to 9 persons (MHLW).

10. Personal support (simple sewing, throwing rubbish, etc)

Home care is essential for the elderly with chronic disease, those at an intermediate stage after acute care, or who are facing the end-stage of terminal illness. Murashima. S, et al (2002) emphasises the increase in service demand from beneficiaries requiring end of life care, because more and more old people prefer to stay at home in their last days.

Before the LTCI, face-to-face service provision in Japan was rarely provided by the private sector; service provision and arrangements were mainly the responsibilities of central government (Suda. Y; 2011). After the initiation of the LTCI, the responsibility was distributed from central government to local governments and private sectors; the private sector could now be allowed to enter operation if it met the required standard. The existence of the social welfare corporation also transformed its role; before the LCTI it was the main holder of governmental contracts in service provision (Suda. Y; 2011). Now, beneficiaries had the freedom to choose the service according to their preferences.

2.2.2.3 LTCI Providers

The issue of for-profit / non-profit have also attracted more research attention, since one of the essential characteristics of the LTCI was the introduction of the private sector in public goods service. In the literature regarding for-profit and non-profit service providers in Japan, the mainstream of the literature in this area focuses on whether the nature of service provider will influence the service provision, and the decisions of the care manager, when they make a package plan for the beneficiary.

Suda. Y and Guo. B R (2011) argue that, due to standardised service regulation, non-profit and for-profit organisations were found to act similarly in such environments, but in services outside of the LTCI framework, for-profit varied from non-profit. It has also been found that within the Japanese care market, the

additional need for services beyond the LTCI has not been able to develop into an independent market (Suda. Y, 2011; Suda. Y and Guo B. R 2011). Comparing the result of care management under public and private entities, Yoshioka. Y, et al (2010) emphasise the significance of the role of private care provision, and point out the quality of care plan from for-profit entities may be questionable, as findings showed the consumptive concerns in deciding the service provision. Based on research from Yoshioka. Y, et al (2010) that scoped approximately 300 beneficiaries living in the suburban area, the number of service items provided from a public entity significantly surpassed private counterparts, whilst community-based services were managed more by private entities than their public counterpart.

The relationship between for-profit and non-profit bodies also continually evolved, Suda. Y (2011). According to a quantitative survey research done by Shimizutani. S and Suzuki. W (2007), there was no apparent difference in quality-of-service supervision between for-profit and non-profit entities. Although non-profit services had more qualified staff, their service-provision quality was lower than for-profit services in some aspects. In light of investigations into quality and efficiency provided by different types of entities, Shimizutani. S and Suzuki. W (2007) also stated a positive influence on the care market when the LTCI introduced a quasi-free market mechanism. There were many concerns in society at the beginning when for-profit service providers were introduced into the market; however, they boosted the quality and efficiency for service delivery in spite of existing problems.

In contrast, there was an opposing perspective that the quasi-market mechanism gave too much attention to standardised payments for each LTCI service, but neglected the quality and variety required by the beneficiary. Tokunaga. M and Hashimoto. H (2012) suggest that price regulation should be modified, taking into account practical considerations in the market and quality of service provision,

irrespective of the nature of providers.

The LTCI has been reformed several times over the past 20 years since its establishment. The range of services have slightly changed according to financial austerity, but remained almost at the same level regardless of innovation. Listing service items is not the primary research focus for most scholars; rather they focus on discussion of services provided by profit and non-profit organisations, the effect on beneficiary when receiving these services, and the differences between different agencies as research themes for the majority of the literature.

2.2.3 Contributions and Problems of the LTCI

The range of literature discussing the significance and contribution of the LTCI since its inception is considerable. There are investigations from various perspectives to examine the contributions the LTCI has made, and the problems existing in the system.

The LTCI achieved a transformation from the era of the 'placement system' under the Welfare Law for the Elderly, to a 'contract system' in the context of the LTCI, by promoting the development of institutional and community-based care. Using the slogan 'from care by family to care by society', socialisation of care has been emphasised since the inception of the LTCI (Tsutsui. T and Muramatsu. N; 2005:522). This approach significantly reduced the care burden on women and changed the gender discourse regarding female responsibility in Japan.

According to an investigation into caregiving time among women aged 40-64 years (Muramatsu. N, et al; 2016), universal services provided by the LTCI helped reduce the family burden caregiving, and facilitated women's involvement in both the workforce and care provision. In Nagoya, a survey conducted towards 3000 residents showed that the original family caregivers affirmed a positive contribution in reduced care burden since the adoption of the LTCI (Umegaki. H, et al; 2014).

Reduction in the mental responsibilities of caregivers was also highlighted by (Kumamoto K. et al, 2006; Suzuki W. et al, 2008). These effects varied according to the income level of the household. Research literature found that high-income families will have more time liberated from care provision, whilst there were no significant differences for low-income households, as they keep usage low to control payments (Yamamoto. N and Wallhagen. I. M, 1997; Tamiya N. et al, 2011).

Care provision from the LTCI also brought both physical and mental benefits for beneficiaries. Kato. G, et al (2009) tested 624 participants to discover the changes in level of care required after using home-visit care provision. The conclusive result stated the co-relationship between service use and decreased level in 'care required'. Masafumi. K, et al (2006) investigated the co-relationship between mortality and day-care utilisation, and found a positive effect of daily care that reduced mortality of the elderly in the community. In addition, daily care and respite stays were proven to reduce the rate of being hospitalised for the elderly, according to the investigation conducted by Tomita. N, et al (2011). Imai. H, et al (2008) used the indicator HRQOL (health-related quality of life) to find what level of HRQOL has been achieved by utilising the LTCI care service, based on experiments in Kyushu.

Aside from the benefits for beneficiaries, the major significance of the LTCI is in introducing a quasi-market mechanism into care provision in Japan, and thereafter the private sector could also become involved in-service provision—the increasing competition in providers has enhanced the quality of care provision. Igarashi. A, et al (2014) addresses the idea that the main contribution of the LTCI was in providing universal service access to elderly people, regardless of physical disability and household situation.

With the socialisation of elderly care, the LTCI transformed family culture by reducing the burden on the caregiver at home, and shifted societal structure. The LTCI has promoted the socialisation of elderly care, transforming traditional family

culture as well as social structures (Tokunaga. M, et al; 2015). Before the LTCI, only the elderly on low incomes with no family support could access free services; disabled people or those diagnosed with chronic disease had to purchase services at a higher price, or apply for hospital-based services that caused over-expenditure on government medical costs.

After adopting the LTCI, the beneficiary now has a direct contract with the service provider. Moreover, after allowing the marketisation of care provision, the function of community-based care has been enhanced by mobilising more organisations, which included private or voluntary organisations. The provision of community-based care enhanced collaboration among different organisations.

The LTCI also opened a job market for women who sought part-time jobs. Many of them have become qualified care workers after receiving training, passing exams and accumulating work experience (Tomita N. et al, 2011). Mor. V (2014) underlines the contribution of the LTCI during financial austerity and other social issues, in the transformational period after the economic bubble collapse. The administrative procedure became more efficient because of the standardisation of eligibility assessment. After a prolonged economic recession, despite fluctuations in tax revenue, premiums provided a stable financial resource for the LTCI (Tsutsui. T and Muramatsu. N; 2005).

On the other hand, the LTCI also received criticism in several aspects. Ikegami. N (2007) addresses several social reasons for such criticism. Firstly, initially, those with lower care needs were not eligible for IADL (instrumental activities of daily living), as they were only for the severely disabled elderly. Thereafter in the amendment, the justification of care provision was rewritten. Secondly, as low-income elderly people received the care provision as a social service, it was difficult for them to manage a 10 per cent co-payment (Tamiya. N, et al; 2011). As a solution, the government reduced the rate in the first three years. Finally, the computer algorithm itself has been criticised for not accurately reflecting

beneficiary needs: as it was developed from medical data, physical disability was emphasised more than cognitive impairment when evaluating applicants.

Ikegami. N, et al (2012) points to the problem of financial austerity in many places. In the beginning, a home-helper was available to visit the beneficiary's home at night; however, this service was removed due to its high cost. Additionally, people tended to rely on institutional care to provide comprehensive support and substantially reduce the burden of family caregiver; hence, the waiting list for such care is always long.

As well as challenges for the service recipients, there are also problems on the side of those providing services. The care demand has kept increasing; however, it has become increasingly challenging to recruit and retain people working in the care industry, due to low pay and the stressful workload (Tsutsui. T and Muramatsu. N; 2007). The care worker's job has been deemed '3K'[9] in Japanese terminology, meaning 'risky, weary, dirty'; this makes young people reluctant to involve themselves in the care industry, in spite of training for and graduating into related professions. Prolonged working hours and inadequate financial reward made for low motivation for people working in the system (Tamiya. N, et al; 2011). Care workers also commented on the high 'cost', in terms of time, of negotiation among different sectors, particularly in the case of a care manager's work. A care provision plan requires support across various institutions and actors. Communication is essential, however, time-consuming, which means care managers often encounter prolonged working hours (Tamiya. N, et al; 2011).

Moreover, the biggest concern is regarding the sustainability of finance to support the LTCI system. Kato. R R (2018) uses a general equilibrium model to indicate that

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[9] 3K: K is the initial roman character from the pronunciations of three Japanese words: 危険(*kiken*: risky/dangerous)、きつい(*kitsui*: weary/stressful)、汚い(*kitanai*: dirty). When describe the characteristics of elderly care, Japanese people usually said 3K instead of the three Japanese adjectives.

the cost burden on people aged 40-64 would be unsustainable within the next 40 years, and suggested an increase in co-payment will be preferable to other approaches, such as high consumption taxes, or a cost distribution from a younger age.

Although the LTCI has received criticism since its inception, it has successfully tackled the social pressure of care requirements caused by a massive ageing population. The contribution of the LTCI has been underlined by Mor. V (2014)—the LTCI has almost fulfilled its task, despite existing against a background of financial austerity and other social pressures in the transformational period after the economic bubble collapse, and has achieved a nationally-scaled system from which contributed to improve the general healthy levels of population, less complex and usable system at lower cost in the national scale.

2.3 Literature on Japanese Care Manager

2.3.1 Career of Care Manager

As noted, sufficient financial resource and adequate workforce are essential to sustain an elderly care system in any society. The adoption of the LTCI reduced the financial burden for Japan in the rapid ageing process of its population. At the same time, finding enough people—either in quantity or quality—who can provide the service is pivotal, after setting up the macro-level policy framework.

To fully understand the roles of Japanese care manager and care worker, it is necessary to look at the LTCI first, since the care manager/worker is characteristic of the Japanese LTCI. The roles are rooted in and paid by the system, which is different from other national systems. The previous three sections have reviewed the LTCI in three main aspects (operations, services and providers). Here, we will conduct a literature review regarding the role of the care manager in the context of the Japanese LTCI.

In elderly care, there are two main dimensions that must be discussed and confirmed in any policy design: money and people. Money is the financial guarantee, making the social structure sustainable to provide the care service. Considering the design structure at macro-level is not enough—qualified people working at the micro-level within the structure are essential for the regular operation of the whole system. Combining both of these paves the foundation for an effective system. Therefore, our research focus now shifts to the care manager, who works at the 'front line' in the care industry.

Regarding Japanese care manager research, most of the academic literature was conducted in the Japanese language and few articles were written in English. Even within the Japanese literature, the research focus was scattered according to location, time and resources. Lack of consistency and a limited perspective are the existing research gaps in regard to research on the role of the Japanese care manager. In spite of the currently limited literature, this section will provide a review of both Japanese and English research to date.

The care manager is the highest professional level in the care industry career path. Most care managers have experience of working as care workers or other related backgrounds. A care manager can be licensed after sitting a municipal examination, alongside consideration of practical work experience. After becoming a care manager, there is still annual training to confirm the candidate has mastered updated policies aligned with any LTCI practice reform. It was usually found that a care manager would be affiliated with one of three types of agency: a home-based care agency (*kyotaku kaigo shien jigyosho*), the local comprehensive care centre (*chiiki hōkatsu senta*), or facility-based (*shisetsu*) care institutions, such as social welfare corporations, which accommodate the elderly to the end of their lives. Candidates come from various backgrounds, from the medical training system to the social welfare background.

According to the definition of 'Care Manager' in the LTCI Act, the care manager is

responsible for two main components of the system: the beneficiary who receives benefits from the LTCI; and making the system operate well. Many care managers worked as care workers at the beginning of this career path. Some care workers are home-helpers, who do not hold a professional educational background in elderly care, but started work as helpers with daily chores; the other care workers typically received standardised university education and obtained relevant qualification, such as those graduating from welfare universities (*Fukushi Daigaku*). This group—with higher education in contrast to the home helper care workers—can expect to be promoted quickly after some work experience. Through the route of home helper, home-visiting care worker, junior care worker and senior care worker, care staff can finally reach the top level as a care manager, after examinations.

Care managers usually affiliate to one of three types of agencies in Japan. The first is a home-based care provision agency (*kyotaku kaigo shien jigyosho)*, providing home-based care provision packages to the beneficiary, according to their care level. In this case, the care manager functions as a coordinator working with municipal government, care providers and beneficiaries, to set up a home-based long-term care plan. Another type of care manager works in local comprehensive care centres (*chiiki hōkatsu senta*), usually as a directive care manager and experienced registered nurse, with accumulated knowledge about both care treatment and the social resources existing in the area. Such care managers come from various backgrounds, such as a medical nurse, care worker or social worker. They possess knowledge and skills related to elderly care, and will give their evaluation after assessing the beneficiary's physical and mental condition and their family context. The third type of care manager works in facility-based agencies, where care managers provide consulting services, establishing care plans for residents. At times, they cover nursing support and daily staff for residents in the facility alongside, other care staff. The facility-based care manager

works in institutional care agencies, such as social welfare corporations that accommodate elderly people at end-of-life stage.

Care managers can come from various backgrounds, including:

- *physician (ishi),*
- *dentist (hakka ishi),*
- *pharmacist (yakuzaishi),*
- *public health nurse (hokenshi),*
- *midwife (josangshi),*
- *registered nurse/assistant registered nurse (kangoshi/jun kangoshi),*
- *physiotherapist (rigaku ryohōshi),*
- *occupational therapist (sagyo ryohōshi),*
- *social worker (shakai fukushishi),*
- *care worker (kaigo fukushishi),*
- *orthoptist (shinō kunrenshi),*
- *prosthetist (gishi sōgushi),*
- *dental hygienist (hakka eiseishi),*
- *hearing therapist (gengo chōkakushi),*
- *masseur, acupuncturist (harishi),*
- *moxa (kyushi),*
- *bonesetter (jyudō seifukushi),*
- *dietitian (eiyōshi),*
- *psychiatric social workers (seishin hoken fukushishi).*

2.3.2 The Work of the Care Manager

The care manager belongs to the group of people who hold the necessary specialised knowledge for elderly care to support independent daily living, and to provide consultancy for beneficiaries. They also function as a ‘bridge’ in contacting government services, families and service providers. In particular, in the case of a

home-based care management agency, care managers must combine comprehensive services that meet the needs of beneficiaries and their families. Care managers serve as the team coordinator. At the same time, the care manager is required to provide consultancy to the beneficiary, make a care plan, and adjust it according to the change of the elderly's conditions, to support and sustain the beneficiary's independence.

To receive LTCI services, a beneficiary or their family members must first apply for assessment. They are required to visit the municipal government to initiate an assessment. Before the 2005 reform, the first assessment could be conducted by a care manager, but post reform, the assessment may now only be operated by a municipal official.

A municipal officer will visit the beneficiary's home and evaluate the level of care needs, using a questionnaire about the beneficiary's physical, mental and life conditions. All information is put into a computer system to achieve a score classification. The final result is decided using consideration of physical and mental conditions via a Nursing Care Need Certification Board, composed of physicians, nurses and other experts, to determine the appropriateness of the result from the first assessment. This board can re-determine the level of care need if necessary (Tsutsui. T and Muramatsu. N; 2005).

After reviewing all the relevant conditions of a beneficiary, the care manager will prepare and arrange for people from different institutions to meet, to discuss and formulate a concrete plan for care provision. The municipal employee, physician, nurse, care manager, and family members will attend this meeting, which aims to promote in-depth communication among people from different perspectives, to complete a comprehensive plan for the individual need (Kageyama. K, et al; 2014).

After the meeting, the care manager will determine a care plan, visit the beneficiary to reconfirm details in the plan and make sure it is accepted. If the

beneficiary is identified as *care required*, a care manager will be assigned for the next step of the care plan. If the beneficiary is identified as *assistance required*, they do not have access to facility-based care provision. Time required for care will be estimated (after evaluating nine categories of service provision including clean/bath, eat, toilet, eat, transferring, assistant support with instrument of daily living, behavioural problem, rehabilitation and medical service) and the level of care need will be assigned (Tsutsui. T and Muramatsu. N, 2005; Imai. H et al, 2008). The care manager will monitor the process of care provision, and adjust the plan according to any changes in conditions and requirements of the beneficiary.

The responsibilities of care managers differ according to the type of affiliation. Although research on the care manager is so far scattered in academia, there is a strand of literature that mainly focuses on the working conditions of the care manager, and most of this research is in the Japanese language.

Despite the reform in 2005, which reduced the number of cases that each care manager was supposed to tackle, the work—both in volume and substance—has continued to rise, due to the ever-increasing elderly population. Aside from the services directly related to the beneficiary, the care manager is also supposed to complete other tasks within the LTCI context, such as making contracts, payment management, and miscellaneous administration, since different care managers affiliate to various agencies, and they usually have different workloads beyond core responsibilities (Kageyama. K, et al; 2014). In most cases, the care manager will have to face multiple tasks in their affiliations. Paperwork and indirect work occupy a considerable amount of their time (Yu. X J; 2014). Many care managers consider they do not have enough time for their core work (Idesoe. Y; 2004).

Imura. H (2006) underlines the factors that cause pressure for care managers—including time-costs in communication, and the complexity of managing relationships with various different actors. It was emphasised again by (Idesoe. Y; 2004) that many care managers thought they did not have enough time for their

core tasks. They claimed that they did not have enough time to visit the beneficiary or fully understand their situation, as the time allowed for this activity was limited. Toyoshima. M (2007) points out that if communication did not work well during the initial process, most of the care manager's time was spent on negotiation, which added to the stress of then facing the large amount of administrative work required to document beneficiaries (Yoshikawa. T, et al; 2002). Wake. J (2004) also indicate that care manager's lack of time for core duties also influenced the quality of care management they were able to provide.

According to Baba. J (2012), despite the average number of cases for which each care manager was supposed to be responsible reducing from 2003 to 2007 in the time study, the average length of working time actually increased. The work of 'recording' (*kiroku*) increased most in contrast with other work, and therefore the time left for other parts of workload was reduced. Therefore, there was widespread discussion on work efficiency, with many care managers arguing that overly detailed and complex paperwork did not benefit long-term care in practical terms. Sakou. K and Naito. K (2005) find the role of care manager was unclear in the Japanese LTCI system; additionally, as care managers have different perceptions of their responsibilities thereafter, they function differently in many aspects, according to Kageyama. K, et al (2014).

Yuhara. E, et al (2012) indicate disappointment arising from the vague understanding of the job specification of care manager. Despite the standardised certification set up in the LTCI system, care management has also been influenced by care managers themselves, regarding their function and role (Kageyama. K, et al; 2014). The lack of understanding of the care manager's role has potentially influenced the relationship between care managers, care providers and clients. Takasaki. K (1997) states that the primary responsibilities of a care manager were problem analysis, home-based care planning, and as a contact point for service provision. Hashimoto. T (2003) argues that, except for investigation, insurance-

related payment management (‘*kyōfu kangri*’) and service support, other work items did not originally belong to the care manager.

Research from Tsutsui. T and Higashino. S (2011) addresses the primary responsibilities of care managers’ work, stating that these are the creation of the care plan, contacting service provision, and monitoring the updated conditions of beneficiaries. During the practical working processes of care management, Ōno. I (2000) indicates that the care manager spends too much time on payment-related work; they are usually overwhelmed by the heavy workload in payment-management paperwork.

Aside from literature that discusses the role and working practices of the care manager, literature also sheds light on the how the social environment influences care managers and care workers, under the policy changes in the LTCI with progression privatisation. Broadbent. K (2014) argues that the privatisation of home care services after 2006 has led to the intensification of work for care workers, and a deterioration of employment conditions. She illustrates that, in interviews, care workers expressed that they would rather work in a supermarket than the care industry, since payment does not correspond to the pressure of the work, and energy required. As many care managers were previously care workers, the lack of care workers will directly influence the number of care managers in the future. Unlike advanced social workers in other OECD nations, care workers will eventually occupy most of the care manager roles in the Japanese LTCI system, Baba. J (2012) suggests that the Japanese care managers are supposed to pay more attention to the assistance for the elderly. However, this becomes rather difficult when the care manager is immersed in paperwork.

It is also argued by Kawano. T (2013) that the most crucial problem in care management in Japan is that care manager became an LTCI role who spent most of their time and energy on administrative work in the system, and less time invested in more communication with the beneficiary. There are many regulatory

policies for standardising care manager's work. However, the balance between fulfilling bureaucratic requirements and providing practical assistance for a beneficiary is an essential issue, worthy of reflection. Amongst many criticisms of the role that the care manager plays in the LTCI system, dealing with many insurance-related documents and connecting with the beneficiary at the same time are cited as too burdensome for the care manager. Thereby, a possible mitigation would be to involve a social worker to work with the care manager together in the LTCI system, benefiting both, to achieve a higher quality of service provision.

The literature above is conducted from the perspective of the care manager. There is also research conducted from the perspective of the user, but this is less in evidence. Imura. H (2006) discusses the feedback given to the care manager. Some beneficiaries complain that the care manager lacks adequate training. Since changing LCTI policy in 2007, the care manager must renew their certification every five years after initial training. Care managers mainly require knowledge in three aspects: knowledge about the long-term care system, related medical knowledge, and familiarity with local resources. However, in reality, care managers only take up one or two municipal training courses at present, and most of these are delivered as lectures for multiple trainees, lacking individual practice and supervision.

In addition, complaints are also made that care managers recommend services from organisations by which they can make personal financial profit, rather than those best suited to the beneficiary's care plan. There have always been concerns that personal financial preference might affect care managers' suggestions regarding long-term care insurance services. This was accentuated by research from Feng. M, et al. (2017), demonstrating that financial benefits from different care management agencies profoundly influenced beneficiaries' expenditure. When a beneficiary used service providers and care management agencies

belonging to the same organisation, beneficiaries are found to incur higher spending for their care service, even adjusting for control factors. As a result, an effective and proper mechanism is needed to minimise this influence.

There are, of course, potential benefits for the beneficiary if using the same service providers and care management agencies: it is easier for the care manager to monitor beneficiary needs; the care manager can deal with emergent issues in a timely manner, as referrals can be carried out immediately if necessary; the beneficiary may get a preferable outcome in physical or cognitive terms; and as the increase of service used in the process, the agencies also succeed.

This section of the literature review explored different perspectives of care managers, including job specification, working conditions and existing problems. Most of the literature was conducted in the Japanese language, and little was in English. In the limited literature available, contents were not consistent, either in topic or timeline. Moreover, analysis was only completed as an empirical study, without further interpretation from different philosophical frameworks. Consequently, my research aims to fill the research gaps existing in the English literature, and deepen the understanding of the role of the care manager from a broader philosophical reflection.

2.4 Literature on Elderly Care in China

2.4.1 Historical Development of Elderly Care

China has a special socio-economic context in the world. Its rapid economic development drew worldwide attention, whilst it has also faced numerous domestic problems. One of its biggest concerns is the rapidly ageing population. By 2040, people aged over 60 will occupy 28 per cent of the total population, according to the estimation by UNDESA (2013). The Chinese population has two significant demographic characteristics: the upcoming rapidly increasing elderly population, and low fertility rates due to the one-child policy. People born between

the 1950s and 1960s are known as the 'baby boom' generation, due to the policy of encouraging people to have more babies—'more people, more power' under the instruction of former president Zedong Mao. Those group of people from baby boom will become the largest cohort within the whole population around 2030 (Dannefer. D and Phillipson. C; 2010).

To deal with the future challenges of an elderly society, since 2016, the Chinese government have begun to promote long-term care insurance in certain areas and cities of the country. Considering the context of a super-ageing population in China does not only complement research in this area for academia; finding solutions will in themselves become beneficial for other nations facing the ageing process, even though these countries may not face the same intense pressures as China, with its already massive population.

Japan has already moved into the context of a rapidly ageing population process, and has become experienced in finding practical solutions, by developing the policy framework of the LTCI. There are distinctive differences between Japan and China with regards to political-economic structures at the macro-level. However, they share many similar facets of lifestyle, family values, social thinking and emotional understanding at the micro-level, through long-term intercountry communication throughout their history. Therefore, Japan can provide important lessons as a reference for China in tackling the issue of an elderly population.

There is not yet much research about the Chinese LTCI, since it has only been a short time since its establishment. This section will provide an overview of the literature researching the development of Chinese elderly care. This might not directly pertain to the LTCI, but has paved the foundation for understanding the Chinese context before the initiation of the LTCI. Initially, I used the keyword 'elderly care China' and picked up the resulting academic literature from all data resources. After this, I found five areas which had received attention from scholars: general development in elderly care, living arrangements of the elderly, types of

service provision, the 'lost-one-child' family and human resource work for the elderly care.

There is a body of literature indicating the characteristics of demographic conditions in China before the establishment of the LTCI. Dannefer. D and Phillipson. C (2010) underline two significant demographic characteristics of the Chinese population: a rapidly increasing elderly population, and low fertility rates after the one-child policy. Alongside the long-term operation of the one-child policy, the rapidly increasing elderly population accelerated the social phenomenon of the 'empty nester' family: a large group of Chinese elderly people chose or were forced to live alone (Li. D, et al; 2014). The 4-2-1 structure of a family (i.e., four parents, two children as the only child in both families and one infant as the third generation) became the standard structure in society (Flaherty. J, et al; 2007).

There were three historical phases in the policy development of elderly care, after the Chinese government was established after the civil war in 1949. The first phase is 'family-centred' from 1949 to 1982, during which family was given the central role in supporting elderly people. The second phase, called the 'combination of family and society', was from 1982 to 2006, during which the government introduced socialised approaches to help with elderly care. However, family remained the main actor in taking care of elderly people. The third phase, 'comprehensive care from family, community and institution', started from 2006 to the present (Yu. C W and Leung. J; 2012); long-term care was initiated in certain areas from 2016.

In the family-centred phase, the government was responsible for primary societal functions. It was newly established after the civil war, and economic development lagged far behind. In the late '50s, elderly people identified as 'three without' (*sānwúlaorén*): people over 60 years old and without (i) working ability; (ii) without money resource; (iii) without family support. Living in urban areas

became a new social phenomenon. The government started to establish public welfare social homes (*fúlìyuàn*) to accommodate this group. In the case of elderly people living in rural areas, the production teams[10] (*shēngchǎnduì*) in villages were responsible for basic life support, providing what was known as a 'household with five guarantees' (*wǔbǎohù*), guaranteeing (i) food, (ii) clothes, (iii) medication, (iv) financial living costs, and (v) cremation (Zhang. H; 2007).

The second phase, the 'combination of family and society' from 1982 to 2006, occurred as China went through several important historical epochs, such as structural reform in the economy after the 'open and reform' policy, and adopted the one-child policy. The structural reform in economic policy was called 'break the communal pot', i.e., it broke the egalitarian concept of distribution, and shifted attention to productivity and efficiency in economic development. Along with this transformation, many workers who worked for national or public factories lost their jobs and were forced to enter market competition. Since many of them had thought they would have life-long jobs for nationally owned factories, little attention had been paid to gaining specific qualifications in the job market. Therefore, they chose early retirement, or reluctantly accepted the reality of losing their jobs in this significant structural reform. Consequently, senior-aged people without incomes flowed into the community, and required the government to promote welfare at community level.

From 1994 to 2000, the government initiated the policy of The Seven-year Development Plan on China's Ageing Work, which emphasised the principle that elderly care was a combination of household-based and community-based care. This policy encouraged the expansion of social service provision in China. In 1996, the government launched the Law of the People's Republic of China on Protection

[10] Production team,生产队,a basic administrative unit for farm production in people's commune system in rural China from 1958 to 1984.

of the Rights and Interests of the Elderly, which underlined the importance of the development of community-based welfare; however, reliance on family was still the central pillar of this approach, and was stated as such in the Act. Meanwhile, as the market opened beyond the first phase, more and more private care homes appeared (Jin. W G; 2011), in the context of a lack of standardised regulation.

The third phase—'comprehensive care from family, community and institution'—started in 2006, and continues now. Since 2001, the demographic structure in China has officially moved into an ageing nation, and has drawn greater attention with the rapid increase of the elderly population and an expanding group of elderly people with dementia.

In 2005, a 'Circular on strengthening the preferential treatment for older people' policy was issued by 21 state ministries, to enhance the economic, health and daily support for elderly people. In 2006, the state council initiated 'Notice of the State Council on Issuing the Plan for Development of the Services Industry', which also included an emphasis on care for elderly people with dementia, and also stated the three pillars in the development of elderly care: family support, community support, and institutional support. In 2011, the '12th Five-Year Development Plan on China's Aging Work' amended this policy and stated the fundamental principles in tackling Chinese elderly care were of family home care as 'foundational', community care as 'support' and state institutional care as 'complementary'. In 2012, the city of Qingdao became the first city in China to test the model of long-term insurance. Despite the conflicting opinions on policy solutions for the forthcoming ageing population in China, the government officially started and expanded the trial of the LTCI system in designated areas in 2016 (Yang. J H, et al; 2018).

There are other approaches to categorising historical periods when discussing the development of elderly care in China—however, rather than defining these periods from a chronological perspective, it is more important to understand the

significant social transformations that happened during the process, which formed the historical rationale for establishing LTCI in China.

First of all, from a macro perspective, the size of China's population means the speed of ageing is faster than in any other advanced and developing nation (WHO; 2015); secondly, the traditional value of filial piety under Confucian culture gradually changed after the 'reform and open-up' policy, which promoted high-speed economic development in China, as well as reshaping values in family and gender discourses (Feng. Z L, et al; 2012). In particular, along with the long-term operation of the one-child policy, it accelerated the social phenomenon of the 'empty nester' family, wherein a large group of Chinese elderly people either chose or were forced to live alone (Li. D, et al; 2014). Last but not least, the structure of '4-2-1' family (i.e., four parents, two children of one-child generation and one infant) became a normal structure in society (Flaherty. J, et al; 2007).

Looking back over 40 years of development (Wu. P and Wang. Y M; 2018), all policies related to elderly care in China shifted diachronically, according to the macro situation. Yang. W, et al (2016) claim that the LTCI system would be the best choice in the present social structure of China; building up the public insurance system could work well for those at a middle-level of income in the country (Rhee. J C, et al; 2015).

2.4.2 Current State of Elderly Care and Challenges

In an overview of the development of elderly care in China, Feng. Z L, et al (2012) outline future challenges, against a background of profound social transformations happening in China. Aside from estimating that there will be 119 million people over 65 years of age by 2040, most families only have one child,[11]

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[11] One-child policy,一孩政策: in 1980, the central government initiated the standardized policy – one child per family nationally (parents from some ethnic minority or those whose firstborn was handicapped were allowed to have more than one child), under the background of rapid population growing after Mao

due to the rigorously enforced policy limiting family size. With the increasing mobility of young people due to industrialisation, the empty-nest family has become a concern in society. Filial piety is a concept rooted in Confucian culture, and one which has firmly influenced people's thinking patterns in China, despite the family structure's dramatic shift from large extended family to nuclear family, under social transformations through economic development (Gu. D D, et al; 2007). Like Japan, the elder son and daughter-in-law or elder daughter have been expected to take responsibility for taking care of parents (Wu. B, et al; 2005).

There has been a long-term discussion on whether China should commence a LTCI system, both in academia and industry. The debate was conducted around different models, i.e., the German model of social insurance, the Scandinavian model of tax-financing, and the Japanese model of a combination of both. Which model can be more easily located into the Chinese socio-economic context has been widely discussed.

Since a long-term care policy is still in its preliminary trial stage, and the social infrastructure has not developed sufficiently (Peng. R and Wu. B; 2015) at present, home-based elderly care still occupies more than 85 per cent of the private sector market (Yan. H R; 2006) and the empty-nester family increased to 50 million in 2013. Municipalities encouraged voluntary services, community-based hospitals and day-care centres to assist in the operation of care provision, to respond to increased demand. However, this combination is still not sufficient, due to many requirements and regional differences (Liu. L J, et al; 2014). Consequently, how to design and sustain a system for the elderly population has drawn wide attention in Chinese society.

Hao. J F and Li. X Y (2014) indicate the main factor that made the German LTCI

Zedong's encouragement in increasing population. This policy has been repealed in 2016.

system operate successfully was refined policy design, which included a robust financial approach (exact items of benefits, cost control, and scrutinising quality) confirming the sustainability of the whole system. Zhou. C S and Li. Y X (2015) point out the necessity of NGOs/NPOs in promoting the combination of local resources working more efficiently for elderly care, since these are still undeveloped in China. The structural design of macro policy is also essential, since the market lacks standardisation in many aspects (Ding. Y and Li. X J; 2013). Zhu. M L and Jia. Q X (2009) suggest the package of combining social insurance and commercial insurance is appropriate for the Chinese context at present. Dai. W D (2015) argues that compulsory insurance will confirm finance for the low-revenue group, whilst commercial insurance can be offered to high-revenue elderly people. W Wang. X J and Zheng. C (2014) also suggest the possibility of separate layers of finance resource. This leads to a discussion on the responsibility of government.

Edward. P and Deng. Q H (2008) examine the data of elderly income from 1988 to 2002 in rural and urban areas, and found that it has shown an expanding gap, causing uneven distribution of service delivery between rural and urban areas. The difference was also underlined particularly in the care for disabled elderly people (Li. M, et al; 2013). Taking care of disabled elderly needs presents a substantial cost, in particular for rural households, without a complete pension system. Therefore Li. M, et al (2013) suggest developing community-based care and LCTI to support a stable policy structure to protect disabled elderly people, with particular attention paid to rural areas.

Li. W Y (2014) points out that in the past, elderly care was provided mainly by family members under the influence of Confucian culture; community-based support existed only as a supplement, and public institutions were the last choice for a family. However, this attitude shifted according to the profound changes happening in the economic structure. Li. W Y (2014) also emphasises the unevenness in the service delivery, even in urban areas. In urban areas, the

distribution of elderly care provision is still unfair. The nature of services, i.e., state-owned or private sector, influences the welfare policies regarding elderly care.

Wang. J, et al (2016) clearly state the situation immediately prior to the establishing of the LTCI in China, which included a lack of standardisation of health evaluation, limited funding from medical insurance, a shortage of qualified care workers, and complex societal situations due to local disparities. By investigating the context and background of elderly people who chose to live in institutions, the research shows that although institutions fulfil basic life needs, there is still significant room to improve the quality of care provision.

In the examining the literature on the living arrangements of elderly people, Lei. X Y, et al (2015) utilised the data from the China Health and Retirement Longitudinal Study (CHARLS), collecting patterns of living arrangements of the Chinese elderly. From the data range of this research, it was found that a significant portion—nearly 45 percent—of elderly people live alone or with a spouse, without any children.

In the meantime, the availability of housing has also become an essential factor in deciding co-residency (Meng. X and Luo. C L; 2008). The decrease in co-residency has been caused by 'housing reform'—that helped the elderly to choose their preferred living environment—whilst economic reform changed ways of thinking about elderly care through the social transformation, moving from the traditional extended family to the nuclear family structure becoming the norm.

Chen. L and Ye. M Z (2013) conducted qualitative and quantitative research to discover whether the children agree with sending their parents to live in long-term care institutions (*yǎng lǎo yuàn*), or similarly into nursing homes (*tokubetsu yōgo rōjin* homu) in Japan, analysing by service type. The research found children were indeed involved in the decision, and influenced whether their parents chose the

facility-based care provision. In addition, the children's financial and emotional support could impact the parents significantly.

There has also been research examining the co-relationship between health conditions and living arrangements (Li. L W, et al; 2008). Data were extracted from two waves of the Chinese Longitudinal Healthy Longevity Survey. The findings showed an active co-relationship between living arrangements and mortality, daily living activities, and self-rated health from data in the second wave; the association between living arrangements and mortality differed by gender.

Wang. J F, et al (2014) discovered a co-relationship between psychological well-being (PWB) and types of living arrangements for elderly people. They find that widowed elderly people will have better PWB compared to those who live alone; for a couple, living with children did not impact the elderly person's PWB. Also, they argue that the living arrangements of Chinese elderly people are becoming more mentally independent, unlike previous generations where large families lived together; the majority of old people were adapting to the nuclear family structure, understanding when their children did not choose to live with them.

Liu. G Y, et al (2012) also compare the PWB between the institutionalised elderly and elderly people who are supported in the community. Their research found that institutionalised elderly people have worse psychological health than their counterparts supported in the community. However, it's important to note that this may not apply in other countries, since there is only a very short history of the development of institutional care in China.

In the literature regarding the types of care service provisions, Wu. B, et al (2005) indicate that in the transformation after China's economic reform, the government started to promote community-based long-term care (CBLTC) for the elderly. In the case of Shanghai, CBLTC provision was composed of a community service

centre, a '*bǎomǔ*'[12] or '*Jiāzhèng*'[13] coordination centre (in which the centre is responsible for sending workers to households according to the requirements of the client). The community service centre is public sector provision, acting as intermediary between the elderly and the agency which sends the caregiver. *Baomu* and *Jiazheng* coordination centres contains both public and private institutions. The public sector usually belongs to the street station committee,[14] Labour Unions and Women's Federation; while the private *bǎomǔ* or *Jiāzhèng* coordination centres are for-profit enterprises. In terms of institutional care, government sponsored public institutions and private institutions in Shanghai (Wu. B, et al; 2005).

Chang L, et al (2014) conducted a cross-sectional study to evaluate the causal relationship between the ownership of care facility and the service quality. They also made a comparison regarding the type of residents in public-owned and private-owned facilities. The result showed higher occupancy rates from government-owned facilities which accommodate old people with lower ADL on average. They argue that there are no clear results to suggest which is better between private and public facilities. In the case studies in Nanjing and Tianjin, their data indicates a greater shortage of human resources in private providers.

In addition to Wu. B, et al (2005)'s research on the situation of Shanghai, Lin. C and Wen-Jui. H (2016) shifted their research attentions in Shanghai by investigating popular dining services since 2007 to investigate the development of community-based elderly care. They listed the challenges in regard to the community-based care provision, including: concerns about service quality due to the frontline care staff being poorly educated; concerns about sustaining the community care in the

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[12] Bǎomǔ,保姆:home-helper.
[13] Jiāzhèng,家政:house-hold work assistance.
[14] A street station committee,街道 is one of the smallest administrative divisions in China; it may also be called a subdistrict.

context of a great shortage of workforce against a demanding workload in the market; concerns about unevenness in development between different districts within the city.

Despite the challenges in developing community-based care, China continuously promotes its development. Qingwen. X and Julian C. C (2011) investigated the service provision model regarding community-based elderly care in China, stating current difficulties for the old people using institutional care, including: greater institutional costs compared to home-based care; the quality of the care an institution can provide; and the implications of traditional culture making children feel guilty if they send their parents to a care institution. As a result, community-based care became an option, and has been encouraged to develop in China (Qingwen. X and Julian C. C; 2011). Against a background that family care remains the primary approach for caring for old people, community-based care offers supplemental service items or respite care for the household (Qingwen. X and Julian C. C; 2011).

At the same time, institutional care has kept growing (Zhanlian. F, et al; 2011). The data from a survey in Nanjing in 2009 and a piece of government data in other seven cities indicated government-owned nursing institutions decreased from 96 per cent before 1990, 60 per cent in 1990s and 23 per cent after the 2000s. Private sources increased dramatically, of which 86 per cent of the private sector is eligible to receive a per-bed government subsidy (Zhanlian. F, et al; 2011). The major problem found in institutional care was the lack of professional staff, also underlined by Qingwen. X and Julian C. C (2011). The findings imply a significant transformation regarding the ownership of elderly care institution in China.

The fourth type of articles regarding elderly care focus on the tragic research issue of families who have lost only children. There is a body of literature researching the life of parents who lost their only child, but very little discussing how these parents live in their last stage of life. Yu. S (2014) reveals that around one million

families in China have lost their only child. From several qualitative studies and 12 case reports from the media in 2012 and 2013, Yu. S (2014) suggests establishing a comprehensive supportive system in elderly care for these families. This suggestion does not only apply to households without children, but could also benefit families whose children live distantly from them (for example, whose children have moved abroad). Tianhan. G and Tanya. K (2016) conducted in-depth semi-structured interviews with Chinese young people who study and work in Montreal, Canada. These young people face a dilemma between their personal life and caring for old parents in the future without help/support from other siblings. Although these families have not lost their child, the situation of living separately means parents cannot access any support from their children directly, increasing the need to adopt other approaches to fulfil their needs.

Regardless of the different themes in the literature regarding Chinese elderly care, the workforce shortages—either in quantity or quality—have been mentioned in many articles. Bei. W and Francis G. C (2009) did in-depth interviews with administrators and field observation in care institutions in rural China. They found that the reason for such institutions rejecting elderly people with dementia or disability was due to the great lack of specialised staff, and it was difficult to hire such skilled people in the market. Yuting. S, et al (2014) conducted a systematic literature review on the staff characteristics and care provision in nursing homes in China. They point out the majority of caregivers working in urban nursing institutions are migrant workers without sufficient professional education. Their findings suggest improvements in caregiver training through regulatory policies can standardise qualifications for people working in elderly care. Yuhang. Z, et al (2019) examined the quality of caregivers in care institutions from a case study conducted in Zhejiang Province via a cross-sectional survey done in 2016. The collected data showed most caregivers were middle-aged females, holding educational diploma below middle school. Many had not had training before becoming employed. Their jobs were high-stress and labour-intensive, but low-

paid. The average quality of caregivers in Zhejiang Province is lower than the average quality level in developed countries (Yuhang. Z, et al; 2019). According to a cross-sectional questionnaire conducted in 12 nursing homes in Liaoning Province (Huijun. Z and He. S; 2019), the data of participants indicated the low educational attainment of caregivers. Caregivers who received higher education had more satisfaction in their job, and had higher positive attitudes towards the elderly people they worked with.

Compared to the studies of institution-based caregivers, articles on community-based caregivers are far scanter in current research (Honglin. C, et al; 2016) since community-based caregivers have a more ambiguous professional identity. From the case study in urban Shanghai, via interviews and group discussion, confusion was found regarding the working identities of community-based caregivers, and Honglin. C, et al (2016) suggest possible improvements in work environments. Wang. J and Wu. B (2017) suggest to developing training and educational programmes for domestic helpers who provide community-based care at the elderly people's homes, via a systematic review of Chinese frontline care providers.

The issue of elderly care comprises different strands; this section has listed publications from general developments in elderly care, the living arrangements of the elderly, types of service provision, the 'lost-one-child family', and care workers. Although these topics are scattered across time and location, they have helped my wider understanding of elderly care in Chinese society.

2.4.3 Formation of the LTCI

To deal with the future challenges of an elderly society, since 2016, the Chinese government decided to promote LTCI in designated areas and cities. Since the time of trial has been relatively short and was conducted in limited locations, not much research has so far been done in regard to the Chinese LTCI system. Notwithstanding this natural limitation, the issue of working conditions for

caregivers in the new system has not been researched enough.

The debate on whether China should adopt an LTCI, and how to build it up has drawn attention from scholars. Several discussions consider the possibility of establishing the LTCI, as well as its potential limitations in the Chinese context. Zhong. R Y and Song. X C (2017) indicate several strands of research on a Chinese LTCI thus far in academia.

Hao. J F and Li. X Y (2014) indicate the elements that made the German LTCI successful, and emphasise the social characteristics present in China. In contrast to more advanced nations, not only is the LTCI system lacking in policy design, but another problem for China is also a lack of multiple participants in the market so far, in particular, little or no developed activity from non-governmental organisations (NGOs) / non-profit organisations (NPOs) or volunteer organisations (Zhou. C S and Li. Y X; 2015). Properly activated, these organisations might have great potential to make local resources work efficiently for elderly care.

Ding. Y and Li. X J (2013) note the importance of social structural design in tackling the issue of elderly care. They emphasise the low efficiency in care provision, due to an incomplete policy structure without standardised regulation across the market. Also, it has been challenging to effectively combine the different types of local resources with no institutional guidelines. With regard to the approaches taken in financial resourcing for the LTCI, Zhu. M L and Jia. Q X (2009) argue that the combination of social insurance and commercial insurance is appropriate for the present Chinese context. They suggest social insurance should be compulsory for everyone, so that this part of financial revenue can underwrite basic necessary care provision for the elderly; commercial insurance could be operated to encourage various actors to become involved in this market.

In addition to this point of view, the necessity of building separate layers of finance resource was emphasised by Dai. W D (2015), who argues that compulsory

insurance is to confirm finance for elderly people on low incomes, while a package of commercial insurance can be offered to the elderly on higher incomes. Wang. X J and Zheng. C (2014) underline the potential for a comprehensive role of commercial insurance in the market, aside from social insurance, to gradually reduce the burden on the government and public enterprise to fund the LCTI. However, this analysis led to further discussion on the government's responsibility in this area, and equality in welfare distribution.

Zhong. R Y (2011) cites a case study about demand and supply with respect to elderly care provision conducted in Shanghai, pointing out the practical restrictions at present—most elderly people still do not have sufficient finance to fund their care solely from the private sector, therefore government is still an essential source of funding, alongside other possible participants in the market. From the perspective of supply, it is possible to promote provision in two steps (Jiang. C G; 2016). The first phase would be to establish an entire social care network during the first ten years of LTCI, realistically assessing the demand on the market. After understanding the macro situation clearly, it would then be possible to gradually build up the long-term care service system alongside a long-term care financial system.

Despite many disputes over the policy framework design of the long-term care elderly care system, the city of Qingdao in Shandong Province became the first place with an established LTCI in China as a pilot trial, set up on similar principles to the German model. The finance came from medical insurance and other surplus funding, without revenue from individuals (Li. F Y and Otani. J; 2018). The State Council issued proposals No. 35 and 40, aiming to promote the development of a health insurance product and the concept of LTCI in 2013; in 2014, government proposed the document 'Opinions on Acceleration of Modern Insurance Service Industry', which raised an idea linking commercial health insurance and medical insurance. In 2015, the exploratory proposal of LTCI implementation was recorded

in 'The Thirteenth Five-Year (2016-2020) Plan of China' in the 18th Central Committee. The following year, in 2016, the Government issued a document, 'Guidance on Pilot Cities to Launch Long-Term Care Insurance', which indicated the official start of the LTCI in China (Li. F Y and Otani. J; 2018).

15 cities[15] were designated as LTCI trial cities in the first phase; Jilin Province and Shandong Province were the most crucial pilot provinces (Yang. J H, et al; 2018). Government aimed to formulate LTCI at national scale by 2020 (Wang. Q, et al; 2018).

There were different practical conditions to consider in conducting the LTCI in these areas, but in principle, beneficiaries under the LTCI were covered by Urban Employees Basic Medical Insurance (UEBMI). UEBMI funds resourced the LTCI in its pilot phrase, transferring a pooled fund and adjusting the contribution rate (Yang. J H, et al; 2018). The problem of UEBMI was its unsustainability (Lu. Y, et al; 2016)—the stable mobilisation of funds will be essential to support a national LTCI system after the trial stage. Zhang. Y (2019) indicates a problem existing in funding the LTCI—transferring funds from medical insurance was not enough for its operation. Moreover, the payment rate of service differed in areas, making standardised regulation difficult.

In a comparative study among different cities, conducted by Yang. J H et al (2018), the differences as well as similarities are specified in terms of insurance, premiums and services; it was suggested that local government should expand the range of benefits in the LTCI to ensure the success of its operation, using good coordination among different resources. Jiang. C G (2016) emphasises the

[15] The City of Chengde in Hebei Province, the City of Changchun in Jilin Province, the City of Qiqihaer in Heilongjiang Province, Xuhui/Putuo/Jinshan districts in the City of Shanghai, City of Nantong and City of Suzhou in Jiangsu Province, City of Ningbo in Zhejiang province, the City of Anqing in Anhui Province, City of Shangrao in Jiangxi Province, City of Qingdao in Shandong Province, City of Jinmen in Hubei Province, the City of Guangzhou in Guangdong Province, City of Chongqing, City of Chengdu in Sichuan Province, City of Shihezi in Xinjiang Province.

importance of supply from the market. The lack of market supply is also underlined by Chen. H T (2017); additionally, he points out the importance of having sufficient numbers of qualified people working in the LTCI system. In fact, Chen finds that policy has not been operated comprehensively, and a gap in policy conduction exists among various regions.

The lack of standard regulation in training care workers is also stressed by Zhong. R Y (2011); he uses the example of Shanghai, where migrant workers or unemployed workers composed the majority of people working in elderly care, only receiving short-term training from the Municipal Civil Administration Bureau; most of the workforce did not hold any professional skills or medical backgrounds.

Zhao. X H, et al (2017) point out that the one-package policy, i.e. one standard for all, did not apply in the Chinese social context, as there were regional gaps in different provinces. Central government tried to promote a series of service items for elderly care, however, there were practical constraints to implement these centrally, due to unique local contexts.

The significant gap in terms of economic development and, accordingly, the establishment of welfare policy across urban and rural areas is an important factor in policymaking in elderly care (Dai. W D; 2015). Dai. W D (2015) explores this gap, and underlines the reality that, in spite of official documents about the quality that should be achieved in elderly care, there are still many practical difficulties to achieving this, such as lack of workforce due to the outflow of migrant workers into the urban cities, and inadequate fiscal reserves in rural areas.

To resolve fiscal austerity in developing provinces and rural municipalities, a public-private partnership (PPP) was introduced to explore the possibility of a new financing model in elderly care (Zhao. S X and Fang. M; 2018). In their research, Zhao. S X and Fang. M (2018) use the successful PPP cases of the Yíhéyuàn Elderly Service Centre in the city of Shanghai, and the Jǐnpéng Elderly

Care Home in the city of Jinpeng, to highlight the possibility of inviting in private resources, and the high potential they can provide in completing a project in partnership with the public sector.

As described before, despite scholars shifting their research attention to the Chinese LTCI since its establishment, there is not yet enough existing literature, and research attention is scattered. Therefore, it is difficult to review the literature according to a specific categorisation or in a systematic way. However, this section has attempted to list all the research perspectives explored in the Chinese LTCI system.

2.5 Literature on Chinese Care Worker

At its heart, elderly care is face-to-face care behaviour. Therefore, the people who conduct this behaviour are the deciding factor in whether the LTCI system can work well or not. In terms of workforce, it is not only about finding enough staff in numerical terms, but also the quality provided. Sufficient and qualified people are crucial for the operation of the LTCI system.

Since the LTCI was established in China, people working in the system have not yet formed a clear career path (such as home helper, home-visiting care worker, junior care worker, senior care worker and care manager), as in Japan. In principle, care workers are working in institution-based, community-based and home-based agencies, similarly to the Japan system. However, they come from various backgrounds and organisations, and many of them have not gained standardised qualifications. Given the challenges of making a systematic review of the Chinese care worker in these three contexts (home-based, institution-based, and community-based), due to the lack thereof, either in number or academic quality of research, articles from various perspectives were collected to give an overview of the realities faced by care workers in the Chinese LTCI system.

As stated earlier, in Japan, care work has been seen as '3K' work; in China it is

labelled 'low-end' and 'precarious', due to the lack of legal protection, low average pay, and providing unstable access to social welfare (Wang. J and Wu. B; 2017). Two groups of people comprise the present Chinese caregiver market: migrant workers and lay off workers[16] (Dai. W D; 2015).

The reason for the inflow of a large number of migrant workers into urban areas has been the social transformation after the 'reform and open-up' policy. This policy opened up China's domestic market, and encouraged competition and efficiency, rather than the egalitarian ideological preferences of the past. Thereafter, certain cities—particularly cities around the east coast of China—soared quickly in economic development. The gaps in life situation, infrastructure, and welfare policies expanded sharply between urban and rural areas, resulting in people living in rural areas deciding to move into big cities to pursue better payment and welfare packages.

Care workers are a vulnerable group also because of the predominantly female identity of workers in this sector, as well as the lack in social support (Li. M; 2012). In the late 1970s, millions of women moved into urban cities seeking better job opportunities (Wang. J and Wu. B; 2017). Afterwards, with the collapse of many national or publicly-owned enterprises under market-oriented guidelines from government, many workers in factories lost their jobs or chose early retirement, suddenly creating a large low-skilled casual workforce without employment. Many lay-off workers often shifted their work into home-based services. In the mid-1990s, the Chinese government began to recognise home-based services as a particular type of occupation (Wang. J and Wu. B; 2017).

In home-based care, services are mainly provided by live-in home helpers or

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[16] Lay-off workers,下岗工人: Since 1985, China started to break down the planned economy and opened the market for privatisation, which put efficiency as priority for an enterprise, encouraged bankruptcy and merging of enterprises for economic effectiveness. A large number of workers lost their job in this reform. This group of people were called lay-off workers in the specific scenario.

hourly-based part-time workers, called *bǎomǔ* or *Jiā zhèng*. They assist in daily chores such as cooking meals, cleaning the house, buying food (similar functions to Japanese home-helpers). There are no standardised or detailed regulations about such services. Home-based care workers usually correspond to family needs, which tends to create ambiguous borders of responsibility, causing misunderstanding and contradictions between family members and care workers (Wu. B, et al; 2005). Moreover, most of them have only received minimal or even no general care training, and little or no medical training.

Despite some areas requiring a registered nurse within institution-based care, a registered nurse would not be present in the institution all day and night. Therefore, there is still a skills gap to cover for institution-based care workers.

At present, despite the great future development potential for community-based long-term care, institution-based care and home-based care occupy most of the market (Chen. H L, et al; 2017). Accordingly, care worker research attention tends to focus on home-based and institution-based care; the literature on community-based care workers is far from adequate. As a result of the fragmented structure of community-based care providers, questions on the practical working conditions care workers in this sector, and how they work, are almost unknown (and unasked) in academia (Chen. H L, et al; 2017).

Ye. D J (2017) uses a case study in one city (pseudonymously named *K*) to elucidate the problems faced by existing care workers, so-called '*hugong'* in Chinese. She indicates three inadequacies in the team of care workers: the lack of institutionalisation, standardisation, and qualification. Ye. D J (2017) suggests setting up a data pool for storing personal information of care workers, which helps to control the situation, and establish the standard for service quality. Wu. B, et al (2005) indicates, in the case of home-based caregivers, the confusion occurring from the ambiguous line of responsibility, which leads to misunderstandings between family members and care workers. Additionally, most

care workers are females, and they quickly become vulnerable groups due to gender discrimination, weak social support as migrant workers, or lay off workers (Li. M; 2012).

On the other hand, institutions managers claim that recruiting sufficient numbers of care workers is not easy (Zhou. J, et al; 2017). One reason lies in the low pay offered, and the other is due to the high mobilisation in this market. Many care workers only chose the role as a transitional job, and are unlikely to feel much job loyalty if they find another type of work, or can find higher pay in another situation.

In case studies examining the willingness of nursing undergraduates to take up the role of care worker for the elderly, Li. K Z and Jin. C (2017) conducted quantitative research collected data from cities of Qingdao, Jinan and Nanning, through a questionnaire for 500 students. The result showed that the willingness was still low—although respondents had studied nursing, students felt the unclear about the possible career path offered as a care worker after graduation.

Aside from the low willingness of young people working in elderly care, Zhang. Q Q (2016) underlines the realities faced by community-based care as well as community-based care givers. At present in the development of community-based care, the financial support is not enough to establish community centres through the municipal government, and even recruiting permanent care workers is difficult, hence encouraging private sectors to become involved in provision. Volunteers are actively involved in care provision, but it is not a stable context, because people mobilise frequently if their work position is not as stable as they require.

In a national study in 2015, around 230,000 care workers were working in elderly care in China (Zheng. X Y; 2017). However, the number of aged people had already reached 0.2 billion, with 40 million elderly people living with dementia, requiring a high level of care provision. The care market still needs a further 10 million care

workers to tackle the care needs of the elderly population, if every elderly person is to receive proper care (Zheng. X Y; 2017).

In the government's 'Outline of the 14th Five Year Plan (2021-2025) for National Economic and Social Development and Vision 2035', the urgency of establishing an efficient social structure for the upcoming massive ageing population was underlined. The importance of keeping a sufficient workforce for elderly care has drawn wide attention from policymakers and related scholars. The main solutions to the current problem—regarding a workforce lacking both quality and quantity—are: (i) to incentivise more eligible and better educated people to work within the elderly care industry, via increasing the financial rewards, and setting up a clear and sustainable career path; (ii) to promote professional training into the workforce for layoff and migrant workers; (iii) to improve the social status of care workers and attain society-wide recognition; and (iv) to avoid frequent turnover by stabilise careers within geographical locations through subsidies (such as helping care workers' children to register at local schools, and financial support to households).

Since there is no established position of care manager in the Chinese LTCI system, there is no direct literature on this topic, nor yet even any literature discussing its potential, which makes this thesis pilot research for this issue. Reviewing articles on other related people, such as care workers in the industry, can help to clarify their present conditions, and provide a foundation to explore the possibility of establishing the role of care manager in the working environment.

2.6 Literature Review Conclusion

2.6.1 Summary of Elderly Care in Japan and China

This chapter has outlined an overall understanding of the elderly care systems in Japan and China. Regarding the macro LTCI system, which Japan initiated in 2000 (earlier than China, in 2016), Japan conducted the LTCI on national scale; in China

the LTCI has only been operated in designated cities and districts. The financial resource for the LTCI in Japan is composed of tax revenue and premiums, set at a national standard. In the Chinese LTCI, the cities of Ningbo, Guangzhou and Qingdao constructed the financial resources of LTCI from social pooling funds of basic medical insurance (*yībǎo tǒngchóujīīin*); other designated cities adopted multiple approaches, including social pooling funds of basic medical insurance, personal pooling funds of basic medical insurance, employee subsidy, local medical support subsidy and public welfare lottery. In Japan, the LTCI provides direct services towards the elderly as a benefit; meanwhile, China offers a combination of financial subsidy and direct services according to the various regional policies.

At the micro-level operation of LTCI, the Japanese care manager plays a key role in making the system function well. Japan has developed a relatively complete career system for people who work within elderly care. In 1987, over a decade before the initiation of the LTCI system, Japan enacted the Certified Social Worker and Certified Care Worker Act (*shakai fukushi shi oyobi kaigo fukushi shi hō*), which confirmed the professional status and social position of care workers. This Act also encouraged the establishment of specialised education in elderly care provision. In 1993, Japan promulgated the Act for Securing Human Resources in Welfare Provision (*fukushi jinzai kakuho hō*), which started to build up a complete training system from central government to municipalities. These actions happened before operation of the LTCI, and paved the foundations for its function. Up to 2013, the JNA Report (2014) indicated that over 90 per cent of care workers have completed high school level education or received higher degrees. Also, the age distribution was even, not too old or too young, in terms of the workforce. The school-based systematic education and standardised professional training after school guaranteed the fundamental qualifications of care staff. It is difficult to investigate all types of care staff—therefore, this thesis focuses on the care manager as the top position on the career path, which also reflects the actual situation of the elderly

care in Japan at both macro and micro levels.

On the other hand, in China, the LTCI has operated for a shorter time and on a much smaller scale. The two documents published in 2019: 'Opinions of the Ministry of Education and the Ministry of Commerce on Developing and Improving Human Resources in Social Welfare Industry'[17] and 'National Occupational Skill Standard for Nursing Care Workers',[18] pointed to the lack in quantity and quality of human resources within the Chinese care industry. The statistics in these two documents show that disabled and partially-disabled elderly people reached around 40 million, requiring at least 13 million care workers in the market, according to the international care standard of a 3:1 ration of care. However, at this point, existing care workers did not reach half a million—there was a huge gap between demand and supply. In addition to the lack in quantity, the poor quality of care workers was underlined in the document of 'National Occupational Skill Standard for Nursing Care Workers'.

It is not easy to make a comparative study between Japan and China regarding the elderly care system, because of the differences in their socio-economic and socio-cultural aspects. Further, it is not perfectly data-robust to compare care workers from two different social structures. As a result, this research is exploring the possibility of applying one social mechanism (care manager) into another system, from the perspective of functionality. This chapter provides background knowledge on elderly care at macro and micro levels, both in Japan and China, supporting the understanding of the case studies and research findings in the latter chapters.

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[17]Opinions of the Ministry of Education and the Ministry of Commerce on Developing and Improving Human Resources in Social Welfare Industry:关于教育支持社会服务产业发展提高紧缺人才培养培训质量的意见
[18]National Occupational Skill Standard for Nursing Care Workers:养老护理员国家职业技能标准

2.6.2 Research Gap, Questions and Thesis Contribution

This chapter comprises a literature review of elderly care in Japan and China, looking at both the macro-level system and the micro-level actor. Reviews of the Japanese LTCI and care manager, and the Chinese LTCI and care worker build an empirical foundation for this research. This section summarises the literature gaps discovered in terms of empirical information found in academia. In this thesis, the last chapter of theoretical reflection also entails a literature review regarding theoretical perspectives on the research issue. This part of the review has been placed in the last chapter, to support inner logical consistency therein.

The literature review has been undertaken by working through articles in English, Chinese and Japanese languages. There are many perspectives forming the discussion on elderly care in academia; the contents chosen for my review were decided by the research questions I wanted to ask through this thesis. My curiosity covered two main aspects: one in exploring the Japanese LTCI by investigating the role of care manager, since it is a vital role in bridging all participants in the macro and microsystem. The other is to look at Chinese LTCI, by considering the applicability of the care manager role in terms of functions fulfilled in care provision. There is no position as a care manager in Chinese LTCI, and also many services can be attained from Japanese LTCI that not available in Chinese care system. Therefore, exploring the care manager role provides reflections on the difference regarding elderly care provision between Japan and China.

Consequently, the first part of this analysis provides an overview of literature pertaining to the Japanese LTCI, followed by a review of the Japanese care manager role. Thereafter, the focus shifted to elderly care in China and Chinese care workers. As there is no care manager role in China and accordingly no research on it, academic literature on the Chinese care worker has been reviewed. Although the role of care manager is different to that of care worker, this very fact poses considerations for the structural design of the LTCI in China, after mastering the

conditions for Chinese care staff and the system they work in—such considerations are the substance of one of the research questions in this thesis, indicated in Chapter Three.

In the literature review on the LTCI and care manager in Japan, articles relating to the historical development, operation and types of services in the LTCI and the working conditions of the care manager have been reviewed. There is a body of literature researching the Japanese LTCI from political and economic perspectives at the macro level in academia; however, there is only a small number of articles examining the LTCI by focusing on the care manager role, and the dynamics of the interaction between the macro structure and micro actor. Several articles are directly related to English-language research, and a small body of articles undertaken in the Japanese language regarding the care manager role. Therefore, there is not enough research regarding the Japanese care manager role thus far. Within the limited literature, the contents were inconsistent, since they have been written in different historical periods, geographic locations, and from different knowledge backgrounds. Additionally, much of the research was done from an empirical standpoint, concerned only with data analysis, failing to provide deeper interpretation from a sociological or philosophical perspective.

On the part of research in China, since long-term insurance is still new area with regard to elderly care, the literature on the Chinese LTCI is even less in evidence. Several English-language articles shed light on the historical rationale of the establishment of the LTCI in China. However, since the LTCI has only been conducted for six years, it is rather difficult to evaluate the system as a whole, using standards or short-term data. Most of the English research about elderly care in China was completed before 2016; there is a small body of articles done in the Chinese language after 2016, and several articles in the English language.

As a result, my PhD research aims to add up three layers of contribution, filling the current gaps in the literature. First, from the perspective of building the English-

language research on this area, this research seeks to compile content on Japanese care managers, and expand research on the Chinese LTCI and care workers.

The second layer is from the angle of contents: research on the role of the Japanese care manager was not consistent, due to time, location, and interpretation. Consequently, I will build up research based on the latest data, formulating analysis time-consistently, and content-cohesively. My research on the Chinese LTCI, care workers, and reflections between Japan and China after 2016 is pilot research, which will increase the literature on this issue.

The last layer is related to theoretical and philosophical reflection. Research on the care manager role and the LTCI was drawn mostly from data analysis at an empirical level, while some extended theoretical interpretation using separate sociological theories. The last chapter in this thesis expands theoretical reflection on the care manager role and related care issues. It discusses the individuality of an institution and further explores the depth of our understanding such individuality, in a short section of free writing. This work is a trial in combining empirical findings and deeper theoretical understanding, an approach rarely seen in other literature on this topic.

After uncovering the gaps in existing research, the next chapter naturally moves to more detailed introduction of research questions and methodology.

Chapter Three: Research Question and Methodology

3.1 Introduction

This chapter introduces the research questions and methodology towards these questions. Research questions as well as research methods have been detailed respectively. As stated in the first chapter, the data of this thesis is composed of first-hand and secondary data. The first-hand data has been collected from fieldwork, and the secondary is from study of the literature. This chapter introduces the research design and methods during the whole fieldwork, followed by the reflection on the robustness of data at the end of this chapter.

3.2 Research Questions

As addressed in the first chapter, this research aims to understand three aspects of questions regarding elderly care in Japan and China. The first aspect is elderly care and the role of the care manager in Japan. The second aspect is elderly care and the role of the care worker in China. The third aspect is about the theoretical reflection on researching the care manager role and the related expansion in understanding life and care.

- ***1 Japan***
- *1.1 What is the situation of elderly care in Japan, investigated via the operation of the LTCI? How does the role of care manager work in the LTCI system?*
- *1.2 What is the function fulfilled by a care manager, and what problems do they have at work? What is the actual dynamic between the macro structure of the LTCI, and the micro actor of care manager?*
- ***2 China***
- *2.1 What is the situation of elderly care in China? Since the Chinese LTCI has been instituted for just a few years, the majority of the literature review comprises studies before the LTCI was adopted.*
- *2.2 Since there is no position like the Japanese care manager in the Chinese LTCI, is there any possibility of applying this mechanism in the Chinese context? If so, how?*

- ***3 Theoretical Reflection***
- *3.1 Why choose the 'body' discourse to interpret the research issue of the care manager?*
- *3.2 How does the 'body' theory enrich understanding of the care manager role?*
- *3.3 How does the 'body' theory comprehend the issue related to 'care' of life?*

In conclusion, two aspects of the research questions are rooted in empirical studies, investigating the concrete social contexts of Japan and China. The first-hand and secondary data has been collected from literature and personal fieldwork. The theoretical reflection relates to philosophical reflection and interpretation of the data.

3.3 Methodology

There is a large amount of literature pertaining to methodology in academia, making it impossible to read it all, even as a methodologist (Hammersley; 2013). There are substantial theories and methods in sociology. From my perspective, building research and logically solving the problem with data is primary, rather than focusing on specific methodological knowledge.

This section indicates the research methods adopted in the research process. Aside from demonstrating the methods that have been applied, there is also explanation of the reasons for choosing such methods, and how they logically link with the research questions, showing the rationale of methods towards the research questions.

3.3.1 Literature Review

The literature review, in Chapter 2, provides insights into the operation of the LTCI systems in Japan and China, and investigations of people working in the system. It also examines the existing academic articles on this topic so far, and reveals the literature gap found. Finally, it logically helps formulate the research questions for this thesis and establish the originality of this research.

The second chapter of the literature review contains two layers, regarding empirical research questions: the Japanese LTCI and the care manager role, and the Chinese LTCI and the care worker role. The literature review is conducted according to a logical sequence: the first section investigates the Japanese care manager from both macro and micro perspectives. Since most academic literature focuses on the LTCI rather than the care manager role, the LTCI literature review accordingly occupies the major part of this section, and at the same time provides a macro-level introduction for the background to researching the care manager role. In the second section, focusing on the Chinese context, the first part reviews the LTCI system, and then examines the care worker role (the crucial factor in understanding the Chinese LTCI), and discusses the possibility of establishing the care manager role within the Chinese context.

The last chapter of this thesis is a theoretical reflection on the research issues of the care manager role. A part of literature review is located in this chapter, in order to combine data analysis with reflection / discussion, aiming to enhance the logical consistency and fluidity of the chapter.

3.3.2 Fieldwork in Japan

In the second year of my PhD, I was involved in a cross-national doctoral programme arranged between the University of Sheffield and the Tohoku University of Japan, allowing me a long-term opportunity to investigate the research topic first hand. The fieldwork included a one-year investigation in Japan and several weeks' visits in China. In Japan, my fieldwork was mainly conducted in Tokyo and Sendai. Tokyo is representative of Japan in many aspects regarding welfare services. Furthermore, Tohoku University is located in Sendai; giving me, maximum opportunity to get to know people and conduct surveys. In China, I visited several facilities, geographically distributed across different cities to explore the Chinese research question.

The participant and non-participant observations as well as semi-structured interviews are the primary approaches for data collection in the fieldwork. There are three case studies of facility-based, agency-based and community centre-based care managers in this research. The participant or non-participant observations provide valuable opportunities to be in the working environment with care managers, and have close proximity to the environmental elements of their work. In addition to the observational approach, I also conducted in-depth semi-structured interviews after the observation process. In each case study, one participant or non-participant observation was conducted towards the care manager. After observing the working process of the care manager some questions rose automatically. I then conducted follow-up interviews with the care manager, as well as her/his colleagues, to broaden and deepen my understanding of their work.

With limited time and resources, I examined one facility-based, one agency-based and one community-centre based care manager on site. In addition to observation, independent interviews were conducted towards other care managers of all three types outside of their workplaces. These interviews helped to complete my understanding of each type of care manager's work in more detail.

3.3.2.1 Japanese Care Managers Interviews

In-depth semi-structured interviews were conducted at first towards Japanese care managers. Tohoku University, Sendai, is in Miyagi prefecture—therefore some interviews were collected there; the others were conducted in the Kanto area, mainly Tokyo. The interviews with the two groups of care managers also gave me an insight into the differences in their work due to the demographic gap between Tokyo and Miyagi.

Supervisors, past teachers, and friends in Tohoku and Tokyo used their networks and introduced me to their contacts who are care managers. This network formed

the first group of care managers I was able to interview. Subsequently, some of these care managers kindly introduced me to others they knew in the industry, and the interview field quickly widened beyond my expectations. This was a huge benefit, since as a student it is not easy to get in touch with unknown Japanese people, and it takes time to build a network in Japanese society, due to cultural norm of '*meiwaku kakenai*'[19].

Before conducting interviews, I sent an agreement form to confirm the interview was conducted through free will, accompanied by a form with my questions. I also informed the interviewees that they could initiate other comments or questions, in addition to my prepared questions. I tried my best to put interviewees at ease before starting; most of the interviews were conducted in a coffee shop or cafeteria close to their workplace or home. Whilst there was no payment made for interviews, I did subsidize refreshments during our conversation. Many care managers in fact took a longer time than I expected to have the conversation with me, and seemed to be entirely willing and even enthusiastic to share their experiences, spontaneously offering more information beyond my research questions. Many of them demonstrated an interest in my research, and the situation in China, since ageing is a worldwide issue. I recorded answers for essential questions and made notes throughout the process. I made immediate notes, and kept my records both as digital and paper versions after finishing each interview. The whole process of connecting and interviewing care managers was unexpectedly smooth, which made me feel very grateful as a PhD student with limited resources.

The pre-prepared questions in the semi-structured interviews has been divided into three dimensions, as follows:

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[19] *Meiwaku kakenai*, 迷惑かけない, try your best not to interrupt/bother other people or cause trouble for other people.

1. Care Manager's Personal Career Path *(the basic work and life information of the care manager)*
2. Care Manager & Individual *(the relations with individuality in the work)*
3. Care Manager & Institution *(the relations with institution in the work)*

The first sort of question is about care managers' personal career experience before becoming a care manager, and whilst a care manager. It is fundamental to understand the care manager from individual and professional perspective. The second sort is regarding the relations between the care manager and care-receivers and their family members. The third sort is about relations between care manager and institutions (affiliations, municipal offices and service providers). The concrete questions towards the care manager are as following lists:

1. Care Manager's Personal Career Path

a) *What was your job experience before becoming a care manager?*

b) *What was the influence from your previous job?*

c) *Does it connect with your present position?*

2. Care Manager & Individual

a) *Do you feel it is difficult to decide the service types and items for a beneficiary when making a care plan?*

b) *How can you confirm the elderly and their family members express their honest thoughts? (usually expressed as* honne[20] *in Japanese language)*

c) *Is it difficult to build mutual trust between you and the beneficiaries?*

d) *Are there any contradictions happening regarding the opinion of service provision between you and beneficiary?*

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[20] *Honne*,本音, the true opinion or real opinion of a person.

e) *Do you feel you fulfilled beneficiary's expectation efficiently?*

f) *Have you met any complex in dealing with the relations with the beneficiaries as well as their family members?*

g) *Is there any difference in dealing beneficiary with dementia or other mental disabilities?*

h) *Do you have any moment that you feel you reached the upper limit in your job? If you have so, what moment made you feel in such?*

3. Care Manager & Institution

a) Care Manager with Affiliation

i. What are your working contents in the affiliation?

ii. Have you met any difficulties in your job?

iii. Do you think there are places needed to change or improve in you working environment?

b) Care Manager with Municipal Office

i. What do you do with municipal office?

ii. Have you met difficulties in working with municipal office?

iii. Do you think there are places needed to change and improve in the work with municipal office?

c) Care Manager with Institutions Necessary for Care Plan: Medical Institution and Service Providers

i. What is your work with medical institution and service providers?

ii. Have you met difficulties in working with medical institution and service providers?

iii. Do you think there are places needed to change and improve in the work with medical institution and service providers?

The three dimensions of research questions were decided by the layers of work

relationships that a care manager has to manage. As noted in the introduction, a care manager mainly interacts with two layers of relationships: with the individual as the beneficiary; and with the institutions (affiliated institution, municipality and service providers). Therefore, the interview questions were listed according to this logical sequence. As reviewed in the second chapter, the Japanese care manager is featured as an endogenous part of the LTCI system; they are rooted in it and paid through it. They bridge different system participants, and are vital for the flow of the LTCI system. Therefore, the questions asked were aimed at building up a complete understanding of the role, and further benefit my understanding of the LTCI itself.

There were 16 care managers interviewed in the Kanto area and Miyagi prefectures. They have been listed here by number, and named by the first Roman letter of their Japanese family names according to the pseudonym principle used.

Table 1: Care Manager Interviews

1	Female	Tokyo	Direct Care Manager	agency-based	T1-san
2	Female	Tokyo	Care Manager	institution-based	U-san
3	Male	Miyagi	Direct Care Manager	agency-based	M1-san
4	Female	Tokyo	Direct Care Manager	community-based	K-san
5	Male	Tokyo	Care Manager	institution-based	O2-san
6	Female	Miyagi	Care Manager	agency-based	S-san
7	Female	Miyagi	Direct Care Manager	community-based	M2-san
8	Female	Miyagi	Care Manager	institution-based	T2-san
9	Male	Tokyo	Care Manager	institution-based	I-san
10	Female	Miyagi	Care Manager	agency-based	Y1-san
11	Female	Miyagi	Direct Care Manager	agency-based	O1-san
12	Male	Tokyo	Direct Care Manager	community-based	W2-san
13	Female	Tokyo	Care Manager	agency-based	J-san
14	Male	Tokyo	Care Manager	agency-based	Y2-san
15	Female	Tokyo	Care Manager	agency-based	W1-san
16	Female	Tokyo	Care Manager	institution-based	N-san

[21]

[21] Direct care manager,主任ケアマネ, Direct care manager is a position settled in 2006 after reform in LTCI

In addition to the care manager for the case study, most of care managers were interviewed in informal settings places outside of their workplace. In the case studies, care managers allowed me to observe their working processes in the working places, as participant observation or non-participant observation according in different cases. These chances are truly difficult to attain and precious as well since the '*meiwakukakenai*' cultural consensus in Japan. It is nearly impossible to be allowed in the working environment without first establishing a trusting relationship. My previous networks in Japan helped me significantly in reducing the time required for this sort of negotiation. It is certain that some care managers rejected my request due to their rigorous institutional policies. I was extremely fortunate to be allowed to do the observation for each type of care manager in Japan, forming my case studies for the latter chapters (Case study 1: facility-based care manager of social welfare corporation in Sendai City (Miyagi); Case study 2: agency-based care manager of private agency in Tokyo; Case study 3: community-based direct care manager of local community centre in Tokyo).

3.3.2.2 Interviews with People Working with the Care Managers (Japan)

Aside from interviews with care managers directly, people working with care managers became part of my research during fieldwork. They either connected with the care manager, or worked with the care manager in the same workplace. In the case studies, to grasp more aspects of the care manager's role, it was important to look at other people working with them in the same environment. This information formed a complementary analysis of the care manager.

In facility-based institutions (the type of agency providing long-term accommodation for the elderly with a high level of care), care workers and administrative staff are the people who work with a care manager. The facility I

in 2005. It is a higher-level position to lead and guide junior care managers.

visited had a large space and public hall; therefore, I stayed in this public area to observe the work conditions dynamics. After observing a full day of work, I interviewed the care manager and her colleagues.

For care managers working in agency-based environments (aiming to provide home-based care plan and service), it was challenging to spend a lot of time in the office because their office area was small and private. I was allowed to accompany one care manager to do home-based visit service, and visit the municipal office. Back at the agency, I interviewed people who worked with the care manager.

In the community-based centre, registered nurses or municipal officers work with the care manager. In this context, I stayed in the rest area close to their office (designed for older people to take a seat and have a rest). I also had an opportunity to attend an event in the community centre, which enabled me to have a chance to talk to staff who worked directly with the care manager.

Interviews with care managers established for me a direct understanding of their work. The people who work with them provided a more complete perspective, seeing the manager in different working environments. As a result, for each case study, in addition to the observation and interview with the care manager, the analysis is based on the interviews from those working with the care manager, to formulate an overarching comprehension of each type of Japanese care manager.

3.3.2.3 Case Studies

Although I introduced the case studies simply in the previous sections in this chapter, this section extends further detail regarding case study methods for this thesis. The case study has been widely used and varied in formulating causal explanations, contextualization, and theorizing regarding the context of the question (Eric W.K; 2012). In this research, three case studies are conducted according to three types of Japanese care managers, categorizing them by their affiliations type.

Case study 1 is an investigation of the care manager who works in a facility accommodating the elderly until the last stage of their life. This facility is a social welfare corporation (*shakai fukushi hojin*) in Sendai. The care manager interview towards was conducted first, and other approaches then completed to collect information. Elderly people requiring 'care requirement' over level 3 are usually accommodated in a social welfare corporation; this facility has a public space, which provided me with somewhere to observe the daily work carried out. Initially I had tried to apply for a part-time job (*arubaito*) in advance of my visit; however, this is impossible for a foreigner with no related training in this area; therefore, after negotiation with the administrative manager in the institution, I was allowed to stay and observe as a non-participant. However, I was able to talk to elderly people at times as they passed by. I stayed there until the care manager finished their work, at which point I interviewed the care manager and other staff working there.

Case study 2 pertains to a care manager working in an agency providing home-based elderly care plans, located in Tokyo. Before carrying out the case study, I met the care manager at the house of a long-standing mutual friend. We were introduced and built up a trusting relationship in this way, otherwise it would be difficult in Japanese culture for me to accompany her the whole day and record the information. The main business of this agency is to offer care plans and suggestions for elderly people who are using the home-based care service. Several care managers are working in this agency; I made contact with one of them. There was no space for me to stay as it is just the office of an agency, so the care manager allowed me to accompany her on for the whole day as an observer, as she visited beneficiaries. I did not interrupt her during her work, such as examining the physical and mental conditions of the elderly, conversations with the elderly and family members; I asked questions in the car on the way to the next household, or during a break on the way.

Case study 3 is about a care manager working in a community-based centre. The office is located in a large shopping mall in that area. As a result, local people, particularly elderly people, can go inside the office directly after daily shopping, whenever they want to seek help or consult anything about care service. The space in the office was too small to allow me stay inside. However, since the counter desk was an open-style design, I could see and hear clearly what was happening between elderly people and staff in the office.

Additionally, there was public space to take a seat and rest close to the office. I was able to sit there and record what I saw all day, as elderly people came and left. There was an event that afternoon, and I was able to assist the staff in their preparation and made a participant observation. After official work hours, I interviewed care managers and other willing staff members.

Unlike the care manager interviews, which provide only the perspectives of the care managers themselves, the case studies included other people working and interacting with the care managers, building up various layers to observe and understand the nature of the role within the LTCI system. In the case studies, my methods contained in-depth semi-structured interviews with the care manager, and open interviews with people working in the same organization. Three case studies of facility-based, agency-based and community centre-based organizations provide a general recognition of care managers' work.

3.3.3 Fieldwork in China

After fieldwork in Japan, I also conducted fieldwork in China, and stayed there for several weeks. China adopted the LTCI in 2016, and everything related to it is still at the trial stage. In addition, LTCI was only implemented in designated cities and districts. As a consequence, the literature study on it to date is far from sufficient. The data directly collected from the workplaces as well as my personal experiences have formulated a vivid recognition and understanding to the

research questions regarding Chinese elderly care.

Alongside the lack of academic research on the Chinese LTCI, the vast gap between the socio-economic environments of Japan and China poses significant difficulties in developing this research as a rigorous comparative study, even though Japanese studies and Chinese studies are often put together in research discourse as 'East Asian Studies' in the western context. After exploring the role and problem of the Japanese care manager, the next question is to discuss the possibility of applying this care manager role into the Chinese context, via analysis of how one might achieve similar functions to those three types of care managers within the Japanese LTCI.

Since there is no position of Japanese care manager in the current Chinese LCTI, accordingly there are no articles discussing such a role in Chinese elderly care. The literature studies in China focus on elderly care and care workers, creating a foundation to understand the general conditions regarding elderly care. In Japan, care managers work in facilities, agencies and community centres. By contrast in China, there is no agency in the market yet (hence all visits and interviews conducted towards people working in facilities or community centres). The potential for the transferability of the care manager role is discussed in two layers. The first layer is whether it is necessary and possible to establish the care manager role in a facility or community centre. If so, how might one establish such a role in the corresponding environment of an agency, were it to exist? As there is no home service agency yet, first we must examine whether such agency is needed in Chinese market. And next two layers are based on the first answer.

My time spent in China was much shorter than in Japan, and thus I could not collect an equivalent number of interviews. Regarding my investigation of the facility-based situation, I interviewed a manager as well as a medical doctor in one facility in the city of Nanjing, Jiangsu Province. A professor specializing in ageing society in Nanjing University introduced me to this manager, as well as taking me to other

facilities (without interviews) for short visits inside the facilities; whilst accompanying me, the professor expressed her opinions on the issue of elderly care. In respect to the visit to a community centre, I was introduced to visit and interview with someone who had established a community centre in the city of Shenzhen, Guangdong Province. I was also allowed to interview a care worker in that centre.

Through examining the functions of the facility-based and community-based Japanese care managers in the LTCI, I have discussed the necessity and possibility of applying their role into a Chinese context from a functional perspective. It is impossible at this stage to discuss the applicability of agency-based Japanese care managers, due to the absence of such agencies in China. I have asked this question in every interview during fieldwork in China, and the answers have been analyzed in combination with opinions collected at from workplaces, as well as the literature.

3.4 Reflection on Research Ethics, Method and Potential Improvement

I am grateful for having the chance to stay in Japan for a full year, during which I had time and space to finish interviews and case studies; it took considerable time to make contact with people at a personal level as a foreigner in Japan. I am fluent in Japanese and have experience studying and working in Japan before my PhD, so I understood the proper balance in communication with Japanese people, endeavoring to collect information whilst respecting cultural preferences for distance and privacy, both from a research-ethic perspective and out of humanitarian consideration.

My initial plan was to be a volunteer alongside care workers to conduct my observation study in Japan, but I was rejected by the facility because even being a helper is not '*arubaito'* (a part-time job) in the normal understanding of the term. In order to work '*genba'* (on site), I needed to have an elderly-care related

educational background, i.e., the subject or discipline studies from a welfare university or professional training college ('*senmon gakko*'). Therefore, my only option was to conduct interviews and observe for a short time.

According to research ethics, I sent the agreement form in advance to confirm my participants' voluntary involvement, and promised to keep their personal information confidentially. Although I designed the range of questions before interviews, the experience of interaction with interviewees was influenced by a sense of '*jyunansei*' (flexibility), which is an important personal characteristic that Japanese culture favours. Some care managers were very talkative and thus I could extend our conversation into a broader range. Some preferred to talk outside of their workplace, so I arranged meetings according to their preferences about location and time. There were also more nuanced choices in the face-to-face meetings, such as what type of drink or snacks to provide, not being aggressive or making the interviewee feel that I was only interested in the research question to finish my task; I tried my best to ask questions involving their personal thoughts and feelings, understanding more about their early life if they did not resist this line of discussion, so that they felt more involved and connected to me, as attention was being paid to them personally, rather than a list of questions, and so on. From my fieldwork in Japan, I think the research ethic is not only the uniform procedure that we should complete before fieldwork. Research ethics in area studies is more about understanding another culture and people who are living in this culture; it varies somewhat according to the concrete social context.

Three case studies indicated the working conditions of Japanese care managers in the context of the LTCI. Although these absolutely could not represent all cases in Japan, they still raised current issues in the LTCI in recent years, and offered insights into the dynamics between the care manager and the LTCI system. Besides case studies, interviews with other related participants in elderly care enhanced and enriched the layers of comprehension for this research subject. Whilst

undertaking research in China, I also visited some places; however, the data was not for formulating case studies, but to extend discussion on policy design in the Chinese LTCI by focusing on the functions that the Japanese care manager fulfils in elderly care. As a result, the discussion has been constructed from a limited data source, but is supported by a personal, tangible experience in understanding related issues.

Due to time and finance limits for PhD research, some places could improve data scale and data quality. My fieldwork in China was finished within one month. However, China is a large country with great geographical differences in economy and lifestyle. The LTCI is new in China, and research on this new system is far from sufficient in academia at present. Therefore, I hope to have more time and financial support to look at this issue deeper, especially the transformation that is happening post-pandemic.

Chapter Four: The Japanese Facility-Based Care Manager

4.1 Case Study of Facility-Based Care Manager

As stated in the previous chapters, care managers mainly affiliate to three types of agencies: institutionally-based agencies (*shisetsu*), home-based care management agencies (*kyotaku*), and community-based general care support centres (*chiiki hōkatsu*). This chapter is a case study of care managers affiliated with institutionally-based agencies.

4.1.1 Background Introduction of the Case Study

The chapter aims to answer two major questions: what is the role of a facility-based care manager in their work; and what are their work challenges? The role of a care manager will be analysed through their work relationships between individuals and institutions, as described in the last chapter. Investigating the 'on the ground' work situation, and exploring problems they encounter helps to benefit my comprehensive understanding and further enhance depth of insight into Japanese elderly care.

The Japanese LTCI system provides care benefits—rather than cash, as in other elderly care models in OECD countries. The service benefit is divided mainly into two genres: *assistance required* (*yōshien*) and *care required* (*yōkaigo*), as introduced previously. Each service item has been standardised on a national scale. Home-based care, community-based care, and institution-based care compose three pillars of care provision in the LTCI (Mayumi. H, 2015; Mikiya, S. et al; 2006). Services for the elderly are separated into long-term care service and preventive service (Hirohisa. I, et al., 2008).

There are three categories within facility-based care (Hidenori and Kiyohide; 2012). The first type are welfare institutions: special palliative nursing homes (*tokubetsu yōgoin*) for the elderly close to the end of life (John. C. C and Naoki. I;

2000), nursing homes (*yōgo rōjin hōmu*), and low-income nursing homes (*keihi rōjin hōmu*). These are operated by social welfare corporations (*shakai fukushi hōjin*). The second type are health care institutions which provide long-term health care, including rehabilitative services and care for the transitional period for elderly people leaving hospital and moving back into the community. The third type are institutions for chronic hospitalised care. There are also other forms of institutions that provide private nursing care. However, the LTCI does not cover all types of needs for the elderly, forcing many clients to purchase services at extra expense. Each type of service has a corresponding rate. Beneficiaries buy single or multiple slots of the required service, in line with the care manager's decision after assessment.

4.1.2 Case Study Overview

This case study is an investigation of a care manager working in a social welfare corporation in Sendai.[22] *T²-san* refers to the care manager in this case study, *K-san* and *Y-san* are an administrative staff member and care worker, respectively.

The institution is a new type of special nursing home, 'unit care' (*shingata tokubetsu yōgo rōjin hōm'*). It is one of the biggest large-scale facilities in city of Sendai, Miyagi Prefecture, operated by the Social Welfare Corporation, designed to accommodate the elderly until the end of life. This facility was different from other facilities I visited in Tokyo and Miyagi. It is spacious, both in public areas and elderly care areas. The Social Welfare Corporation in Japan has a shabby image, designed similarly to a charity; this institution provides the beneficiary the option of a bed until the end of life, at the lowest price point. Therefore, many people were on the waiting list to get into the facility, which forced many facilities to make the

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[22] The name of the institution and the interviewees involved are all pseudonyms, to protect privacy. Since there will be inevitable repetitions of titles of care manager and other related involvers for the research, the titles have been abbreviated, used the initial letter of their family name in roman pronunciation, as *T²-san* (2 indicates the second person with the initial letter T in the name among the care managers have been interviewed; *-san* is a title of respect added to a name).

best use of limited spaces and reduced the average space for each resident to the minimum size.

The building has two wings (west and east), and there are five floors in total in this facility. The first floor is composed of separate spaces for conducting multiple activities for the elderly who live in the facility and community. The first floor has a bathroom, multi-functional room, winter garden, sunroom, hair salon, the entrance to day-service, the cafeteria, water pool for rehabilitation, training room, communication hall, reception room, and first floor medical room. Elderly people can utilise these rooms separately in different time slots. The second and third floors are mainly residential care rooms, as well as multi-purpose Japanese room (*washitsu*), winter garden, bathroom and sunroom. Multi-purpose rooms are furnished with essential appliances, such as a TV, refrigerator, table and chairs, microwave, etc; they are used as a public communal space for social contact for residents, especially for the communication between the elderly and staff working in the facility.

Unlike the second and third floors, the fourth floor is mainly for short stays and day service (west wing and east wing for day respectively). Short stay rooms *(tanki nyusho seikatsu kaigo*) provide short-term respite care for beneficiaries who usually receive home-based elderly care. There are several reasons for applying this type of service: when care providers feel exhausted after providing long-term care for the elderly at home; when there are significant events happened in the family, e.g., marriages, funerals, festivals, (*kan kon sō sai*); when care providers are working shifts or occupied with travel / business trips; when the beneficiary's physical condition deteriorates unexpectedly; for a transitional period of care for a patient leaving hospital before going home or awaiting transfer into another facility (e.g., on a waiting list); or when the elderly person cannot adapt to another nursing facility.

In short stay rooms, people receive assistance with meals, bathing, recreation and

rehabilitative practices. The short-stay service is provided in five types of facilities: special nursing home *(tokubetsu yōgo rōjin hōmu*), private nursing home (*youryo rōjin hōmu*), professional short stay facility (*short stay senmon shisetsu*), geriatric health service facility (*kaigo rōjin hoken shisetsu*), sanatorium medical facility (*kaigo ryoyōkei iryo shisetsu*). The time length for a short stay is 30 days to the maximum, or half of the designated care period at most. Users can consult with care managers if there are difficult situations that they have to postpone the time length. 'Assistance Required' (*yōshien*) 1st and 2nd level and 'Care Required' (*yōkaigo*) 1st to 5th level are applicable for short stay. In principle, a short stay cannot accept elderly who can live independently.

Day service (*tsushuo kaigo*) is a provision for the elderly designated as *care required*. It aims to support the elderly to continue to live well at home, supporting their physical condition through practice/support in the day-service centre. The nursing home also provides transport services for users in the community. Elderly people can meet and communicate, reducing loneliness and delaying dementia symptoms through social interactions.

There are several types of day services that can be categorised by their characteristics. One type is usually established with the medical institution that mainly focuses on rehabilitative service provision for elderly outpatients; another type is specialised day-service. Professional machines and medical staff in the facility provide certain specific service items for elderly people according to their physical conditions. Moreover, dementia patients receive special attention within day-service. Staff working within the dementia profession day-service have received related education and practical training before working inside.

In the facility I visited, staff provided daily health checks, daytime meals, assistance in toileting and bathing, recreation and rehabilitative practices.

According to an MHLW[23] national survey on care payments (*kaigo kyufuhi nado jitai chōsa no gaikyo*) in 2018, day service was utilised most frequently in Japan compared to other home-based services provided by the LTCI. Despite many potential advantages of day service, some elderly beneficiaries cannot adapt to this environment; for example, some people feel challenged by the social implications, or feel embarrassed if they cannot communication smoothly.

Also, on the fourth floor are public bathrooms, multi-purpose rooms, a sunroom, a room for oral care, and communal spaces. The fifth floor is given over entirely to communal spaces: a public bath area with great views from the top of the building, and a sauna room. There is also a roof garden cultivated with different flowers and plants.

This institution is naturally popular in the local area, especially compared with other social welfare corporation facilities, because of its large spaces and scale of accommodation. This facility accommodates 100 elderly people living to the end of their life. It contains rooms for 20 short-stay residents and 35 people receiving day-service support. The facilities such as pool, cafeteria, rehabilitative tools and communal areas mina it is used as a club for people to get together and conduct social activities.

The area's community centre office is also located in the building. The community centre provides information about elderly care; it also plans local activities and encourages people to increase their community involvement. In 2006, after the 2005 care reform, the Japanese government began to actively initiate community-based comprehensive elderly care provision. The community centre became the place to combine different resources according to concrete situations in each community, for highly efficient service provision. The institution also provides free

[23] MHLW: Ministry of Health, Labour and Welfare,厚生労働省.

preventive care provision (*Kaigo yobō sābisu*) to local elderly people.

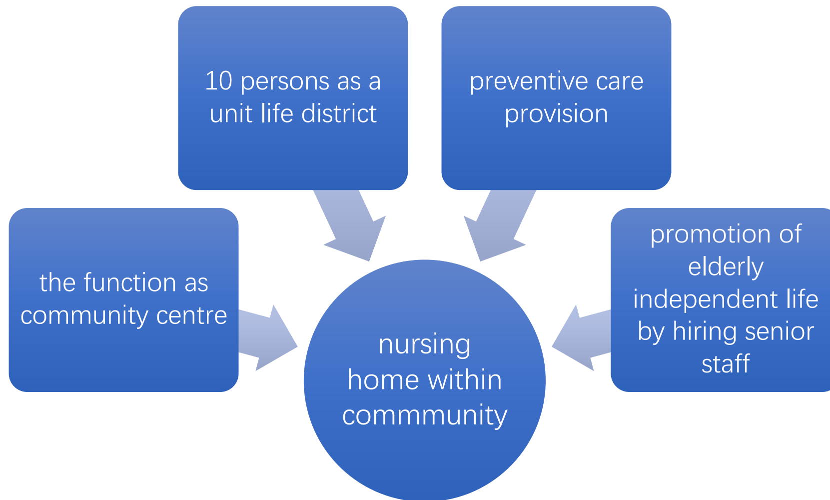
Another notable characteristic of this facility is preventive day-service provision. Oral care, nutrition planning, and physical fitness help elderly people maintain their physical condition and live independently. When I observed this institution, I found they conducted exercise classes twice weekly, therapists leading the elderly people to do stretch work and other exercises. This preventive care service is targeted towards the group designated *assistance required* (*yōshien*). In addition to benefits for the elderly residents, the centre provides *unit care* for people who live in the community (ten elderly people = one unit), using the IT machine, care machine and other related aspects of the facility to heighten the QOL (quality of life) for the elderly.

In terms of the quality of service, the staff aim to 'make elderly people feel at home', putting efforts into work to bridge the potential gap beneficiaries might feel between home and the facility. For the residents in the building, staff respect each person's life pace and character. There is no standardised time to wake up, take a bath or have a meal. After living in for a while, staff grasp the schedule of each resident and provide services according to their pace. Some elderly people cannot adapt to the tableware in the facility for meals, so staff ask family members to bring their elderly relative's home tableware to the facility so that the resident feel they were eating at home, using a familiar bowl and chopsticks. Additionally, staff sometimes take meals together with residents in their communal spaces, and work with sufficiently able beneficiaries to make simple preparatory steps for cooking a meal. As a result, the facility is not only a space for service provision; it becomes a space for sharing life and building real relationships.

The last notable feature is that this facility will hire senior-age people who are still physically and mentally functional, to promote a connection between the facility and the people in the community. Moreover, this helps people who have got retriement have more financial resources and enhance their interaction with the

community. The comprehensive functions of this institution are described in the table below:

Figure 1: Comprehensive Community Care Functions of Social Welfare Corporation Institution, Sendai



Data from introductions and interviews with staff of the facility, created by the author

4.1.3 Methods Adopted in the Case Study

Understanding the facility's environment is important when investigating a care manager works within it. Although policy dictates that the care manager is responsible for making care plans for beneficiaries within the LTCI system, their actual functions may be different according to the institutions they belong to. Even if they belong to the same type of institution with similar working practices, their work will still be subtly different.

In this chapter, the research approach includes a case study, semi-structured interviews, and open interviews. Observation and semi-structured interviews were undertaken with the care manager; open interviews were undertaken with care staff and administrative staff working with the care manager. In addition to the case study, as part of a whole package of research on the care manager, semi-structured interviews were conducted with care managers outside of their working environments, aiming to complete the understanding of the research question.

In this section, the first part is a case study about a care manager working in a social welfare corporation. I was allowed to stay in the institution from 9 AM to 5 PM for one day to silently observe the care manager T^2-san's working situation. After working hours, I was allowed to interview the staff who work with T^2-san: administrative staff member K-san, and care worker Y-san. The case study will provide an overarching view of the care manager T^2-san, by examining the environment, staff, beneficiaries and others as a whole. The second part is my analysis from interviews of facility-based care managers, undertaken outside of their working environments, to supplement the data and further evidence working dimensions of care managers.

In regard to the research method of the case study, Gillham. B (2000) indicated the importance of context in deciding human behaviour, thoughts and feelings. Their context, and how they operate in that context, are essential to understand the reality of a person's life. That is also the main reason for this research, since interviews alone cannot formulate a comprehensive picture. In a case study, discovering a care manager from the context of their working environment will bring a more complete understanding. The behaviour, feeling and thoughts can be understood only from knowing their environment and what they do inside the context (Gillham. B; 2000).

It is not easy to be allowed to observe a care manager at a site in Japan without a care-related qualification. Fortunately, the facility I visited was large-scale, providing services to the community with more flexible spaces to allow people to stay and experience the facility. Additionally, I kept silent and tried to reduce my influence to a minimum in the working environment.

Observing is a sensible method for a new social situation and important for a naturalistic researcher (Gillham. B; 2000). Through observation from awareness and sensitivity at a low profile, it is easier to get social acceptance in that environment. According to Gillham. B (2000), there are three aspects to

observation: *watch what people do*; *listen to what they say*; *sometimes ask them to clarify questions*. Since I could not interrupt the care manager's work, I made notes and did interviews after working hours. There are two types of observations: being involved and detached, and different approaches yield different results. My approach was a combination of both. My quiet observation of the working process was detached, and the interviews after work involved participant observation.

There are pros and cons to the observation approach. Gillham. B (2000) indicates the directness in terms of data access compared to literature research. Observation provides first-hand data of what has been done instead of a theoretical understanding of what is supposed to be done. However, what has been seen, recorded and interpreted is influenced by the observer's bias in selection. Therefore, in addition to detached observation, interviews with care managers working in this institution and care managers working in the same institution were conducted, to reduce bias to the minimum.

Observation also can function as various approaches for research (Gillham. B; 2000). It can be seen as an exploratory approach that starts with a low-profile beginning. It can be used as the initial-phase method, when there will be other approaches as the primary method afterwards. It can function as a supplementary method to expand the illustrative dimensions of research. It can be used as one part of multiple approaches, which is the heart of a case study (Gillham. B; 2000). 'Notion as convergence' comes from various pieces of evidence gathered through different methods. It can also be used as the primary technique in an explanatory description. Observation was used as one of the approaches for the case study, but was not observation from the starting point—literature review and theoretical research about care managers were undertaken before conducting observation. After observation, interviews were used for complementing the questions that came up through observation.

In regard to interviews in this research, semi-structured interviews were

conducted towards care managers, whilst open interviews were conducted towards people related to the care manager role. Semi-structured interviews contained closed questions as well as open ones, and thereby obtaining specific answers directly towards the research question, and at the same time avoiding rigidity regarding the responses that might come from interviewees. Open interviews were conducted with people with connections with the care manager at work. The open-ended interviews also include critical questions about the care manager, keeping an open space for any content that might come out during the conversation, on the basis that natural conversation may lead to more discoveries, sometimes in contrast to confined interviews.

4.1.4 Empirical Findings

As introduced in the previous section, the facility I visited was a large-scale nursing home in the community. There were two care managers affiliated with this institution. One of them allowed me to do the observation, and the other was absent that day due to a working shift. Compared to the care manager of a home-based care provision agency (*kyotaku keamane*), facility-based care managers' working routines vary according to the environment of each institution, their primary task of making care plans notwithstanding. In large-scale institutions, since more beneficiaries live in the institution, the care manager's primary function is to create care plans, and workload mainly constitutes administrative duties and communication with the beneficiary and their family members. Therefore, care planning occupies most of the time for care manager working in large-scale institution. In contrast with the massive number of beneficiaries that have to be dealt with in large institutions, care managers in small-scale facilities do not have many beneficiaries to plan for. However, they might have to do other work related to care provision, such as operational care in assisting the elderly in having meals and toileting.

I arrived at the institution around 7:30AM to a simple Japanese-style greeting

(called *aisatsu* in Japan) from the care manager T[2]-san and her colleagues. Most of the time I stayed in the first-floor hall (a large public space containing the staff office, community centre, hairdressing salon, pool, public bath, etc.). Therefore, it was also relatively convenient to observe the beneficiaries and care staff interactions, and other external people utilising the facility. I was allowed to follow T[2]-san when she visited each floor in her morning routine. She also gave me a more detailed introduction of the facility, although I had obtained general online information before visiting. When T[2]-san went back to the office, I kept silent in the hall and used a computer to record what I saw and heard. I went outside for a simple meal when T[2]-san took her lunchbreak. I continued to stay in the hall until T[2]-san told me she had finished her work. After her official work hours were complete, I interviewed her and the other two colleagues working with her. Then she continued to stay in the office for finishing overtime work (*zang gyo*). According to one-day track of her job, the routine was concluded as below chart in general:

Table 2: One-Day Schedule of Institution-Based Care Manager

8:00	During the breakfast time for the elderly, listen to the reports from care staff who work in night-time shift, checked the general situation of every floor, master the condition of the elderly of the whole facility お客様のお食事の様子を見たり、入居者の夜間帯の状況把握、夜間スタッフさん達の申し送りを受ける
9:00	Report the day’s general schedule to other colleagues after communicating with the leader of each floor, collect any information related to care provision フローリーダーと協議し、全体の流れの確認して一日のスケジュ

	ールを確認と報告、介護と福祉についての情報収集
10:00	Create care plans, including communicating with beneficiary and his/her family members face to face or through telephone call ケアプランの作成、入居者・家族との面談・連絡などを行う
12:00	Help the beneficiaries to have lunch, communicate with staff, social time お客様の食事介助、スッタフさん達の手伝い、社交時間
12:30	Lunchtime 昼食
13:00	Visit the hospital and have a conversation with a beneficiary who will move into the facility. On other days, this time would be spent communicating with different old people and their family members who intend to reside in the facility or come for consultancy 病院に行き入居予定者との面接、外出の用はなければ施設内でケアプランに関する連絡を行う
14:30	Make care plan and related administrative work / participate in various meetings for care plan ケアプラン作成、書類整理や各会議に出席
17:00	Overtime: complete administrative work such as records of

	supporting plan for elderly in facility 終業、残業をして入居者の「支援記録」作成などを

T²-san started her work from 8 AM; I was allowed to follow her to see her usual morning routine. Since over 80 people were in residence that day, she visited each floor and saw about 20 elderly people each time. She talked to the care staff that worked in the night-time shift. Care staff reported the latest condition and any change in the physical condition of the residents over the previous night. It seemed that she was quite familiar with residents since she greeted all of them, and most of them realised who she was and greeted her back. At the same time, care staff started to provide breakfast. She told me she sometimes would help with the distribution of food or do other chores if necessary.

After a morning routine that mastered the general conditions of the elderly, T²-san talked to her colleagues about her rough schedule of the day. Sometimes she had to visit other places, such as hospitals or councils. Therefore, she would let her colleague know in advance about her plan on that day. She spent time on creating a care plan before lunch. I stayed outside of the office and watched her. She made several calls to family members. On that day, she also had a meeting with a beneficiary's family. The family member came to the facility and had a conversation with T²-san about whether to let the elderly person move into the facility. These contents are related to privacy, so I stayed outside the office and observed other people and their environment. At lunchtime, T²-san had a meal with her. After lunchtime, T²-san had a meeting in the hospital, visiting an elderly person who would shortly leave the hospital and was considering a move into the facility; T²-san discussed the case with the physician and family members. I waited until she came back, at which point, T²-san finished her paperwork. She accepted my interview after her official working hours. She chose to stay in the office to

continue formulating documents after my interview.

The interview towards T²-san was semi-structured. There are specific questions decided in advance (listed in Chapter Three and the Appendix) to answer the research questions investigating the role and problems of the care manager's work, in the form of 'purposive sampling'. The interviews were recorded and had been transcribed into Japanese words within 24 hours. The analysis was according to the thematic genres inside the research questions. The interviews towards administrative staff K-san and care worker Y-san were open interviews; however, my questions and their answers were still closely linked to the work of the care manager. They also provided unexpected information supplementing the answers attained from the pre-prepared questions towards the care manager. These insights were further broadened by talking to other people who work with the care manager, in addition to the data collected from the care manager herself.

From the investigation of literature in previous chapters, it is known that care manager behaves as a bridge between people from different groups to formulate a proper care plan and provide care service for the elderly under the LTCI. Hence, they have to deal with varying types of relationships:

- *individual to individual, i.e., the care manager with the beneficiary and their family members;*
- *individual to institution, i.e., the care manager with affiliations, municipalities, medical institutions and service providers.*

Thus, the questions entailed:

- *the personal career experience before and being a care manager;*
- *work in the relationship with beneficiary and their family;*
- *work in the affiliation;*
- *work with the municipal office;*
- *work with medical institution and service providers, for plotting data in*

details.

These sub-questions were aimed at answering one central question about the role and problems existing in the care manager's work, leading to an understanding of the Japanese elderly care delivery in the LTCI system, and to further extend discussion on its transferability into Chinese society.

Table 2: Summary of Interview Questions and Answers from T2-san インタービュー問題と回答のまとめ

Past career experiences and current experience of being a care manager ケアマネジャーになる前の仕事経験及び影響 • ***T^2-san Female Care Manager in 7th year (34)*** • *One-day Service Centre > Group Home > home-based care provision agency > institution-based care provision agency* • *Accumulated experiences in different institutional contexts*	
Individual-Individual	• *Issues extracted from the relationship with the beneficiary and their family members:* • *利用者・家族との関係* • *Help to decide the service items from balance between demand and supply* • *'Honne' and mutual trust* • *Varying family values and possible contradiction occurred*
Individual-Institution	• *Issues extracted from relationship with their affiliation:* • *事業所との関係* • *Different challenges regarding care manager's work between home-based and facility-based* • *The balance between the identity as a team member as well as a service examiner*

	• *Issues extracted from relationship with municipal office:* • *市役所との関係* • *Over-workload of administrative work* • *Less time and space for the quality of communication*
	• *Issues extracted from relationship with medical institution and service providers:* • *医療機関・サービス提供者との関係* • *Different evaluations on beneficiary's situation due to varied knowledge backgrounds* • *Time consuming in establishment of cooperation*

T^2-san was 34 years old, and it was the seventh year of her career as a care manager. She changed position three times before becoming a care manager. She started as a care worker and then took responsibility in management in the institution. At last, she was recognised as a care manager after passing the exam and receiving compulsory training. When she worked as a care worker she worked in the day-service centre (one of the institutions she is working with now). She worked in day-service for one year and then worked in a group home for five years. Then she transferred to the home-based care agency and worked for seven years. Finally, she became a care manager and stayed in the institution I visited until the present.

Regarding choosing care provision as a career, T^2-san told me she had wanted to master a professional skill and utilised it in her work, rather than go to university to receive a comprehensive education. Therefore, she chose to enter technical school (*sen mon gakko*) after high school graduation. One day she found an article about speech-language-hearing therapist, which triggered her interest; hence she decided to go for a technical school of care professionals. In her first year in a technical school, T^2-san interned in a geriatric health service facility. In her second

year, she worked for a month in the institution, and took the certificate as a Grade II helper. After leaving the technical school, she first worked as a contractual worker (*haken shain*) in a day-service centre. She helped the elderly with toileting, bathing, recreation, etc. there. She worked from 7:30 AM to 16:00 from Monday to Friday and did other part-time jobs at weekends. After one-year contractual work in the day-service centre, she joined a group home as a full-time regular staff member (*seishain*). Group homes in Japan mainly accommodate elderly people with dementia or mental disability. Her work covered cooking and cleaning for the elderly, assistance with toileting, bathing, community activities, and gathering with family members. The most stressful place working in the group home was the night shift. There were two floors, and each floor accommodated nine elderly people. Only two staff members worked in the night shift, so she had to look after nine elderly people in the night. After working in that group home for two years, she became manager (*shisetsu chō*) in the institution and obtained the certificate as care worker (*kaigo fukushi shi*). When she later started her own family, she studied for and passed the care manager exam, and transferred her job to a home-based care provision agency. She worked there for five years, then came to this institution as a care manager.

T^2-san's career experience is distinctive in that she worked as a care manager in two types of agencies, compared with other care managers (first in home-based care provision, and then facility-based care provision). Accordingly, she accumulated many experiences in these two different institutional contexts.

As mentioned above, work relations for a care manager contain two layers (*individual to individual* and *individual to institution)*. The former are the interactions between care manager and beneficiary, making care plans, and tracking the beneficiary in order to adjust the plan. The latter refers to the relationship between care manager and different institutions, acting as a bridge to connect with the council, medical institutions and their own institution. Therefore,

they must consider how to arrange all these collaborations efficiently.

4.1.4.1 Individual to Individual Care Manager Relationships

For T[2]-san, the factors influencing relationships at *individual to individual* level were: firstly, balancing the demand from the beneficiary side and supply from the facility side; secondly, building mutual trust and getting beyond a superficial pleasant response, understanding authentic thoughts and feelings (*honne)* from the beneficiaries; thirdly, mature skills to deal with complex situations, i.e., the values of different beneficiaries, such as possible conflicts with their care manager as well as their family members at times.

In the connection between a facility-based care manager and beneficiary, the first important decision required to be made was what type of services should be included in their care plans. In addition to certification from medical institutions, relevant information regarding the beneficiary's other life aspects (such as family support, financial status, life habits, personal preference and so on) were also considered in making the care plan. On the other hand, a facility-based care plan normally is created using the hard resources (i.e., technological machines, medical machines, rehabilitative equipment, etc.) and soft resources (care workers, care managers, other medical staffs) within the facility. Therefore, making a care plan within a particular range of resources, to meet various types of needs for the beneficiary is a challenge for the care manager.

> *The nuanced places lie in the distribution of human resources… The hard infrastructure as you can see, the rehabilitative tools, spaces, it is easy to decide what to utilise externally for the old people… the difficult place, or detailed place is to organise my colleagues within this facility to provide service suiting the beneficiary as well as considering their personal preference… For example, one the beneficiary is a 70-year-old man, he has been very independent for his whole life, but unfortunately, he got cerebral*

infarction last year. His son was very busy with his work and his wife alone could not support his life at home, he chose to come here and aimed to recover positively, expecting he can return home one day, so he insists on doing things himself if he can… Taking excretion for example, our staff are responsible for helping him to take off the trousers but he insists on sitting on the chair by himself with handrail in the toilet.

T^2-san, 34, female, facility-based care manager, Miyagi

As addressed by T^2-san, beneficiaries prefer to hold onto some habits or insist on a way of behaving in the same way as when they were at home, before coming to the facility. The merit of home-based care provision is that the elderly can feel comfortable living at home, i.e., 'age-in-place'. Many of them may not adapt to collective living within a short time, both physically and mentally. However, living in the facility helps greatly to reduce the care burden from the family caregiver, especially if there is only one person at home as the primary care provider. Additionally, living in the facility is safer and more stable for the elderly person living alone. Although facility-based care life means certain compromises to the beneficiary's standard life pace, the process of connecting with staff and peers can establish a sense of belonging for the beneficiary.

T^2-san told me, as a care manager, it is essential to outline all the merits and demerits of each option to the beneficiaries. When they come for consultancy, care managers are supposed to avoid a bias that only suggests the option which financially benefits to their affiliated institution. However, in reality, this is sometimes tricky. Feng. M et al (2017) indicates how the economic benefit for care management agencies might significantly impact client service expenditure. However, whilst this research did not state a direct relationship between the care manager's decisions and the beneficiary's expenses, inevitably, an agency's benefit will influence the care manager's decisions.

The second factor is in regard to the *honne* culture in Japan. *Honne* means real voice, the authentic thoughts of a person. Anyone familiar with Japanese literature knows the pair of concepts called *tatemae* (façade voice) and *honne* (real voice). Japanese culture emphasises maintaining a harmonious atmosphere between people, to avoid conflict, at least directly on surface, if possible. To achieve the harmony in social circumstances, speaking pleasantly on the surface is inevitable. For example, in the five years of living in Japan before my PhD, in my personal experiences, no matter what we ate when having a meal, Japanese people always said it was *oishii* (delicious). I only heard the real opinion—instead of *oishii* for what they eat—when I had formed close personal connections with people. It takes time to move from *tatemae* to *honne.*

This cultural characteristic also applies to the relationship between a care manager and beneficiary. T^2-san underlined that people usually need time to get acquainted with each other, especially for Japanese people. It is seen as good manners to try one's best not to bother other people (*meiwaku kakenai*), a widely shared societal approach. Therefore, it takes time for a care manager to grasp the real intention and needs of a beneficiary through several conversations. T^2-san also mentioned that questioning / investigating the conditions of the elderly and their family situations requires strong social skills because asking the family issue is usually crossing some 'safe border' in a psychological sense. T^2-san has experienced cases in which a beneficiary did not understand her role as care manager and hence did not provide complete information in the initial interaction. In Japan, the *honne* usually can be heard if the relationship becomes mutually trustful; it requires time to achieve the trust of the beneficiary.

T^2-san indicated that the standardised training from the municipal government and passing the exam were not enough when making a proper care plan for the beneficiary, since there might be several difficulties in the practical process. Mastering the beneficiary's needs is the first step; afterwards, connecting the

problems and solutions smoothly is essential. Making a care plan contains both physical and mental aspects, as T^2-san mentioned:

> *For example, one of the beneficiaries is a woman close to 80 years old, she got bone fractured in her right leg two years ago and had been living in the wheelchair since then. However, from the interactions with her, we began to know that she actually would like to go outside, like shopping, go to the library… she dreamt of living in the same way as that before getting bone fractured… I discussed with our colleagues and found such expectations exist widely among old people… our facility then decided to organise a picnic once a month near the facility, or in the facility if the weather does not allow us to go outside. We also arrange meetings to meet their cousins and relatives once every two months. These activities aimed to make her feel she still connects to outside world and attends certain social activities to some extent.*
>
> *T^2-san, 34, female, facility-based care manager, Miyagi*

T^2-san continuously explained that the effort put into making the elderly feel at home is essential for home-based care provision. To achieve comprehensive improvements in the health condition of the elderly, the proper utilisation of the facility and staff in the institution, according to the care manager's suggestion, is necessary in the care plan. In addition, some services may not be written in the care plan, especially in home-based agencies; services can be provided according to the infrastructure and environment in the facility.

The third issue addressed in the relationship between care manager and beneficiary are the possible conflicts. T^2-san said she had dealt with cases where the beneficiary might expect different care provision than what their family caregiver expected. For example, a family care provider may want the elderly person to stay at home and utilise more services from the LTCI, whilst the elderly person wants to stay at the facility to reduce the care burden on family members.

Some beneficiaries are shy, and they concerned about living with others in the same environment, which may be that opposite to the perspective of the family member, who would be thinking that living in the facility can guarantee the best quality of care provision, since professional staff are working for them. T^2-san emphasised specific considerations for beneficiaries with dementia or mental disability. Understanding their needs is vital, using in-depth comprehensive investigation to obtain complete information, including family requirements and personal preferences. T^2-san addressed the process of listening to their needs—both the beneficiary and family members—to find a balancing point in making care plan for this family: what they want and cherish, as well as what to avoid. It requires a care manager with communicative skills, sharp observation and accumulated knowledge towards this special group.

4.1.4.2 Individual to Institution Care Manager Relationships

The *individual to institution* level of relationship has three layers of connections to confront: the relationship with the care manager's own affiliation, the relationship with the municipal office; and the relationship with medical institutions and service providers.

In regard to the relationship with the affiliation, T^2-san pointed out the differences between home-based and facility-based care. T^2-san worked in home-based care provision before working as a care manager in facility-based care. She said the main work for home-based care was to visit the beneficiary's home and create care plans. In contrast to home-based care, whilst in principle, facility-based care facilities still require the care manager to make care plans as main task in their job, many facility-based care managers also have to cover workloads containing direct care services to elderly people (which would otherwise be done by care staff).

> *Many care managers were care workers before becoming the care manager... some of them might think, working as the facility-based care*

*manager can exactly exert their previous frontline knowledge and experiences. However, when they truly work in the facility, many of them encountered the extra requirements that overcame their energy too much, such as night-time work, assistance in elderly eating and taking a bath… thereafter, their responsibility range became vague, which incurred pressure and conflict in the workplace… This situation [the vague working contents in the facility] is quite common in Japan, partly because we are really lacking enough and [sufficiently] qualified people working for the elderly care… Last month, one internship student from Welfare University (*kaigo daigaku*) came to our facility, and told me that half of their undergraduates would not choose the career in elderly care, even though they spent four years learning this; most of her peers are actively searching for jobs in other industries… mounting work is not proportionate to the rewards, these young people understand that… [the responsibilities of a facility-based care manager in our facility] is rather large scale; my job still mainly focuses on making care plans and joining meetings, without too much work pressure from frontline. So, I can concentrate on my field, which I appreciate a lot.*

T²-san, 34, female, facility-based care manager, Miyagi

T²-san then pointed out how different facilities might share varied work codes and policies in their working environments. Apart from the facility itself, a care manager's personal characteristics and understanding also influences their work relationship with the facility. Some of them can accept the complexities regarding the contents of their work; some of them may feel resistant to such work, thinking it is not within their professional range as care manager.

Another crucial point in the relationship with the facility addressed by T²-san was regarding any incidents or accidents. From the beneficiary's perspective, the care manager is seen the same as other care workers, just part of one facility team. Accordingly, if there is an accident due to the improper care arrangements or

insufficient/untimely provision, the beneficiary and their family members tend to deem it the team's responsibility (not just the care manager). Therefore, a facility-based care manager must discreetly consider how to combine all resources, including human resources and facility hardware to make efficient and appropriate care plans. Additionally, the care manager must continuously keep an eye on assessment and monitoring of beneficiaries to prevent potential accidents. Care managers play a vital role in this process.

T^2-san said when she worked in the home-based care provision agency, it was like working independently, since the agency-based care manager is mainly responsible for making care plans, although they have administrative work in the agency. They do not have to work with other care staff as a team. Working in a facility requires the care manager to maintain team spirit (*itaikan*) with other care workers. The care manager is supposed to be the person who is familiar with each aspect of the facility, maximising service items within the care plan.

In addition to recognising the team as a whole, the care manager is also supposed to take a supervisory / monitoring role for the operation of care provision inside the facility (*naibu chuosa*). To oversee the operation, the care manager must occupy a neutral position, to check whether care service has been appropriately provided and keep the beneficiary's family members updated with the latest information. However, T^2-san said in reality, it is not easy to stand in this neutral position for some facilities. If the team wanted to hide information from the beneficiary/family members (although this is rare), the care manager must be able to challenge this position. For the care manager who works in a facility, a high emotional intelligence and interpersonal intelligence are needed, not only for interactions with the beneficiary's side, but also for connecting with colleagues in the team.

The next institution to confront is the municipal office. Facility-based care managers submit administrative documents to the municipal officer each month.

T^2-san said there were no personal interactions between the staff in the municipal office and the care manager. The main problem in this relationship is the large number of administrative documentations the care manager must process. Paperwork occupies too much time, so that they do not have enough time to communicate with beneficiaries and consider improving care provision. Although it is the care manager's responsibility to confirm the services were correctly utilised under the LTCI system, the overwhelming documentation derailed the original intention of setting up an efficient and sufficient LTCI care service.

The last type of relationship at *individual to institution* level is the connection with medical institutions and service providers. T^2-san indicated the importance of a relevant career background for a care manager in their relationship with medical staff. She said if a care manager was a nurse or had a relatable medical education background, they can quickly understand the elderly person’s physical condition, and can cooperate effectively with the physician's agreement in making a care plan. T^2-san did not have a medical education and instead accumulated knowledge through past training and work experience. Therefore, she sometimes did not understand the physician’s evaluation when making a decision. She said for many care managers, communication with medical staff was costly in terms of time, and some misunderstandings happened in such collaborations. Since T^2-san is a facility-based care manager, service items are provided by the facility. Unlike agency-based care managers, facility-based care managers do not need contact with various service providers, but rather focus on how to utilise resources within the facility effectively.

4.1.4.3 Care Manager Personal Reflections

From exploring the work relationships at *individual to individual* level and *individual to institution* level from T^2-san’s responses, I gained a better understanding of the working reality for a facility-based care manager. T^2-san mentioned one particular characteristic that differed from agency-based care

managers being the reduced amount of time she spends on investigating the beneficiary's situation. The necessary information is recorded before the beneficiary moves into the institution, so that the facility-based care manager obtains this report directly, without the need for several home visits. Additionally, an agency-based care manager must continue to visit the beneficiary's home to update records and revise the care plan. In contrast, facility-based care managers can check the conditions each day, and have many more opportunities to communicate with care staff, grasping the situation of the elderly continually over time, able to revise the care plan to adjust the changes whenever necessary.

Finally, I asked T²-san how she was feeling about her job; the positive and negative sides for her. She replied*:*

> *I normally feel fulfilled on three occasions in my [daily] job… at first, when I feel the old people really feel safe and satisfactory living in our facility, they will respond to you with positive feedback, even saying 'I feel better than yesterday', or just simply saying '*arigato*' (gratitude); at such moments, I feel my job truly has its meaning for a human being…*

> *Secondly, when their family members came to visit them, we tried to do our best to fit their needs, for example, when it comes to a person's birthday, we organise special events or birthday celebration with the family member, which makes them feel at home. These kinds of events are easy to conduct for healthy and normal people, but the aged people cannot do the things that we take for granted due to losing mobility and certain physical functions. As a result, the elderly [beneficiaries] would feel thrilled if they can go outside even for a meal with assistance from care staffs, or even drank a bottle of beer at times if the care staff brought it to them...*

> *At last, what made me feel fulfilled in this job might shock you [pause]… for ordinary people, it is not normal to watch the process of a person's passing*

away. We just come across the death issue when our dear ones face that. However, in my job, it is inevitable to witness this. When I saw an old person peacefully passing away in the bed, my heart was full of respect towards life, and I also felt proud in a delicate sense, because we accompany this person to the end via lots of care services, care plans, interactions, conversations and so on. This is a special moment that makes me feel my job is significant, and incentivises me to continue to do it.

T^2-san, 34, female, facility-based care manager, Miyagi

4.1.4.4 Open Interviews with Care Workers and Administrative Staff

As well as my interview with T^2-san, I interviewed a care worker Y-san and an administrative staff member K-san in the facility, in the form of open interviews. Y-san indicated that a care worker does not precisely understand the facility's role in many cases, which easily leads to mutual misunderstandings. The facility where Y-san was working is large-scale. Accordingly, the paperwork occupies the most prominent part of the care manager's work. In small-scale facilities, the care manager has to deal with other work, such as taking care of beneficiaries at mealtimes when there are insufficient care workers present. On such occasions, there would be conflicts if care workers asked a care manager to assist, and the care manager thought it was not their work. From K-san's perspective, there is no conflict between administrative staff and the care manager if they have been clearly informed of their responsibilities.

4.1.5 Case Study Summary

This case study is an investigation of *T^2-san,* a facility-based care manager, who has work experience as an agency-based care manager and then transferred to being a facility-based care manager in Miyagi Prefecture. Field observation and interviews were adopted to comprehend the research questions. A semi-structured interview was conducted with the care manager, and open interviews

were conducted with one care worker and one administrative staff member.

Explorations of the work of a facility-based care manager has been done via looking at the work relationships they experience within their work. Analysing the working contents and problems via *individual to individual* and *individual to institution* levels of relationships helps us to understand a facility-based care manager from various angles. In each type of relationship in a care manager's work, there are contribution and limitations. At *individual-to-individual* level, T²-san emphasised the importance of building up mutual trust, required to consider the personal traits as well as family background of the beneficiary. Negotiation skills to make a proper care plan accommodating conflicting opinion regarding care provision is necessary. At *individual-to-institution* level, the problems often present themselves as a conflict between what a care manager is supposed to do according to policy, and what they can actually do in reality. T²-san suggested simplifying paper records in order to have more time working for the care provision, instead of endless administration. Moreover, she recommended better distribution of medical staff in the facility for emergent issues or medical needs.

The administrative staff member K-san and care worker Y-san addressed the importance of clarity in knowing the care manager's responsibilities. Many internal conflicts can be caused due to vague understanding of each other's roles. Although it is not a problem in their facility, it has been commonly seen and heard in other facilities.

My methodology was restricted; normally visitors are not allowed to stay in the facility long, since staffs consider this an interruption to the elderly's rest and activity. Since this facility has a big public hall on the first floor, I was able to stay there and watched the situation as non-participant observer. I was fortunate in being fluent in Japanese language and cultural understanding (in Japanese occasions this is known as *kūki yome ru,* or one who 'can read the air', able to understand the subtle atmosphere and respond properly). For this reason, T²-san

led me on a visit inside the facility and to meet with the residentsly. It was first time in my life I had seen so many old people. *T²-san* introduced me as a foreign visitor from China who has an interest in elderly care. I could see that many residents showed a personal interest and staring at me. Especially for the generation over 80, with fewer opportunities to travel globally, China is a word frequently heard, but without real understanding. Therefore, it was an exotic experience for them to see a young visitor from another country.

For me, it was just as vivid and fresh an experience to understand facility-based care and the facility-based care manager. Personal visits, observations and conversations provided me with more clarity regarding the role. Dissecting each type of working relationship helped me to understand the role and problems. Although one case study cannot represent all care managers' situations, the multiple approaches adopted in this case study gave me in-depth and contextualised understanding of the research topic. Additionally, in order to supplement information that might be missed in this case study, I also interviewed other facility-based care managers; these interviews were conducted outside of the workplace, and only with the care manager, and no related people.

4.2 Other Interviews for Facility-Based Care Managers

In addition to the case study with T²-san, I interviewed four other facility-based care managers, listed as follows:

- U-san (35), 5 years care worker, 6 years care manager, female, Tokyo
- O²-san (41), 10 years care worker, 3 years care manager, male, Tokyo
- I-san (28), 8 years care worker, 2 years care manager, male, Tokyo
- N-san (45), 6 years care worker, 5 years social worker, 2 years care manager, female, Tokyo

4.2.1 Interview Findings

My interviews were conducted on weekends or rest days, outside of the workplace. We usually met in coffee shops or bookshops. The interviews lasted two or three hours on average.

U-san (35) had worked as the facility-based care manager for six years when I interviewed her. She worked as a care worker for five years before becoming a care manager. She chose to work in the care industry because her grandfather got dementia when she was a primary school student. She could not do anything when she was a child, and so she decided to work for people with dementia in the future.

In terms of the relationship with the beneficiary, *U-san* thought difficulties happened when the beneficiary's opinion contradicted their family. The elderly's family members might expect more rehabilitative services, while the beneficiary may not want to practice so much and reject it; particularly in the case of dementia, the beneficiary may not understand their real condition. For example, sometimes family members thought the beneficiary did not eat a meal, but in fact the beneficiary ate it and forgot it, which led to misunderstanding. These sorts of situations require a care manager's ability to reach a mutual agreement. U-san told me a story in her affiliated facility of a couple both living in the facility. The male beneficiary was physically weak, and his wife had dementia. They lived in different areas in the building, because the old people with dementia live in a different type of room. The female beneficiary tended to forget what she had done, so she asked to visit her husband again and again, despite having already done so on that day. The care manager has to explain this situation to their family member in order to avoid distress.

At *individual-to-institution* level, U-san thought it would be better to have more connections with medical institutions. The elderly who decided to stay for the last phase of their life in the institution need appropriate daily care and efficient

medical support. Although medical staff come to the institution several times each week, and there are the nurses working on site, they do not work during the night shift. The care workers find it challenging to deal with medical situations, especially for end-of-life care. Additionally, the elderly who have problems in swallowing food may need medical treatment. Care workers usually do not have the related qualified medical training. Effective collaboration in medical practice is in high demand for the institution.

O^{2}-san (41) had worked as facility-based care manager for three years when I interviewed him. He worked as a care worker for ten years before becoming the care manager. He found a difficulty in his relationships with beneficiaries when he would ask them if they need a specific service that he thought necessary, but the beneficiary rejected this suggestion and did not recognise its necessity. In terms of the relationship with the medical institution, he said he felt frustrated when his opinions were different from medical staff, and experienced misunderstandings at times in the early stages of his career as a care manager. Although medical staff understood the physical conditions of the patient, they tended to neglect the practical aspects of services that could be provided. It is necessary to make appropriate service plans based on a realistic environment. He said it took him some time to find the best way to balance varied opinions and make the care plan run smoothly.

I-san (28) had worked as a care worker for eight years before becoming a care manager. Regarding his relationship with the affiliation, he mentioned that the facility he was working inside is a sub-institution belonging to a medical corporation (*iryo hōjin*). I-san worked as a facility-based care manager and also work at night for the elderly. In his case, he said the position (*tachiba*) made him feel confused in the beginning after becoming a care manager. Unlike a home-based care manager responsible for the beneficiary on any occasion, his colleagues who are care workers thought they understood the elderly well since they work

for them every day, so they adjust the services without consulting with him sufficiently. This situation made him feel that only function of a care manager was the investigation of care level for the beneficiary (‘*nintei chuosa*’) in the medical corporation. He felt *care manager* was only the job's name—in fact, he did many other things that are not supposed to be a care manager’s work. Such confusion is not rare. In small-scale facilities, a care manager’s work varies according to each facility's characteristics, which can easily incur confusion regarding a care manager’s responsibilities.

N-san (45) also pointed out a similar dilemma in her work. She worked as a care worker for six years and a social worker for five years. She then took the exam and became eligible to be a care manager, having worked as a manager for two years when I interviewed her. She said if she did not assist care staff in providing breakfast for the beneficiaries, her colleagues would complain. Other care workers did not understand that it was not her work to serve the elderly directly and thought if she was too busy, they should hire another care manager, making she feel embarrassed. After a period of negotiation, they rearranged the working schedule, and she could finally focus on her work as a care manager. Having previously worked as a social worker, N-san accumulated much experience in communicating with varied group of people, as well as being well practiced in coordinating different actors or institutions. She said:

> *I know the ‘cross-border’ problem for facility-based care managers is quite common; most facilities ask the care manager to do other job items. I personally would not take it as a quite negative phenomenon. At first, we have a lack of workforce in the elderly care; secondly, if you feel it is too much for your work, it would be better to communicate with colleagues directly. I worked as a social worker for a long time. I think anything is negotiable if we have a sincere and rationally kind attitude. My colleagues did not understand my position at the beginning, but through communication and*

working together, they began to understand what I do, and they would respect the healthy boundaries in our work. Definitely, I know it is challenging process, because you never know whether your colleagues can understand and be supportive or not…

N-san, 45, female, facility-based care manager, Tokyo

N-san also mentioned predicaments confronted when the beneficiary and their family having contradictory ideas about care service. However, she adapted to it during her time working as a care manager. She said the significant challenge for her was the medical knowledge needed in making the care plan. The medical doctor might have different criteria in assessing the beneficiary's symptoms; in some cases, doctors may react in time to a beneficiary's requirement, but they may not always reply promptly, and then there would be major time costs in communication and reaching agreement between the doctor and the care manager. In some cases, beneficiaries felt that they did not have enough opportunity to consult with their doctor, and therefore the care manager had to take time to record the beneficiary's feelings and needs, and then convey these messages to the doctor. Doctors often had a stronger tendency to place attention to the specific medical issue or treatment, rather than the comprehensive quality of life of the beneficiary, which was the main focus of the care manager.

4.2.2 Interview Summary

The four facility-based care manager interviews supplement the case study. The context of the interviews (informal settings and timing) allowed me to touch facets of personal life of the care managers. They felt more relaxed and freer to speak out what they thought and felt, beyond my prepared questions. The responses contain similar replies, and hence in the above section, I have listed the information, rather than repeating similar comments regarding their role and problems at work.

At *individual-to-individual* level connection, similar to the case study, the

challenges occurred when communication did not reach mutual agreement. There were two situations where this happened: (i) the care manager did not have adequate time to grasp the actual needs of the beneficiary due to the amount of administrative paperwork, so that the time spent on communication was reduced; (ii) when the beneficiary and their family have conflicts, and therefore it was not easy for the care manager to reach a point that allowed both sides to feel satisfied. Most care managers found they could successfully tackle these challenges as their work experience increased. However, the situation they could not change was the limited time to build communication with the beneficiary, since care managers also have to deal with other work. The initial purpose of setting up the care manager under the LTCI is to make an appropriate care plan to meet the needs of the elderly and confirm the services have been properly and adequately provided. In reality, care managers are too busy with completing administrative tasks and providing frontline assistance, which may cause them to neglect the initial aims of the care manager in the LTCI system.

At *individual-to-institution* level, care managers deal with their own institution, the medical institution and the local municipal office. For the facility-based care manager, the ambiguous nature of their position (*tachiba*) in the facility was frequently mentioned in the interviews. Care managers work *for* the facility whilst scrutinising the quality of service provided *by* the facility, to guarantee the benefit for the beneficiaries. With the municipal office, the care manager does not have personal interaction with staff in the office, must submit a large amount of paperwork to them. With the medical institution, care managers would like to see more efficient collaboration with medical staff, and pointed out the misunderstandings that potentially occur due to the different knowledge backgrounds. Since more and more elderly people accept and choose the facility as their last home, adequate support in daily life and medical treatment is essential. Closer and more varied collaboration between the facility and the medical institution should be developed.

4.3 Chapter Summary

This chapter investigated the facility-based Japanese care manager role by means of a case study and four in-depth semi-structured interviews. T^2-san was the research target in the case study, an experienced facility-based care manager in Miyagi prefecture. She was introduced to me by a senior colleague at Tohoku University. T^2-san was very cooperative when she knew what I wanted to do for the research. She personally also wished I would share the insights and lessons from Japan to other nations in future; for example, for neighbouring China. She has never had the chance to visit China, but she was excited to have a conversation with me on the topic about which she is most passionate—that of elderly care.

T^2-san supported me to design my field observation within the facility's policies. She also introduced me to her colleagues, enabling me to interview them. Both K-san and Y-san showed very collaborative and kind attitudes, which I appreciate so much as a student without the ability to return this favour.

The non-participant field observation, semi-structured interview with T^2-san, and open interviews with K-san and Y-san comprised the case study. Additionally, I conducted four in-depth semi-structured interviews towards facility-based care managers in Tokyo and Miyagi. T^2-san introduced me to the care manager in Miyagi, and a previous college friend working as a care worker introduced me to the care managers in Tokyo.

It is hard to analyse the facility-based care manager as a whole without logical and categorised detail. Therefore, the role has been considered via work relationships at the *individual-to-individual* and *individual-to-institution* levels. By exploring the reality and problem existing in each level of work relationships, the work condition of the facility-based care manager has become clear. At *individual-to-individual* level, the facility-based care manager is responsible for mastering the ongoing condition of the beneficiary, and for creating a proper care plan. The

conflicts, if they happen, are usually caused by two reasons: the care manager did not have enough time and ability to understand the beneficiary's needs; the beneficiary and their family have different opinions of care provision and thus challenge the care manager in creating a plan fulfilling both sides.

At *individual-to-institution* level, the facility-based care manager sees a dilemma regarding their responsibility within the facility, because most care managers face extra demand from frontline care workload. The skills to balance this requirement and other work items is essential for their motivation. Although there was some criticism over the vague working responsibility in the facility, in fact, many care managers did not take this as a significantly negative factor. N-san mentioned that, according to her observation and her own work experiences, many care managers like to give a hand, energy permitting. She outlined the possibility of resolving this dilemma through good communication skills. In regard to the work connections with the municipal office and medical institutions, responses from the interviews suggested reducing the amount of paperwork for care mangers, and increasing the medical assistance for the end-stage beneficiaries.

The research data of one case study and supplementary interviews may not seem to constitute the amount of research required for quantitative research. However, in fact, coordinating a visit to a facility and meeting the care managers during their busy schedules were highly time-consuming activities—partly due to the cultural phenomenon in Japan noted earlier in this chapter of *meiwakukakenai* (try best not to bother other people). I deeply appreciate the networks and sources I could access through Tohoku University, as well as various friends in Japan, which enabled me to access first-hand research experience for my PhD, which gave me fresh and practical comprehension. It is certain that this comprehension can be deepened and broadened if I am able to access more data and resources in future research.

Chapter Five: Agency-based Care Manager Case Study

5.1 Agency-based Care Manager Case Study

Introduced in the literature review in chapter two, the 'social hospitalisation' phenomenon caused a significant increase in medical expenditure (Tamiya. N, et al; 2011). This resulted in the unnecessary institutionalisation of elderly people, reflecting internal flaws in Japan's institutional design before the LTCI was established. Therefore, one of the primary purposes for launching the LTCI was to encourage the development of home-based elderly care, that supports independent living by means of a variety of services delivered through the LTCI system. Thus, the work of the home-based agency care manager (*kyotaku kaigo shien jigyoshō*) becomes significant for bridging the beneficiary and the LTCI system.

5.1.1 Case Study Background Introduction

The home-based agency care manager gets in touch with the beneficiary by visiting their home directly. However, in contrast to the facility-based care manager for beneficiaries living within the facility, the home-based care manager cannot keep an eye on the beneficiary in the same way. Therefore, the comprehensive ability to manage the conditions of beneficiaries, including physical and mental updates and the relationship with their families, becomes vital for the home-based care manager.

The home-based care manager visits the beneficiary's home to collect information from the beneficiary and their family. After evaluating multiple aspects (physical and mental condition, and how much family support is available), combined with the care-level evaluation from the Certification Committee *(kaigo nintei chuosa*

shisakai)[24], the care manager decides on the care plan the beneficiary will receive from the LTCI. For example, the beneficiary might need home-based elderly care (*hōmon kaigo*), home-based bathing assistance (*hōmon nyuyoku*), or a day-care service centre. In some cases, the beneficiary may need adaptations to their home, such as reconstructing the entryway so that a wheelchair can pass through without difficulty. Therefore, the home-based care manager must also be able to observe the beneficiary's needs based on their environment.

Another significant difference between home-based and facility-based care managers is the number of cases for which they can be responsible. According to the Ministry of Health, Labour and Welfare's current policy, one home-based care manager is allowed to take charge of 35 cases as standard. However, in calculating the nursing-care fees, one home-based care manager is allowed to be responsible for up to 40 *care required* cases (*yōkaigo*) and up to 20 *assistance required* cases (*yōshien*). On the other hand, a facility-based care manager can take 100 cases; almost three times higher than the home-based care manager. The main reason for this gap is that home-based care negotiation is time-consuming. Since the home-based care manager has to visit the elderly directly at home, the arrangement has to adjust to the schedule of the beneficiary and her/his family members. For care planning, assessment meetings must accommodate the schedules of various actors, including physician, medical staff and municipal staff.

After establishing the care plan, the home-based care manager also needs to arrange the service providers meeting (*tantōsha kaigi*)[25] with various institutions (which also requires time to adjust for different schedules). Therefore, smooth communication is essential for an efficient home-based care manager. The facility-

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[24] Certification Committees (介護認定調査審査会) are affiliated to each municipality, composed of at least five persons specialising in healthcare (保健), medical care (医療) and elderly care (福祉) (MHLW).

[25] Service provider meeting ,サービス担当者会議: the meeting for creation or adjustment of a care plan of a beneficiary, care manager invites beneficiary and their family members, service providers, medical doctor and nurse. (MHLW)

based care manager does not have to deal with the complicated schedules of services providers — they do, however, have to manage the resources inside the facility. Therefore, collaboration with facility staff working is essential. The facility-based care manager has to plan in such a way as to avoid putting overwhelming pressure on the care staff in the facility, yet provide adequate service for the residents. The service items are easily concluded in the care plan for older people who reside in the facility, whilst the service delivery f the agency-based care plan needs to be provided from external institutions. As a result, the breadth and depth of understanding of the LTCI and the network are crucial for the home-based care manager.

Kageyama. K, et al (2014) examine the concrete work aspects of the agency-based care manager, using a quantitative method (results listed below in Table 3). This research investigated the working activities of the care manager's workload, and showed that most time was spent on 'indirect care activities', at 174.78 minutes per day. The second most time-consuming item was 'care planning', at 108.01 minutes daily. Following these, 'consultation' takes 34.5 minutes, 'team management' takes 32.87 minutes, 'assessment' takes 25.88 minutes, 'pre-admission consultation' takes 20.19 minutes, 'regional cooperation' takes 13.99 minutes, 'facility administration-related activities, quality improvement activities, conclusion of contracts, in-service/seminars, staff supervision, patients' rights advocacy, complaint resolution and direct nursing care activities' occupied 32.37 minutes (in the table this is represented as 'other major activities') and 'other' items took 31.18 minutes. The most time-consuming of the 'indirect care activities' was 'activities for eligibility assessment', and 'record and create documents' ranked second. In the meantime, in 'care planning', 'make care plan' ranked first and 'monitor' ranked second.

Table 3: working activities of the agency-based care manager's workload

Activity	**Duration (minutes)**

indirect care activities	174.78
care planning	108.01
consultation	34.5
team management	32.87
assessment	25.88
pre-admission consultation	20.19
regional cooperation	13.99
other major activities	32.37
other	31.18

source Kageyama. K, et al (2014)

Another quantitative investigation regarding the amount of work for the care manager was conducted by Baba. J (2012), containing comparative research of the changes that happened in the amount of work between 2003 and 2007, after the 2006 amendment to the LTCI. Data was collected and coded from 26 agency-based care managers in Kanagawa prefecture. The result indicated the overall increase in work after the policy amendment. However, the proportion of the core purpose of the care management as 'assessment and analysis' and 'care plan creation' decreased, as administrative work linked to service provider meetings and monitoring became compulsory at least once every month.

Yu. X J (2014) uncovered how does care manager cognize work time subjectively, and what factors influenced this. Differently to Kageyama. K, et al (2014) and Baba.

J (2012) who scoped in agency-based care managers only, Yu. X J's work (2014) included all types of care manager for statistical analysis. The results show that 'difficulty of forming cooperation' had the greatest recognition for time-consumption in a care manager's work. The factors 'the ability of management', 'inappropriate salary', and 'the extent of freedom to decide' impacted this subjective recognition, following the first factor. In addition, the personal capacity to manage work issues also changed, according to the above factors.

Additional research on the work issues (rather than work amount) for agency-based care managers was carried out by Isumi. H (2016), who indicated the ability to make the beneficiary and their home agree to the care plan was crucial, according to a questionnaire conducted towards 2552 home-based care managers in 23 Tokyo wards. Furthermore, it emphasised the importance of treating the beneficiary's physical functions as a priority in making a care plan, in order for the service provision to continuously support independent living to the maximum degree possible.

The above-mentioned research comprises the existing few articles on the care manager; most were written in Japanese language. They provided precious information regarding the work of agency-based care manager. However, they are not enough to grasp a holistic picture. Izumi. H (2016) collected a large scale of data from the home-based care manager, but focused on the attitudes towards support for independent living, without considering any other aspects in the care manager's work. Yu. X J (2014) contributed to discovering the factors influencing the subjective recognition of time allocated in a care manager's work, but did not address other practical issues. The research from Kageyama. K, et al (2014) and Baba. J (2012) listed the work contents in detail and conducted a precise calculation from collected data—however, the data was gathered in 2011 and 2007 respectively, over ten years ago. In addition, all data showed an average result of each item, neglecting the context and or depth of analysis on the reasons

for these results. Accordingly, to understand the current situation of each type of care manager from a more grounded and direct perspective, I chose close-distance field observation, and interviews with research targets, to formulate a fuller comprehension of the roles.

In this case research on the agency-based care manager, the research target is a female care manager working in Tokyo. The subject is a close friend of my tea-ceremony teacher, and first introduced to me through this relationship, when my teacher heard about my PhD research. The care manager came to visit my teacher's neighbor regularly—as this neighbour needed elderly care through the LTCI system—and became close to my tea-ceremony teacher. I also had a deep connection with my teacher, having I learned the Japanese tea-ceremony *urasenkei* since college. Both myself and the care manager felt deep *goen*[26] with the tea-ceremony teacher. After knowing my research question and purpose, the care manager offered me the precious opportunity to follow her workflow for a day. I was allowed to watch her work routine in the home-based care management agency, and then accompany her as she visited some beneficiaries, for the purposes of field observation. After returning to the agency, I also conducted an in-depth semi-structured interview with her, using prepared questions and questions which arose from the process of seeing her work.

5.1.2 Case Study Methods

The differences in the work attributes of facility-based and home-based care managers dictate the differences in my approach to researching them. For the facility-based care manager case study, the interviews and observation could be completed in the facility. However, the agency-based care manager must travel frequently to visit beneficiaries, and hence the field observation happened outside

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[26] Goen, ご縁, a commonly used Japanese word means fate/pre-destined/doomed bond or encounter, etc.

of any institutional context in this case study, in various beneficiaries' homes / on the road.

T^1*-san* is the agency-based care manager in this case study. For privacy protection, the names of care managers, agency and the beneficiaries appeared in dialogues are all pseudonyms. I first had a long conversation with T^1*-san* in my tea-ceremony teacher's house; they had had a close relationship for over a decade, due to the nature of the relationship between my teacher and the neighbour receiving care (a widower who rented the apartment belonging to my teacher, and who was treated like a family member). Over time, T^1*-san* and my teacher built deep trust and overcame many difficult situations together.[27]

T^1*-san* told me that almost half of her work was on the move, i.e., visiting different institutions and beneficiary's homes. T^1*-san* told me it was difficult to let me be present (*kengaku*) during the process of visiting a new beneficiary, as on such occasions she still needed time to form trust with the beneficiary. Instead, she agreed to visit some long-term beneficiaries she already knew very well, with whom she had built mutual trust strongly, like my tea-ceremony teacher's neighbour. She then picked an appropriate date based on this approach, and allowed me follow her work on that day. After field observation, T^1*-san* agreed to be interviewed by me, and also helped me to persuade one of her colleagues (also a care manager) to have an interview with me.

5.1.3 Records of Field Observation and Findings

At 8:40 AM on our appointed day, I arrived at the front door of the agency, a little earlier than their official start time. The agency is not on a big scale in Tokyo—there are three care managers and one staff member working on daily

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[27] I also had a deep connection with my tea-ceremony teacher since college. For my Japanese Literature class, I chose her to be my tutor in regard to Japanese traditional culture. Since we met, she has treated me as a family member and participated in many significant events of my life.

administrative support. *T¹-san* was the founder of the agency, and therefore combined her work as manager of the agency and as care manager. She informed her colleagues in advance about my visit beforehand, so they were not surprised to see me. We exchanged greetings and introductions around 9 AM when they arrived at the office. The office was composed of two rooms; the bigger space was used for work and another smaller room was used for meeting guests. After greeting *T¹-san's* colleagues, I sat in the guest room and kept silent. Everyone checked the work schedule and had a short briefing meeting, exchanging ideas on some specific cases before starting the work. *T¹-san* gave me a copy of her that day's work schedule, and indicated that while timings might not be so precise, it contained the general tasks she planned to complete that day.

Table 4: T1-san's Work Schedule

9:00	Confirm the working schedule of that day 本日の予定の確認
9:30	Visit a day-service centre, check service provision for a beneficiary utilising the day-service デイサービスの訪問、利用者様の様子を管理者さんから伺う
10:00	Back to the agency, paperwork on care planning, eligibility assessment, etc. 事業所へ戻り・ケアプラン・要介護認定の申請書類などの作成
12:00	Simple lunch, doing computer tassk while eating a rice ball 昼食・お握り食べながらパソコン作業

13:00	Visit two beneficiaries for monitoring, listen to their feedback on the current service provision 利用者様のご自宅へモニタリング（二箇所）・今のサービスに不安不満と期待を伺う
15:30	Visit the municipal office, submit documents and finish some administrative procedures 区役所へ・書類の提出や各種手続きための訪問
16:00	Back to the agency, continue to do paperwork 居宅事業所へ戻り・事務業務
17:30	Official work hours finish 本日の業務終了

After giving me the schedule sheet and a simple conversation with colleagues, *T¹-san* told me we needed to head for a day-care service centre.[28] One of her beneficiaries had recently started to utilise day services. The beneficiary was 83 years, female, just diagnosed with mild dementia, and lived alone. Her daughter lived two districts away from her. Although they did not live far away from each other, the daughter could not watch her at all times because she also had a part-time job to support her family. Therefore, *T¹-san* suggested the beneficiary use the day service when her daughter could not take care of her. Since the beneficiary already had mild dementia, she quickly forgot things and was at risk of falling over while walking. *T¹-san* wanted to confirm whether the services provided by the day-

[28] Day-care service centre, デーサイービス (通所介護とも言う), usually provide one-day service for the elderly, staffs from the centre will pick up the elderly, help the elderly in taking a bath, physical functionality assistance, hygiene check and so on.

service centre fitted all the beneficiary's needs (*T[1]-san* chose to speak to the manager of the centre instead of the beneficiary herself). If the services and equipment were not enough for dementia elderly care, *T[1]-san* would transfer her to another more professional dementia-oriented facility.

During the conversation between *T[1]-san* and the day-care service centre manager, I sat in the hall, and saw all the elderly people sitting gathered around several tables. They were doing some drawings and handcrafts. The staff in the day-service centre taught the elderly to do these activities. They checked everyone's response in the process. One impressive point for me was the name tags on each shoe case in the entry area of the hall. I asked why they put each person's name on the shoe case; they explained to me this was because the elderly sometimes easily forgot what kind of shoes they wore on day to day. I had not expected that elderly care would entail such small details—and in fact there were many details involved in proper care. *T[1]-san* finished her meeting within 15 minutes. She told me the current services here were enough for the dementia beneficiary at present; the manager would keep an eye on the beneficiary and inform her of the latest condition. On the way back to the agency, *T[1]-san* called the beneficiary's daughter and eased her concerns towards her mother. *T[1]-san* said this activity could be termed monitoring, although it was unlike the monitoring that required a visit to the beneficiary's home. She said the major difference she felt between the agency-based and facility-based care managers was the complexity of the relationships in their work. In the facility, services items were already agreed and it was easy to know the beneficiary's condition quickly. The agency-based care manager has to connect constantly with different service providers. They also have to respond instantly to the beneficiary's latest situation, and adjust the care plan to meet the change. Changes frequently happened, hence communication with various service providers being constant.

After visiting the day-service centre, *T[1]-san* and I returned to the agency. (The day-

service centre and the agency located in the same community.) T^1*-san* said being familiar with diverse service providers within the community was essential for her work. Once the beneficiary's assessment and service level have been confirmed, the care manager must immediately have a general idea about the combination of services required, and that the relevant institutions can fulfil this beneficiary's needs.

T^1*-san* went back to the office to continue paperwork for care planning, assessment and monitoring documents, etc. There were two persons with one care manager sitting in the guest room, so I could not stay there, and chose to walk outside to buy some food for lunch in the convenience store. I bought some snacks and drinks back to the office when they came to the lunchtime in the agency and shared them with T^1*-san* and other colleagues. T^1*-san* seemed quite busy, because she told me she had to finish documentation to submit to the council that afternoon. Therefore, she was doing computer work while swallowing the Japanese-style rice ball *onigiri*. Other colleagues were happy to take the snacks and drinks I brought there.

After the simple lunch, T^1*-san* told me it was time to visit another beneficiary at home. Although the location was not distant, T^1*-san* decided to drive to save time on the way. In her briefcase were two folders; each folder contained the beneficiary's paperwork, including records about the beneficiary and their family, the record of face-to-face assessment, the services plan, the assessment process forms, and monitoring forms. I was surprised to see so many documents required just for one person. There was also a tape measure in the bag that piqued my curiosity. T^1*-san* told me it was used for measuring the height of the toilet, the size of the handrail, and furniture, to confirm whether these daily objects were convenient for the elderly person's life. If aspects of the home were inappropriate for daily use, the care manager was responsible for providing advice on refurbishing and using related services provided by the LTCI.

The first beneficiary we visited was an 89-year-old female, categorised as level 1 *care required.* Her husband had passed away two years ago, so she tried to manage life by herself. Her children came to see her two or three times a week. They bought the food and other necessary items for her daily use. She needed to keep doing her activities and communicating with people for physical and mental health. However, her children had no time to accompany her to do these activities. They also had no technical / professional training to assist her exercising to maintain physical function. Therefore, *T¹-san* suggested she use the day-care service twice each week, and a home-visit helper service on the days that her children could not come. After entering the beneficiary's room, I saw a handrail that had been added to her home. *T¹-san* told me the beneficiary had fallen once when she wanted to walk to the kitchen area. From the living room to the kitchen, there was no furniture to hold onto, hence the fall.

Extract of Conversation from the Home Visit with Beneficiary 1:

T¹-san: *How do you feel about the day- care service? Did you use it as planned?*

Beneficiary: *Yes, I think day service works on me. I keep going there. I did walk practice and* taiso *(physical exercise) inside.*

T¹-san: *Did you have good rest recently?*

Beneficiary: *Yes*

T¹-san: *How about the handrail? Do you feel it helped you?'*

Beneficiary: *I use it every day. It helps me a lot.*

T¹-san: *So, you didn't fell again after that?*

Beneficiary: *Yes, I feel safe right now, when walking to the living room.*

T¹-san: *Do you feel you need more services? ...any complaint towards anything?*

Beneficiary: *So far, I felt I am generally fine with the services. They can support my needs well. I might need more services from the helper if my daughter leaves Tokyo for a business trip in the next month.*

T¹-san: *Okay, then I will contact the agency to increase the work hours of the helper. Let me know one week beforehand.*

They continued to talk about more details on food, medicine and exercise. Then *T^1-san* went to the laundry room to check whether the beneficiary has the laundry well done by the home-visit helper. *T^1-san* told me the beneficiary used to put the clothes into the washing machine and forget about them; they would then have mould on them when she took them out (clothes became mouldy easily if they are not dried timely). The beneficiary also asked me some questions about Chinese elderly care. She gave a high compliment to *T^1-san,* calling her a considerable person (*suteki)*; she said *T^1-san* paid attention to details even she would not notice herself. *T^1-san* quickly recorded some information, and then we left the beneficiary's home.

T^1-san told me that we only had 15 minutes to rush to the second beneficiary, so as to arrive in time. We jumped into the car and moved on. *T^1-san* said she usually had to rush here and there when she had to visit several guests in a short time. It was pretty challenging to arrange many guests' schedules one after another; for example, some beneficiaries only have available time to be seen at the weekends, because their children could only come then. Thus, several cases may gather in the same day, which makes that day extremely busy for the care manager.

The second beneficiary we visited was the neighbour of my tea-ceremony teacher. He was 83 years-old, level 2 *care required*. His wife had passed away and his son lived in another area in Tokyo. He had some difficulties in movement, but his mind still worked clearly. He needed more services than the first beneficiary. *T^1-san* told me he received helper's assistance daily, and went to the day-care service once a week, combined with other visiting medical support. When we visited him, he was facing the dilemma of whether it was better to move into a long-term facility that could accommodate his life 24/7, since his son was busy with work and had almost no time to support him.

T^1-san and I entered the room, and I sensed some smell inside the room. T-san opened the window and said he forgot to keep the air refreshed. It was slightly

messy in the room. There were some empty bento boxes and dirty dishes in the water tank. The beneficiary said he would do the washing if he felt physically well, but in most cases, he waited for the helper to clean them and bring the rubbish out. Then I understood why there was a smell in his room. The helper usually came at noon, brought the meals for him, cleaned the room, and helped with personal washing; also they provided help with bathing three times each week.

Extract of Conversation from the Home Visit with Beneficiary 2:

T[1]-san: *How do you feel about the new helper? [The previous helper had transferred to another agency]*

Beneficiary: *She's new to being a helper, but she helped me. I generally was satisfied with her services. I was a little bit shy to talk to a new person. She was also a little bit introverted. But the atmosphere was fine.*

T[1]-san: *That's great. I saw your bento boxes, and too much flavouring was put in some of your food. You still should pay attention to the amount of salt you absorb every day for the problem of high blood pressure.*

Beneficiary: *Okay.*

T[1]-san: *…oh, another important thing I wanted to inform you, the mat for the multiple-position bed will arrive shortly. I knew you struggled with the decubitus ulcer for two years. I finally find the best mat made from good material that will keep you dry, and fresher than the present one.*

Beneficiary: *Oh, that's so happy to hear. The bedside is also a little bit soft, and does not support sitting up sometimes. Another thing I want to consult with you… my son suggested me moving into a facility that provides long-term accommodation with 24/7 care, so he does not need to worry about me when the helper is not here.*

T[1]-san: *Okay, let us talk about it next time with your son together then… There are many things to consider about the location, services, medical advice, payments and so on.*

T[1]-san made some notes on the sheets, as what she did in the first beneficiary's home, and then we left. (Usually *T[1]-san* would then go to next door to update my tea-ceremony teacher on the situation, because my teacher kept an eye on her neighbour. However, my teacher was absent that day.) *T[1]-san* and I then headed

directly to the next destination, the municipal office (*shiyakusho*).

I asked *T[1]-san* what was the most crucial factor in monitoring when she visited different beneficiaries. She said sharp observation is essential in elderly care. Monitoring must confirm whether the care plan was enough for the person, and whether the services were provided properly. For example, a helper who can notice the nutritional balance and purchase proper food is vital for someone with high blood pressure. A care manager may be able to discover early symptoms of dementia, which even their family have not noticed, is helpful for care planning. In addition, the ability to assess potential dangers in the indoor space for an elderly person's movement, or signs of abuse from the family atmosphere, is crucial for a care manager. An inexperienced care manager might feel challenged by such practical details. But as they make progress in accumulating work experience, they develop a sharp eye for these issues.

Then we arrived in the parking area of the municipal office, *T[1]-san* asked me to wait for her. She had administrative documents to submit. I got out of the car and bought some drinks, and waited for her in the parking area. After more than twenty minutes, *T[1]-san* came out and we had a short break with drinks in the car.

Extract of Conversation Between T-san[1] and Myself:

Me: *I followed you outside half a day and felt your job is not easy work.'*

T1-san *Yes, every day is tough (*taihen*) for me. See, there are some new documents again. [she showed me the new paperwork from the office]*

T1-san: *As a care manager, I felt I always being pushed by lots of paperwork. On the surface, there have been only several amendments to the LTCI in the past 20 years. However, there were some minor changes in policy every year. Hence, the administrative form also changed accordingly. It has brought a big burden for a care manager's work.*

Me: *Yes, I see so many sheets already from one beneficiary.*

T1-san: *Except for the paperwork, confirming the schedule also takes lots of time. For example, some monitoring needs the beneficiary's children to*

attend as well. In this case, many of them only have time at the weekend or on a particular date. Therefore, it usually happens that several monitoring interviews are only possible to be done on a certain day. Of course, it would be ideal to conduct them all within one day. But quite often, it is impossible to arrange all of them on the same day, and hence I have to transfer some cases onto another date. Then the beneficiary's family may complain about the delay, and they do not understand what has happened on your side as a care manager...

*... You may feel I am busy when you come with me to see the monitoring—as well as the visits outside, there are other administrative tasks, such as the renew/change of eligibility in care required or assistance required, payment management of the LTCI (*kyufu kanri*)*[29] *and participation in community-based care meetings (*chiiki kea kaigi*).*[30] *There are various types of work involved.*

On the way back to the agency, *T¹-san* answered some research questions that I planned to ask in the interview after her work. She still had some paperwork to finish before closing time. *T¹-san* said she could take my interview after the official working hours were over at 17:30, and after the interview, she would still need to work that evening. After interviewing with *T¹-san,* I was allowed to interview another care manager, her colleague, in the agency. During the time *T¹-san* continued with her work, I walked outside and found a coffee shop. I sorted out my recording and notes, quickly wrote down about what I had noticed, what I did not expect, and what questions I had in the process, as preparation for the interview afterwards.

According to the interview afterwards with *T¹-san*, this is the paperwork she had

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[29] *Kyufu kanri*, 給付管理：agency-based care managers are responsible for recording and calculating the money amount of services that beneficiary uses, confirming whether the services have been provided as care plan settled, making sure the service provider has received proper money, and that the beneficiary has paid money correctly.

[30] *Chiiki kea kaigi*, 地域ケア会議, the local integrated care centre conducts the meetings for increasing the support when dealing with complex cases of the elderly, managing the collaboration among various local sectors. This meeting aims to establish closer cooperation in the community, and utilise social resources to the maximum in elderly care provision.

to finish that day:

Table 5: Agency-based care manager documentation requirements from home visits

1	*Input record of assistant process yesterday* *前日までの支援経過入力*
2	*Care plan sheet 1-3 for one beneficiary* *１名分のケアプラン 1–3 表*
3	*Input monitoring for the previous month* *先月のモニタリング入力*
4	*File records of the service-provider meeting for two beneficiaries* *担当者会議の要点まとめの２名分*
5	*Produce care manager meeting agenda folder* *社内ケアマネ会議議事録の作成*
6	*Confirm policy amendment and materials from sub-committee* *改定に伴う内容確認、分科会資料など*
7	*Input the assessment sheet of one beneficiary* *アセスメント作成１名分*
8	*Adjust the visit schedule for one beneficiary* *訪問の日時調整*
9	*Application for guided training and schedule adjustment* *案内が来た研修参加申し込みと日程調整*

5.1.4 Interviews and Empirical Findings

The one-day field observation of *T[1]-san*'s work provided precious information for

understanding the work of an agency-based care manager. More than just verbal communication from the interview, the observational process gave me broader insights, that I could not discover in directly conversation. The observation process certainly provided more information than I expected, beyond my prepared research questions, which enabled me to refine questions more precisely in interview. The interview with *T^{1}-san* lasted about 40 minutes, not one hour as we assumed, since she already talked to me a lot in the day, as I followed her work. After interviewing her, I also interviewed one of her colleagues, *W^{1}-san*, another female care manager. She is not the manager of the agency, but an experienced staff member working in the care industry.

Below is the core information extracted from the field observation and interview with *T^{1}-san*:

5.1.4.1 Summary of Interview questions and answers from T1-san

インタービュー問題と回答のまとめ

<table>
<tr><td colspan="2">

Past career experiences before becoming a care manager and the impact on the present work ケアマネジャーになる前の仕事経験及び影響
T^{1}-san, Female care manager, Executive manager, in 11th year (age 42)
Home helper > One-day Service Centre > home-based care management agency > establishing a home-based care management agency by herself
Accumulated experiences in different institutional contexts, established a care agency

</td></tr>
<tr><td>Individual-Individual</td><td>

issues extracted from the relationship with the beneficiary and their family members 利用者・家族との関係
The 'kodawari' in the relationship between the care manager and the family
The difficulties for family in providing assistance
Reflecting on building mutual trust

</td></tr>
</table>

Individual-Institution	• *issues extracted from relationship with their affiliation 事業所との関係* • *The pressure as a manager (kanrisha) of the agency and the care manager at the same time* • *The time distribution of various work*
	• *issues extracted from relationship with municipal office 市役所との関係* • *too much administration / documentation* • *less time to guarantee the quality of communication*
	• *issues extracted from relationship with medical institution and service providers* • *医療機関・サービス提供者との関係* • *The relationship with the medical institution* • *The relationship with the service providers*

T[1]-san worked in the care industry for 17 years when I interviewed her. She graduated from a welfare specialised training college (*fukushi senmongakko*)[31]. She first worked as a home-helper for two years, and got the certificate as a care worker in the second year. Then she transferred to a day-service centre and worked there full-time for four years. During the four years, she also got certified as an occupational therapist (*sagyo ryohōshi*), which helped her assist the elderly people that came to use the day service with a physical or mental disability. She then had her son and had to take maternity leave during this period. She then decided to take the certification to be a care manager; studied and passed the exam. After taking the necessary training, she became a care manager in a home-based care management agency. She worked in that agency for six years, accumulated adequate experience, and finally established the agency I visited by herself. This

[31] *Fukushi senmon gakko*, 福祉専門学校: different to a university or college, this specialised college provides the training towards specific working skills, so that the student can go into an actual work placement more quickly (on average, after two years) than students from a university.

newly-initiated agency was small scale, but had developed smoothly for five years.

T^1-san indicated her past working experiences as an occupational therapist allowed her to hone her capability of observing the elderly beneficiaries' physical needs.

> *As a helper, we also learned some medical knowledge as basic training for helper's work but taking the certificate as an occupational therapist let me learn the related medical knowledge systematically and broadly. It benefitted me a lot in work as a care manager afterwards. I could understand medical staff well and notice the early symptoms of the beneficiary that easily be neglected if without medical knowledge.*
>
> T^1-san, 42, Female, Agency-based Care *Manager*, Tokyo

Regarding the relationship with the beneficiary, *T^1-san* began by mentioning the differences in the work between a care manager and other type of care staff, from her previous experiences:

> *Compared to work as a helper and an occupational therapist in the day-service centre, the care manager is involved very deeply in the privacy of the beneficiary and their family… I feel I can handle each beneficiary's condition after working 11 years as a care manager. However, I have to say I still have to hold my nerve to deal with the situation with each beneficiary, because of their personal traits...*
>
> *For example, some beneficiaries feel it is difficult to talk about toileting problems when they are not familiar with the care manager; some families have complex money issues, and hence the beneficiary does not want to tell anyone about it... As a care manager, if I cannot discover these in time… the problems become more serious and difficult. The key is patience. I need to invite their true voice (*honne*) without judgement, give them the feeling of*

security that they can say anything they want with me. The first-time meeting is important, like we often say the first impression is important…

Each family has their specific 'kodawari'.[32] *For example, in one of my cases… the beneficiary rented a department in an expensive mansion but wanted me to reduce the part she was supposed to pay as much as possible… She had a disability in physical movement. Therefore, I suggested her to move to a lower-price mansion and live on the first floor if possible. But she rejected my advice… At first, I thought she truly did not need to live in that way, nothing was good enough for her… Afterwards, I realised that was my personal judgement… Her attachment to living in an expensive mansion had lasted perhaps all her life. She thought that was basic to her life. Other things can compromise for it…*

T[1]-san, 42, Female, Agency-based Care manager, Tokyo

In regard to the difficulty in assisting the beneficiary and their family, *T[1]-san* also mentioned the word *honne* (real voice), in the same way as the facility-based care manager in the previous chapter:

It is the principle that we put the beneficiary's voice as the priority—but in reality, the family members and the beneficiary form a team. Therefore, the emotion and attitude of the family members strongly influence the elderly person's situation.

T[1-]san continued to give me concrete examples:

A son might tell me, 'I dislike my father', but I knew that was not his honne *in the long-term. On the contrary, he cared about his father very much.*

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[32] *Kodawari*: a widely used Japanese word, meaning the subtle preference regarding a person's choice, i.e., food taste, fashion taste, way of speaking, behaving and so on.

> *A daughter-in-law complained about her psychological dilemma: she did not have a child and felt inner guilt for the family. She took the responsibility of looking after the mother-in-law, but the burden of care provision overwhelmed her. She did not dare to say let anyone else help her, because she felt somehow guilty that she had not given birth in marriage.*
>
> *An elderly lady stayed in the hospital. Her husband urged her, 'hey, hey, come back home quickly, how long do you want to stay outside?'... Her husband sounded pushy and said it with an impatient attitude… but actually, he wanted to push his wife to do more rehabilitative treatments… at last, the female beneficiary really tried hard to do the rehabilitation and was successfully discharged from hospital.*
>
> *T[1]-san, 42, Female, Agency-based Care Manager, Tokyo*

T[1]-san concluded that each family has a unique bond and character. As a care manager, she must sense the nuances in each family. This is important for her to do, in order to create a care plan most appropriate for the beneficiary and the whole family. She told a story about building the mutual trust she experienced in her work:

> *Establishing mutual trust takes time. The first impression is vital. Listening to the patient without a judgmental mind creates a harmonious atmosphere. To be honest, each person's character is unique. In my initial years as a care manager, I sometimes had judgements about very tricky family issues. Their way of thinking contradicted my original expectations, such as that lady who would spend on an expensive mansion, but not on her health as I told you… I have to admit, in such cases, I brought some judgements from my own value system. I reflected later, after realising my judgement, I think they are from my previous life experiences, like my family values, education, work… But gradually being in touch with different families, I right now understand my*

judgement was a framework, and it's better just being open-minded.

People have varieties. Gradually in my work, I removed my judgmental mind, and tried to stand in other people's shoes. Rather than resisting a specific family attitude, I would look more at the reasons behind it, and tried to solve the problems to suit their needs. In the past 11 years of getting in touch different families, I could say, I practised equality in heart in viewing things. I think this is a good practice for me.

T[1]-san, 42, Female, Agency-based Care Manager, Tokyo

At the *individual-to-individual* level of work relationship, the person-to-person contact between a care manager and a beneficiary is primary and essential for the core purpose of the LTCI system, especially for an agency-based care manager, who needs to visit the beneficiary at homes unlike the facility-based care manager getting in touch with the beneficiary in the facility directly. Communication quality, a flexible attitude and an open mind are all important factors which contribute to establishing mutual trust between persons. At *individual-to-institution* level, in regard to the relationship with the affiliated institution, *T[1]-san* talked about how she felt about being an executive manager and an agency-based care manager at the same time:

Different from my previous working experiences as an employee in another agency, I have many extra tasks to do as an executive manager of the agency. There are documents about staff management and operations that I need to submit in this position. Sometimes the work on the administrative side is more urgent than the beneficiary side. Therefore, I have to finish the management work for the whole agency first, and then the paper documents of beneficiaries have to be done as 'zangyo' *(overtime). There are many records regarding the management that are necessary to be finished, and the recording formalities are quite complicated in terms of the standard of*

how you should write them down.

Management requires not only knowledge within the LTCI system, but also familiarity with other systems, such as the medical system and the municipal system. As an executive manager, organisational issues are more than the beneficiaries' issues, making me feel I sometimes lose the perspective of a care manager. The administration usually has to face many grey areas regarding policy. It takes much time to confirm whether a decision is appropriate or not. Additionally, I have to manage the complaints towards our work, and that increases my mental stress. These are the significant differences during the work in contrast to just working as a care manager.

T[1]-san, 42, Female, Agency-based Care Manager, Tokyo

T[1]-san has to work on administrative documents for the agency, as well the for the beneficiaries. Regarding the connection with the municipal office at *individual-to-institution* level, *T[1]-san* indicated that the biggest challenge was the great number of administrative documents, which was the same challenge indicated in the case of facility-based care manager in the last chapter.

The policy constantly changes,[33] so it takes time to explain to the beneficiary every time... At the same time, the formality of the paper documents also change. Therefore, I genuinely hope the formalities can become easier, to save more time for communication with the beneficiary.

For example, a male beneficiary needs to update his eligibility for the service level of the LTCI. He was originally level 2 care required, and was reduced to level 1 because his physical condition got better after utilising care services.

[33] The reforms in the LTCI: the first reform happened in 2005, shifting attention to preventive care and community-based care provision; thereafter, there were five reforms conducted in 2008, 2011, 2014, 2017, 2020. Each reform brought the changes in paper forms, form details, and calculation of the service cost.

He used day service twice and had visiting carers for personal and daily routines four times a week. I kept the same service items when he was designated as level 1. Then I was informed from the service provider that his case fell into a 'grey area'[34] *(around the maximum of services usable for each level). I hope the municipal office can provide a precise definition. As a care manager, we cannot represent the policy itself. To persuade the beneficiary to accept the changes in services, a clear policy from the municipal level will seem more authoritative and persuasive.*

T[1]-san, 42, Female, Agency-based Care Manager, Tokyo

After expression personal expectation regarding the working contents with municipality, at *individual to institution* level, *T[1]-san* continued to talk about the connections with the medical institution and service providers.

*I know that care managers might find difficulties in communicating with medical staff sometimes. One reason is that care managers themselves lack the related knowledge. Most care managers used to be care workers, and hence their attention to caring for the elderly is mainly focused on the daily routines. Another reason is that the beneficiary and their family usually tend to believe the person who wears a white uniform (*hakui kōka*)*[35]*. Therefore, the beneficiary and family tend to quickly accept what the medical staff say. This attitude may make some care managers feel uncomfortable during the process.*

From my perspective, visiting and meeting with medical staff is good experience for my work. Some medical staff might not be flexible enough;

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[34] In this scenario, a grey area means ambiguity regarding service items between different levels, some services can be added or not be added in the same case when there was no clear regulation regarding service items and amount.

[35] *Hakui Kōka* ,白衣効, the effect of 'while clothes', the beneficiary tends to believe staffs who wear white clothes since white clothes is the symbol of the medical profession in people's heart.

however, most people are communicative and willing to work together with our care managers. There might have be a standard for each type of work… such as what kind of ranges are your responsibilities, what kind of ranges are their responsibilities… I think, in work, we should become more flexible…not only obey the so-called 'rules'… working for the elderly needs actors from different positions… as a care manager, acting as the bridge is crucial.

This kakugo *(recognition) also applies to connections with other service providers. It seems that a care manager has complicated relationships to face in work. Indeed, we have to communicate with various people efficiently. However, our work is significant for the elderly person who needs life support. Whenever I felt frustrated dealing with some complex cases, I also realised the meaningfulness of this job, because it can help people practically. In Japanese, we call it* yarigai*. I felt it strongly when someone said, 'because of your work, it saved me from the struggles'; only one word or two words of gratitude can make me feel fulfilled.*

T[1]-san, 42, Female, Agency-based Care Manager, Tokyo

Beyond the answers to my prepared questions, *T[1]-san* suddenly remembered one touching story in her work, and shared it with me:

Once, I visited an old lady together with the home-visit helper. Her husband had just passed away two days before. When we arrived at her house, it seemed that she had not eaten for the past two days. When we greeted her, her reactive response was quite slow.

The helper began to clean the house. I saw a flower vase put on the Buddhist altar in her room. The flowers in the vase started to wither because the water had dried up. I said, 'the flowers seem dried up. So, I put some water into the vase'.

That old lady seemed to realise something, and said to me, 'yes, they are drying up… thank you for coming… the flower can recover with water, I... am… also good to live longer (like them), right?'

I nodded and said sure. After silent second, I felt I touched the significance of my job in a subtle but deep way. Just a tiny behaviour of putting the water into the vase, at that specific moment, brought out her hope to live longer.

T[1]-san continued to share her insights:

*However, we also face the subtle dilemma, or I can say it is an unconscious danger in self-recognition working as the care manager. It is a self-reflection I want to share with you. Maybe it can be called 'egoistic care manager' (*erasō na keamane*) and 'obedient care manager' (*goyōkiki keamane*)*

'Erasō na keamane' *means the care manager feels herself/himself a big person during work. It can easily happen, because when the care manager conducts the monitoring, service providers might show a flattering attitude. For example, you accompanied me to the day-service centre today, and you already knew what it was like for the monitoring. Today was quite normal.*

Once I visited a day-service centre, the staff brought out tea and a chair, treated me like a customer to a shop. My purpose was to find out whether the beneficiary received the service correctly, they don't have to put effort into treating me.

*A similar thing also happened when I work with a 'welfare equipment agency' (*fukushi yōgu jigyosho*). They treated us to a luxurious dinner and also sent us little presents after the meal. I could never imagine such treatment when I worked as a care worker.*

Also, when I did monitoring in a short-stay centre, the care workers welcomed me kindly, although they have work on their hands, which made

me feel sorry to interrupt their busy schedule. It reminded me of when I was a care worker—one day when I was working, the administrative staff called out one of my colleagues, 'the care manager came, treat him first, don't let him feel our attitude is rude'.

*These care providers are cautious of their interaction with the care manager, because they are afraid that the manager would not introduce their services to the beneficiaries if don't they treat the care manager well enough. These phenomena are quite normal in the care industry, which potentially gradually makes the care manager egoistic (*erasō*) in their work.*

On the other hand, another tendency for a care manager is 'goyō kiki' *(listen and fulfil the beneficiary's needs in whatever situation). Some care managers are very responsible, and thus they try to master all the situations of the beneficiary. Their intention is good, but it is impossible to be perfect. As a result, they might have guilt in their heart and become totally obedient to the beneficiary's voice.*

For example, the helper is the person who stays at the front line with the beneficiary. They will discover new problems by assisting them. However, the helper usually doesn't have enough knowledge and experience; they quickly report to us whenever there is any change. They react to the beneficiary speedily and suggested an increase to the service level. In this case, a 'goyō kiki' care manager may start to change the care plan immediately… However, a more proper attitude should be 'we can see and discuss more' with discretion.

Many care managers worked as care workers or nurses before, so they are supposed to easily understand the staff position. However, with time passing… a care manager may also become proud or even egoistical under the long-term influence of flattering conditions, or become even more obedient when they do not have clear boundaries and have perfectionism.

T[1]-san, 42, Female, Agency-based Care Manager, Tokyo

The egoistic or obedient tendency is possible for anyone in the same circumstances. Policy can regulate work standards and codes, however, there are many nuances regarding how to do the work. The personal traits, attitudes, psychological condition, and other factors have an effect on the working process and results in each case.

5.1.5 Summary of Case Study

This case study investigated the care manager working in a home-visit care management agency. *T[1]-san*, in the 11th year of her career, is working as an agency-based care manager as well as executive manager in the agency. The one-day field observation from following her work let me understand her working reality in various aspects. I also interviewed *T[1]-san's* colleague, *W[1]-san,* who was also working as a care manager (hence the data collected from the interview is in the following section, since it includes all the interviews with agency-based care managers as supplementary information to the case study).

T[1]-san worked as home-visit helper, occupational therapist in day-care centre, agency-based care manager and finally an employer of her own agency. She had a long-term experience in the care industry from different roles. In her case, having the certification as an occupational therapist helped her work as care manager in she her work with medical institutions. Moreover, working as an executive manager let her confront more aspects regarding management in the LTCI system.

At *individual-to-individual* level of work connection with the beneficiary, her point about removing judgement was impressive. Human beings virtually live on judgements, from unnoticed small things, i.e., the taste preference in food, preferable colour, clothes, etc., to the larger events in a person's life, i.e. career decision, relationship choice, etc. These issues may not seem to be judgmental without touching some serious value evaluation. But the first-second preference

still represent to some extent what preferences we hold inside because of a long-term evaluation on what is preferred and what is not. Judgement could be influenced by a person's past education, life experiences, family backgrounds, common cultural sense, etc. Usually, people may not realise they made a judgement when they did so. In the work of an agency-based care manager, developing some closeness with beneficiaries' family members is inevitable. It is natural for the care manager to hold personal emotion and attitudes in regard to a specific case. *T¹-san* realised her definition of common sense, comparison between what she assumed to happen and the real situation in front of eyes were from her previous experiences and cognitions, such as she thought the family members of the beneficiary probably should have the same attitude in a circumstance as her own family members. However, she found people many not behave as the common sense she defined. Therefore, it was also an opportunity for her to look at her assumptions and preferences in many circumstances, and help her to become more open and flexible when getting along with various people.

At the *individual-to-institution* level of work connections, too many administrative tasks in regard to management as well as beneficiary records were highlighted by *T¹-san* in connection with the municipal office. *T¹-san* also stressed the necessity of a clearer definition in service items and amount between different care levels to avoid the 'grey area' phenomenon in their connection with service providers. Otherwise, they have to put much time into confirming these details. In contrast to the challenges some care managers might feel in connection with medical sectors, *T¹-san* felt relatively easy, since she received related medical training when she became an occupational therapist. She understood the medical knowledge and communicated with medical staff easily. She thought therefore in connection with medical institutions, a care manager's background plays an essential role. Besides, *T¹-san* also emphasised adopting a personal attitude of being open and wanting to learn.

5.2 Other Interviews with Facility-Based Care Managers

5.2.1 Findings from Interviews

This section provides information from in-depth semi-structured interviews with other agency-based care managers. Apart from one interview with *T^1-san*'s colleague *W^1-san*, other interviews were conducted out of workplaces, in coffee shops or bookshops. In the same way as the interviews with the facility-based care manager, I sent an agreement form and prepared questions before the interview. I also advised my interviewees there was scope to talk about things beyond these questions.

In addition to *T^1-san,* agency-based care managers were as follows:

M^1-san (43), Male, agency-based direct care manager, Miyagi,

S-san (41), Female, agency-based care manager, Miyagi,

Y^1-san (35), Female, agency-based care manager, Miyagi

O^1-san (40), Female, agency-based direct care manager, Miyagi

J-san (38), Female, agency-based care manager, Tokyo

Y^2-san (46), Male, agency-based care manager, Tokyo

W^1-san (37), Female, agency-based care manager, Tokyo

W^1-san is *T^1-san*'s colleague. I interviewed her on the same day after the interview with *T^1-san*. *W^1-san* had worked as an agency-based care manager for two years when I met her. She was a facility-based care manager before that. Regarding her past work experiences and influences, she told me that the first difference she felt between the agency-based and facility-based work was the change in her private lifestyle. As a facility-based care manager, she usually worked quite late in the facility, and had to get up early in the morning. She described it as follows:

*Sometimes I had to do the '*shuku choku *yakin'*[36] *when I was in the facility. There is no work in the night anymore for an agency-based care manager, so I have more time to spend with my family. In the facility, I also assisted with the emergent issues, such as helping to move the elderly person physically from a room to an ambulance, or move them for medical treatment. It also challenged my body in general, and I often felt exhausted.*

*I also have '*zangyo*' (overtime) in the agency as well for sure, but much less than the work in the facility in my case. I don't want to spend all my time at work. I choose to go back home around 8 PM usually. This might be the best place working as agency-based, I'd like to say…*

(W¹-san, 37, Female, Agency-Based Care Manager, Tokyo)

Then I asked *W¹-san* whether there were better places regarding work in the facility in contrast to agency, she replied:

In the agency, assistance work (sōdan enjo[37]*) consumed much energy because most people complained to us, and their negativity just became overwhelming. In the facility, since the residents can access several staff inside, it was like a teamwork for each beneficiary. In the facility, you don't feel you have to tackle everything by yourself, but in the agency, in one-to-one conversation, you feel everything is on your shoulders.*

Continuously, *W¹-san* mentioned the meaningfulness of her work:

Care managers—actually all staff in elderly care—are doing stressful work… But I also felt meaningful in doing my work… I felt thrilled when I saw the elderly becoming better, or their ADL increased with the service help from

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[36] *Shuku choku yakin*, 宿直夜勤: Start the night shift work right after daytime work without rest.
[37] *Sōdan enjo*, 相談援助: consulting for assistance.

> *the LTCI according to my care plan.*
>
> (*W[1]-san, 37, Female, Agency-Based Care Manager, Tokyo*)

W[1]-san said the care manager was like the stage builder, built the stage for various actors to play. The beneficiary is the main actor with actors such as helpers, doctors, service providers. A care manager's responsibility is to organise these actors and let them performance to the maximum, *W[1]-san* said: 'Getting in touch with different people is the best part of my work, I learned a lot and enjoyed many close interactions with people.'

M[1]-san is a male agency-based direct care manager from Miyagi. In regard to the *individual-to-individual* level connections with the beneficiary, he emphasised the crucial ability to create a care plan when the beneficiary and their family hold opposite opinions. He said the contradictions usually happened when the family care provider reached their limit in care provision. He told me one case in his work:

> *The beneficiary is 93-year-old lady. She has a physical disability in her feet. She lives life in a wheelchair. She belongs to level 4 of care-required. Her daughter felt they were already the limit in care provision if she stayed at home. So, she suggested her mother move into the facility. However, her mother resisted it strongly and cried about this.*

Then I asked *M[1]-san* whether there is a limit regarding home-based care, he said:

> *It is a good question. In the case I am telling you about, her daughter has to work, so she cannot take charge of seeing her mother all the time. Although this beneficiary used helpers to assist in many things, however, she is almost dependent on the wheelchair. When she wanted help with toileting, it was impossible for the helper or her daughter to be with her every time, so she had to take off or put on her trousers by herself. Eventually, she could not stand up as she was gradually weakening physically. That was the main*

reason her daughter suggested facility-based care. But her mother resisted it strongly.

*In our work as care managers, the middle level of care required… is most difficult when creating a care plan. Suppose the beneficiary is level 5 (almost bedridden, or '*netakiri*'), it is easier than level 3 or 4 for creating a plan. When the beneficiary needs intensive care like '*netakiri*', they listen to the schedule that other people set for them. Take changing a diaper as an example; the level 5 elderly can listen to the schedule that helpers or family set for them. Therefore, as a care manager, I only have to create a plan to change the diaper every several hours and ask the helper to follow the time. The LTCI can cover a short-time visiting service, such as for changing a diaper. In the care manager's forms, we have a column called shintai (body 01'), which represents 20-minute care. However, when a beneficiary is level 3 or 4, they may still insist on their own independence. They want a meal or to go to the toilet whenever they want. On such occasions, we have to adjust to their decisions—which is different from a level 5, where the beneficiary adjusts to our decision. Therefore, it feels more exhausting for the family member when they cannot keep an eye on the elderly person 24/7 although they use visiting services.*

M[1]-san, 43, Male, Agency-Based Direct Care Manager, Miyagi

With respect to the *individual-to-institution* level of work connections, *S-san* indicated the same point as *T[1]-san* on excessive administrative work:

It takes time to extract the real needs from a conversation with the beneficiary when writing a short report. There are many report samples in the computer system. However, we cannot write the same article for different cases. Spending too much time on documents made me feel we have lost our core meaning as care managers. We are supposed to serve people as a

priority.

The beneficiary is usually weak in physical and mental condition. It is difficult to make them understand the standard policies through our visits and phone calls. However, we are asked to explain every change to the beneficiary in principle. If the documentation became less, we would have more time to communicate with the beneficiary.

S-san,41, female, Agency-Based Care Manager, Miyagi

Y^{1}*-san* did not feel the challenge in terms of the relationship with her affiliating agency. She said it was more complicated when she worked in the facility, because it was a whole team working for the elderly who lived there. The agency-based care manager is more like an independent worker, facing more people outside the agency. She got along with medical staff and service providers well. She said the pressure happened only when she had too many service provider meetings, which took time to arrange.

Once, I was responsible for 33 beneficiaries. There were many difficult cases among them. Their physical conditions changed quickly, thus, the plan had to change in time. I attended 15 service provider meetings in one month, which made me very tired. In addition, as I said, we had many paper documents. I remember I got sick that month. The situation of the beneficiary is not predictable. There is the possibility that several beneficiaries need to change care plans at the same time, because the physical conditions can change anytime for an elderly person.

Y^{1}*-san, 35, Female, Agency-Based Care Manager, Miyagi*

O^{1}*-san* is a direct care manager (*shunin keamane*[38]) in the agency. O^{1}*-san* said as a

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[38] *Shunin keamane*, 主任ケアマネ: Certifying as a direct care manager requires over five years of work

direct care manager; there were two aspects of responsibilities in her work. The first task is to make the environment easier for other care managers, by guiding them, or gathering them together to boost collaboration in the community. In her work, another task is to create work opportunities for other care managers. Although the ageing issue is severe in Japan, *O¹-san* said some care managers could not find enough cases in suburban areas. *O¹-san* lives in Sendai city of Miyagi Prefecture. Her agency is located in a suburban district in Sendai. Unlike the situation in Tokyo, the density of the elderly varies largely according to the geographical location in Sendai. In the district where *O¹-san* works, some care managers have built up solo operating agencies. They did not always have enough work, and thus *O¹-san* helped them by distributing the cases to them.

O¹-san underlined another phenomenon she observed as direct care manager: she noticed hierarchical relationships within the agency.

> *Some care managers think the direct care manager is their boss, but a direct care manager is more like a helper to assist new managers. I am cautious about my attitude when I talk to them. Different people are good at different places. Being humble is very important.*

O¹-san, 40, Female, Agency-Based Direct Care Manager, Miyagi

J-san worked as a nurse before becoming a care manager. She described the difference between these roles, saying the beneficiary's attitude towards a nurse and towards a care manager was varied:

> *Regarding the individual-to-individual level of connection with the beneficiary, when I was a nurse, they normally respected me because they thought I was a professional figure. Also, I adapted to taking the posture of*

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experience as a care manager, or less work experience but with specific training.

*guide or teacher, suggesting to them to do this and that. However, being a care manager is the opposite. A care manager is about listening and serving the beneficiary. At first, I did not visit the beneficiary by myself. I visited them with a hygienist (*hokenshi*) and a social worker. They taught me how to interview the beneficiary when we visited together. If I did not work with the hygienist and social worker together, I could not imagine how I would have managed it. Working as a nurse in the hospital, we supposed the patient would take our advice naturally when we gave it... However, as a care manager, I cannot hold such expectations anymore. I used to say 'why can't you do it?' if the patient did not follow my advice. These are impossible words for a care manager.*

J-san, 38, Female, Agency-Based Care Manager, Tokyo

In regard to the individual-to-institution level of work connections, *J-san* stated the same point about overly-formalised paperwork. She mentioned that the elderly person living alone is more complicated than the usual cases. It took more time to clearly explain the changing policies, causing her to have to do administrative work after office hours. She said regarding the connection with care service providers, she found it was difficult to find a proper service provider for the elderly sometimes; especially when the beneficiaries had severe diseases, many providers refused to receive such cases.

J-san also highlighted that importance of mastering knowledge of the LTCI was essential when speaking to some family members. *J-san* said she once talked to one beneficiary's son. That son was very concerned about details. So, *J-san* had to remember the precise data to explain to him how the LTCI worked, otherwise he would doubt her professionalism.

Background understanding is crucial. Especially, I have to remember factual data to explain the LTCI system to the beneficiary. Without data, some

beneficiaries or their family members think I am unreliable. Therefore, enough study is necessary.

J-san, 38, Female, agency-based care manager, Tokyo

J-san also mentioned the long hours spent on paperwork. She said the whole care plan needed to be rewritten even if it only increased by one service provider. The slight change in content led to a full editing of the plan. She felt this procedure should become easier. She also pointed out the time spent on searching for care providers. She said, especially in the case of short-stays, she had to confirm with each short-stay service provider. This service searching took more time than others.

Y[2]-san pointed out the challenges that may happen at individual-to-individual level of connections with the beneficiary: opening a person's heart needs time, and mutual trust is essential for grasping the real needs of the elderly from their conversation.

I want to build a trustful relationship. When they are angry, they can show their anger. Also, one interesting thing I found was that some introverted people were hard to open up initially. However, once they trusted you and opened their heart, they were even more talkative than the extrovert person. I hope all my beneficiaries can be themselves in front of me.

Y[2]-san,46, male, Agency-Based Care Manager, Tokyo

He also underlined the variety of families, resonating with *T[1]-san* in the case study, noting that the way his own family connected influenced his expectations when he saw other beneficiaries' families.

The image of what a family is supposed to be, how they are supposed to respond and act, came definitely from my own family at first. For example, I took for granted before those family members would like to collaborate

*without a doubt. Once, a beneficiary's son got upset with me, because he did not want to take care of his father, even though he had the time and energy. To be honest, I was shocked that time — a son was reluctant to take care of his dad. In my eyes, it is '*atarimae*' (taken for granted). In another case, the wife did not want to take care of her husband, breaking my sense of* '*atarimae*'*. From these things, I found that my family influenced how I saw other families. Gradually, I realised I should remove any unconscious expectation or judgement first. People have various characters.*

Y^2-san,46, male, Agency-Based Care Manager, Tokyo

Y^2-san agreed with other care managers' comments on complicated administrative work tasks. One significant dilemma he found in work was about the payment (*kaigo hōshu*[39]). The payment for care manager in each case is uniformly decided in the LTCI. However, some cases are more complex, requiring more time and energy. In this circumstance, the one-size-fits-all approach caused unfairness.

Y^2-san indicated that the frequent changes in policy also caused excessive time-consumption in dealing with paperwork formalities. He also needed to spend lots of time explaining the change to the elderly. If the elderly person's physical or mental conditions are weak, it takes even more time understanding what he conveyed. In addition to the paperwork, *Y^2-san* also found arranging for medical doctors and service providers to attend the meeting was time-consuming.

*The service provision meeting (*tantoshya kaigi*) needs the beneficiary's family members. Their son or daughter usually have time on weekends. It is quite difficult to arrange for all the participants, especially the medical staff, to come at the weekend. I have to adjust and change many times in the*

[39] Kaigo hōshu, 介護報酬: the payment for service delivery from the government, in this case it represents the payment that care manager attain from LTCI.

process. Therefore, sacrificing rest time become usual for me. Although we have a bonus for extra work, I still want to spend more time with my family.

(Y^2-san,46, male, Agency-Based Care Manager, Tokyo)

He said '*kikubari*' (delicate attention) is a crucial factor for his work. For example, he is in the habit of asking the nurse to give him a summary regarding the physical condition and care suggestion of beneficiaries when they were discharged from hospital.

5.2.2 Summary of Interviews

Following the last section of interviews with agency-based care managers, this section summarises the findings from the interviews. Although each interview lasted two or three hours at most, pre-interview communication and negotiation took more time. I felt very grateful to be allowed to interview the seven agency-based care managers, in addition to the case study. I extracted information regarding prepared research questions, and also recorded contents beyond these questions, which were valuable for understanding the care managers in previous section.

These seven care managers gave me different impressions. They have different backgrounds before becoming a care manager. The medical background care manager *J-san* pointed out the changes in her attitudes during work when she became a care manager from a nurse. Medical staff usually have the '*hakui kōka'* ('white coat effect'). Thus, she indicated that care managers who come from a medical background might unconsciously guide the beneficiary from a relatively authoritative position. The work as a care manager also consists of providing advice for the beneficiary, but the care manager is closer to a servant rather than a guide, compared to medical staff. On the other hand, the number of care managers coming from medical background are not as many as care managers from a care worker background. The group of care managers who came from being

care workers understand the beneficiary’s actual needs more in a daily-life context.

At the *individual-to-individual* level of connections, all care managers mentioned the importance of building mutual trust between themselves and the beneficiary. *W*^{1}*-san* addressed the stress from the complaints in assistant/consulting services (‘*sōdan enjo’*); but also feeling fulfilled if the beneficiary got better through the services in the care plan. *M*^{1}*-san* mentioned the challenges confronted in making a care plan if the beneficiary and their family member had different opinions. *Y*^{2}*-san* mentioned an interesting phenomenon, wherein he found that the introverted people might become quite extroverted when they became familiar with the care manager. *Y*^{2}*-san* agreed with *T*^{1}*-san* in that removing judgement, respecting the beneficiary’s values and being open-minded help to establish trustful connections.

At the *individual-to-institution* level of connections, which entails the connections with their affiliations, the municipal office, medical institutions and service providers, *W*^{1}*-san* highlighted the difference between working in a facility and working in an agency. She preferred to work in the agency, because she felt the responsibility boundaries were not clear when she worked in a facility. *S-san* mentioned the time costs involved in communicating with the beneficiary to help them understand the latest policy changes after policy revision. Also, she pointed out that writing reports for each case needs time for thought and formulation, although there were many sample reports on public websites for reference. *Y1-san* mentioned that too many service provider meetings took a great deal of time in her work, since a slight change in care plan necessitated arranging another meeting. *O*^{1}*-san,* as a direct care manager, emphasised the effort required to avoid the unnoticeable hierarchy between direct care manager and care manager. In addition to the large number of service provider meetings pointed out by *Y*^{1}*-san*, *J-san* also addressed the difficulty in finding the service providers for the beneficiary with serious illness, or who wanted short-stay service providers because short-stay needs usually happened for temporary circumstances, unlike

the greater stability in service use arising from long-term stay needs. Y^2-san raised the controversial issue of payment (‘*kaigo hōshu*’), which was mentioned by other care managers in the conversation as well. The standardised payment of each case for the care manager might reduce the incentive for them to fully address more complicated cases.

5.3 Conclusion

This chapter explores a care manager working in a home-visit elderly care management agency through one case study (care manager *T^1-san*) and a set of interviews with other agency-based care managers. Similar to my approach to the research on the facility-based care manager, I did a one-day field observation, interviews in an agency, and independent interviews supplementing the field observation data.

Unlike facility-based care managers, agency-based care managers constantly travel, because they have to visit each beneficiary at home. One cannot exactly say their work is ‘24/7’, but they are very responsive to external contacts. For example, after *T^1-san’s* case study, we became friends and exchanged message at times whenever I had questions about my research, or just contact for greetings. I sent messages to her in the Japanese night hours; I saw her replies made around 1am or 5am in Japan, indicating she constantly checked her phone. For the elderly living in the facility, they can call on any staff working within the facility in an emergency. However, for the elderly living at home, except for their children or relative, they can only approach the care manager.

Another detailed difference I noticed was that agency-based care managers always brought a bag with them for visits. The bag they hold is not light, and carried various kinds of documents. (I could only notice this by doing the direct field observation). For example, for a new beneficiary just registered with the LTCI, the file for new beneficiary entailed:

- *consulting application form (相談受付表)*
- *face-sheet (フェイスシート)*
- *visit record book (訪問記録簿)*
- *contract form (契約書)*
- *important information explanatory notes (重要事項説明書)*
- *personal data use consent form (個人情報使用同意書)*
- *agreement form for advice from doctor (主治医意見書を求める同意書)*
- *consent form for providing personal data to external sectors (個人情報外部提供同意書)*
- *temporary care plan application form (暫定ケアプラン申込書)*
- *home-based service care provision plan (居宅サービス計画届出書)*

In addition to the new beneficiary file, usually a care manager needs to bring items for other purposes, as follows:

- *welfare equipment catalogue (福祉用具貸与カタログ)*
- *policy introduction pamphlet (紹介パンフレート)*
- *name cards (名刺入れ)*
- *notebook with schedule (カレンダー付きメモ帳)*
- *seal sets (印鑑セット)*
- *pen (筆記用具)*
- *thermometer (体温計)*
- *sphygmomanometer (血圧計)*
- *hand-sanitiser (手ピカジュエル)*
- *towel with tissue paper (タオルにテイッシュ)*
- *slippers (携帯用スリッパ)*
- *face mask (マスク)*
- *personal wallet and cellphone (財布と携帯)*
- *disposable gloves (使い捨て手袋)*
- *sewing set (ソーイングセット)*
- *agency certification (社員証)*

T[1]*-san* joked she already had big muscles on her back and shoulders, adapted to bring a heavy bag everywhere. Working in the facility does not need staff to collect information like the agency-based care manager, but they do have to cover work

items of other kinds. From the case studies and interviews I undertook; it is hard to say which type of care manager had better working conditions. Their passion, attitude and feeling were also strongly influenced by their environment and past experiences.

At the *individual-to-individual* level of work connections with the beneficiary and their family, all care managers cited mutual trust as an essential factor in their work; they suggested simplifying administrative documents to allow more time for the communication with the beneficiary. *T^1-san* and *Y^2-san* both emphasised the importance of removing judgement and personal values in dealing with different families. In the same way as *T^1-san, J-san* also held a medical background before becoming a care manager. They both experienced the nuance in attitudes towards the beneficiary without the 'white coat effect' (*hakui kōka*). *M^1-san* revealed the challenges in making care plans between *care required* levels 3 and 5. (In which the beneficiary who required a high-level of assistance but exerted a strong personal insistence on the way service provision might contradict what care manager or their family tried to plan.) In this circumstance, negotiation and flexibility were significantly needed.

At the *individual-to-institution* level of work relationships, which for care managers was with their own affiliation, the municipality, medical institutions and service providers, *T^1-san* suggested an improvement in the 'grey area' issue, to reduce time spent confirming the beneficiary's service range and amount. *T^1-san* and *O^1-san* both mentioned their reflections on the personal traits of being a care manager. As a direct care manager, *O^1-san* was cautious of hierarchy in the working environment, whilst *T^1-san* revealed the egotistic tendency that might occur during work processes when service providers flattered the care manager to improve the relationship. Most care managers in the interviews (*S-san, W^1-san, Y^1-san, J-san and Y^2-san*) all emphasised the need to simplify the administrative work. *S-san* and *J-san* stressed that too many service provider meetings were time-

consuming. It is not easy to reduce the number of service provider meetings if the policy does not change. Therefore, refining policy to reduce redundant administration, but essentially to improve the service quality, should be desired and expected by both care managers and beneficiaries.

This chapter has investigated the agency-based care manager in the LTCI system by looking at their work, and the problems within each layer of their work connections. One case study and a set of interviews can never present a holistic picture, but to some extent, they have revealed the frontline situation through direct field observation and conversations. The next chapter shifts our attention to the final type of care manager under consideration—those who work in community-based centres—to depict the complete picture of the Japanese care manager in the LTCI system.

Chapter Six: Community Centre-based Care Manager Case Study

6.1 Case Study of Centre-based Care manager

Following the research on the facility-based and agency-based care managers, this chapter investigates the community-based care manager, a manager who works in a community centre for comprehensive care support, or a community centre for integrated care (*chiiki hōkatsu sentā*).

The care manager who works within a centre is called a *community centre-based care manager*. In contrast to the facility-based and agency-based care managers, this care manager is known as a *direct care manager* (*shunin keamane)* [40] according to the LTCI policy. In 2021, MHLW[41] suggested each home-visit care management agency should have a direct care manager; this new rule will be enacted in 2027. Currently, some direct care managers work within agencies, while most of them work in community centres.

6.1.1 Background Introduction

Against a background of rapid ageing and low fertility, the Japanese government aimed to establish a local comprehensive care support system in each community to provide integrated care for old people. This system operates by combining local resources to support *living, care, medication, prevention* and *life assistance*. After the 2005 LTCI reform, Japan initiated regional comprehensive support centres in 2006, purposing to build an entire network before 2025—when the '*dankai sedai*' (baby boom generation) all surpass 75 years of age.

Community centres mainly tackle the sort of cases that present as 'I haven't seen

[40] *Shunin keamane*,主任ケアマネ: 'Direct care manager' is a position defined in 2006, after the 2005 LCTI reform. It is a higher-level position to lead and guide junior care managers. It is compulsory to set up a direct care manager in each community centre. It is not compulsory, but possible, to have a direct care manager in other elderly care providers, such as home-visit care management agencies.

[41] MHLW: Ministry of Health, Labour and Welfare, 厚生労働省厚生労働省

that single man for a while recently' or 'the neighbouring old couple are not disposing of rubbish properly, and our apartment block is smelling'. Moreover, unlike the agency-based care manager, who meet beneficiaries who have been designated at the *care required* level, community centre-based care managers also provide the primary access point for old people who want to use the LTCI. The community centre is in charge of the initial stage of application—the introduction of the LTCI and designation of appropriate agency.

Essentially, the community centre assists old people residing in the community, mainly in seven ways: firstly, the community centre provides comprehensive consulting support; this can include any life aspects related to the elderly person and their family, and even when the beneficiary has been designated at a specific level of *care required* or *assistance required* in the LTCI, they still can come to the community centre whenever they feel necessary. Secondly, the centre makes a care plan for *assistance required* beneficiaries. Thirdly, the centre arranges various local resources to promote independent living for old people. Fourthly, the community centre organises training or events to boost public cognition and services for preventive care (*kaigo yobō*).[42] Fifthly, the community centre is responsible for monitoring the service delivery, dealing with abusive cases within families, and enhancing support for elderly people living with dementia in the community. Sixthly, the community centre supports continuous and comprehensive care management within the community: it organises regional care meetings (*chiiki kea kaigi*) to promote care delivery for supporting the elderly people's independence, and provides advice on complex cases, weaving the networks between medical institutions, service providers, voluntary groups and the welfare commissioner (*minsei iin*).[43] Finally, the community centre steers the direction of future

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[42] *Kaigo Yobō* 介護予防 is a concept raised in the LTCI reform in 2005: it emphasises the importance of taking proper exercise to prevent physical breakdown and delaying physical deterioration.
[43] *Minsei iin* 民生委員 is contractual local civil servant, working for community-based activities, such as protecting children's rights, assessing the situation of old people living alone, etc.

development for the community, by looking at the current problems and combining local resources for the highest efficiency of service provision.

There are three types of professional positions necessary in each community centre: a hygienist with experience in community care provision, a social welfare worker (*shakai fukushi shi*), and a direct care manager. The *hygienist* provides consultancy regarding medication and elderly care, helps the direct care manager formulate the care plan, arranges events for preventive care, and creates connections with medical institutions, health centres and so on. The *social welfare worker* receives diverse questions from the beneficiaries; they introduce the beneficiary to the proper facility / welfare equipment, visit the facility or elderly person's home to assess their situation, respond to cases of abuse or fraudulent business practices, and arranges events for promoting dementia care, etc. The centre-based care manager does not deal with beneficiaries designated as *care required,* working only with *assistance required* cases. They also receive various queries regarding elderly care from older people living in the community, and provide suggestions. They guide junior care managers in their community, and promote collaboration among different elderly care institutions.

Table 6: Community Centre Roles

	Social welfare worker 社会福祉士	Hygienist 保健師	Direct Care Manager 主任ケアマネジャー
Tasks 仕事内容	Elderly care and life assistance 介護や生活支援 Consumer damage 消費者被害	Health issues 健康 Medical issues 医療 Care prevention	Comprehensive elderly care 介護全般 Care Manager Assistance

	Complex issues 困難事例 Families with complex problems 多問題家族 Abuse 虐待問題 Assistance for adult guardianship 成年後見制度の利用援助	介護予防 Community assistance 地域支援事業 Abuse 虐待問題	ケアメネ支援 Consultancy 相談 Complex issues 困難事例 Family with multiple problems 多問題家族 Abuse 虐待問題 Service Providers Collaboration サービス事業者連携 Care Management Agencies Quality Enhancement 事業者の質の向上
Work contacts 連絡先	Administrative institution 行政 Related professional institutions 専門機関	Health Centres 保健所 Hospitals 病院 Pharmacies 薬局	Service providers 介護サービス事業者

Community centre-based care managers are responsible for the beneficiaries that are designated *assistance required* at the *individual-to-individual* level of work connection, but they connect with local institutions at *individual-to-institution* level, comprehensively promoting elderly care delivery in the community.

The merits of working as a centre-based care manager include:

- *a guaranteed work/life balance, as centre working hours are restricted to daytime;*
- *enhanced professional skills in the care industry, utilising knowledge received from specific training areas required for the position;*
- *a range of responsibilities working in the centre, rather than one specific facility or agency;*
- *broadened insights into the local community from divergent perspectives;*
- *deepened involvement with local institutions, such as the welfare commission.*

On the other hand, since centre-based care managers do not provide elderly care directly, and are only in charge of care plans for *assistance required* care level beneficiaries, it is impossible for them to track a beneficiary in the long term.

Becoming a direct care manager requires specific training (s*hunin kaigo shien senmonin kenshu*). The MHLW has established a national standard, and in addition, each municipality sets up its own training requirements and exams, according to the particular local conditions. The national standard of becoming a direct care manager is composed of three aspects:

1. Experience criteria (eligible if fulfilling any one of these four):

    - *worked as a care manager for over five years (60 months)*
    - *graduate of care management leadership training and also worked as a care manager for over three years (36 months)*
    - *worked in the regional comprehensive support centre and achieved direct care manager status*
    - *possessed adequate knowledge and experience in care management and has been recognised by the municipality as meeting direct care manager standard*

2. Completion of Training Courses I and II (*senmon kenshu katei*)

3. Completion of Care Manager's Advanced Training Course (*kaigo shien senmonin kōshin kenshu)*.

The training fee is expensive, so many care managers complain that it becomes a burden if they are paying for it by themselves; some large-scale agencies will pay this cost for the agency-based care managers. In addition, there are some complaints from care managers that they do not have equal opportunity to take the training, since the municipality tends to select the large-scale agencies or community centres as a priority, instead of the smaller scale agencies with only one or two care managers.

The community-centre based care manager is a comprehensive role within in the community. A centre-based care manager is first supposed to accumulate knowledge and experience as a care manager, so that she/he understands both the beneficiary side and the institution's side of the relationship. Secondly, as an experienced and mature role within the care industry, a centre-based care manager is supposed to provide helpful advice for new care managers. Especially when the local care manager faces a complicated case and does not know how to deal with it, the direct care manager is expected to assist. Thirdly, as the centre-based care manager is in regular contact with various institutions within the community, she/he is supposed to promote the establishment of a comprehensive local support system for the elderly in the area. This was also the original intention of establishing a regional comprehensive support centre.

The position of direct care manager is expected to be active within various aspects in the community. However, there is very little academic study on this role, and for this reason, I conducted a case study and a set of interviews towards this group of managers, to better uncover the reality of this function within elderly care in Japan.

6.1.2 Case Study Methods

K-san is a direct care manager working in the community centre in Tokyo. She has worked in the care industry for over 21 years. She told me she has tackled over 10,000 consulting cases so far. Having worked as a social welfare worker *(shakai*

fukushishi) and a certified care worker (*kaigo fukushishi*), she became a care manager and then a direct care manager.

In contrast to my expectations that the community centre would be a building similar to the council offices, it is located within a large shopping centre, central to the community. The first floor contains a large supermarket, and the other floors above this are regular commercial units selling all kinds of products.

The community centre where *K-san* was working occupied space on the first and second floor. The first floor is the area of administrative work, containing the main office where K-san and her colleagues work, a visitors' room for people who came to consult with staff, a meeting room for routine meetings for the centre and with other institutions. The second floor has an activity room for conducting events for people from the community, or meetings with local care managers and related institutions. Although it is not an independent building, as may be expected in the traditional image of a public institution, the first-floor and second-floor function well together. Moreover, since this centre is located in the most popular shopping mall in the community, almost everyone can see it. Close to the office on the first floor there is a public area (*kyukeisho*) for people to rest after shopping. In particular, many old people use this area after shopping in the supermarket, having a drink or talking to each other. Hence, it is also very convenient to access the community centre consulting window whenever old people feel they need to seek help in elderly care.

In the first case study of the facility-based care manager, I was allowed to stay in the facility's hall to observe the general conditions and do the interview. For the agency-based care manager, I followed a one-day routine in the field, and collected the interviews. In the case of the centre-based care manager, I was allowed to do this case study using two approaches (after discussion with *K-san*)—stay in the public rest area to observe their work situation before noon, and attend as a volunteer at an event including an exercise lesson for preventative care (*kaigo*

yobō) towards the elderly in the community. *K-san* asked me to come on the day that they had preventative care lessons, in order to understand the community centre and her job more directly. After the preventative care session, I interviewed with *K-san* using prepared questions as well additional questions arising from my observation.

6.1.3 Field Observation Records and Process

Table 7: K-san's One-Day Schedule

8:30	Arrive at office 出勤
9:00	Open the consulting window 窓口受付開始 Confirm day's schedule 本日の予定確認 Administrative work for assistance required cases and other administrative procedures 要支援プランと行政などの文件処理
9:40	Appointment with community welfare commissioner 予定の民生委員との面会
10:20	Phone calls to related institutions regarding issued raised by welfare commissioner 民生委員の相談問題を解決するためのアレンジ電話
11:30	Meeting with community welfare council coordinator 地域の福祉協議会コーデイネータ、民生委員一緒の会議
12:30	Lunch

	お昼休憩
13:10	Short meeting with community centre staff in preparation for afternoon event 午後活動の指示と準備、職員達との短い会議
14:30	Preventative care activity for elderly in the community 地域のお年寄りに対する介護予防活動
16:00	Interview with Researcher 私のインタービューを受ける
17:00	Closure of the consulting window 窓口受付終わり Continued paperwork 引き続き事務処理

I met *K-san* around 8:40 AM outside the building that day. The official opening hours of the shopping mall was from 10:00 AM, but there is an external door leading to the office area, and thus people can access the consulting window from here if the shopping centre is not open. I was introduced to *K-san*'s colleagues; I made a simple self-introduction and let them understand why I was there, and they welcomed me with a friendly attitude. *K-san* also introduced me to a hygienist (*hokenshi*), responsible for the event in the afternoon. She would guide me on what I could do and how I could assist with this event.

The consulting window opened at 9 AM. I moved to the public area, and started to record what I saw and experienced. I could not hear staff conversation when I was out of the office, but I could get a general impression of their working processes. Around 9:20 AM, a woman came to the window and one of the staff members talked to her. At 9:40 AM, a woman arrived for an appointment with *K-san*; they

talked for a while and *K-san* made some calls subsequently. Around 11:30, someone else came into the community centre; *K-san* and the two visitors had a meeting in the meeting room. I did not understand what was happening and just recorded what I saw. *K-san* told me in the interview afterwards about what happened in the process:

The woman was a welfare commissioner (*minsei iin*) in the community and the man was the welfare council coordinator (*shakai fukushi kyogikai*). Today they discussed the case of an elderly presenting with mild dementia symptoms. The welfare commissioner had come across the man, who lived alone in the neighbourhood and had recently been behaving slightly unusually. The man's son lived some distance away, so the welfare commissioner was concerned about his situation. She asked *K-san* whether she could do something to solve this concern. *K-san* asked the welfare commissioner how serious were the dementia symptoms (e.g., how serious was his forgetfulness). The welfare commissioner relayed that the man would repeatedly do the same activities, and would sometimes appear to fail to be tracking conversation, making unrelated comments when people talked to him. *K-san* also asked about whether he often went outside or not. The commissioner said that he seldom went outside, and people rarely saw him in the street.

K-san decided to take two steps on this case. At first, she would visit the elderly person to check the actual conditions of that man together with his family members, in order to master the overall situation including his medical history and other aspects of life. Secondly, as an immediate step, *K-san* recommended encourage the man to get outside and have more contact with people in the community. As *K-san* knew the welfare council coordinator had detailed information about the area's resources, she saw that making community links might be possible in this case. Thus, she decided to talk to the coordinator first and see whether he could do something for the welfare commissioner.

In the meeting, the coordinator introduced the working contents of the welfare council. One crucial task for the welfare councils to gather the elderly people together, help them get in touch with each other, and allow each person feel he/she is a member of the community. The welfare council sets up a 'salon' in each district, so the elderly has the chance to talk to each other and have a meal together. They also arrange meal gathering for the elderly living alone. The welfare commissioner was concerned about mobility issues, but the coordinator had made transport arrangements for such events. *K-san* also asked the welfare commissioner to tell the man to come to the community centre for a talk whenever he felt he was facing difficulties.

From 10AM, I noticed more and more people walked into the shopping mall. Young faces were rare. Sometimes, people chose to come into the public resting area and took a rest with some drinks. The location of the community centre's office was indeed convenient for people. They could come for consultancy and do their shopping together in one building.

After the lunch break, the hygienist guided me to the second floor, the activity room of the community centre. The event in the afternoon was called '*yuzu kafe*' (yuzu coffee). This project was to promote preventative care in the community, conducted for old people living with dementia, family members, and people whose work or life related to taking care of dementia patients. Anyone could attend this event for free. Local volunteers came to support the process from the local welfare university (*fukushi daigaku*); these are people planning to work in the care industry after graduation. They wanted to accumulate the first-hand experience of interacting with the elderly from this event.

Around 2:30PM, the elderly gradually came into the activity room. Some of them greeted each other, it seemed that they had known each other for a while. The hygienist sat among them and communicated with each guest. Each attendee received a pamphlet about how to face and prevent dementia. The pamphlet used

straightforward language and vivid pictures to explain the early symptoms and what the family should do if they discovered dementia. One of the volunteers led the group in a game. The whole process had a relaxed and happy atmosphere. I talked to an old man who looked around the same age as my grandfather. He told me initially he was reluctant to join such an occasion because he felt he was not needed by society anymore. However, after occasionally attending such an event, he realised he was still a community member. After communicating with other older people and staff in the community, he did not feel he was confronting ageing alone anymore. In turn, he would intentionally get in touch with his old neighbour to see whether they needed assistance.

The last part of the *Yuzu Kafe* event was a *kotsu kotsu kyōshitsu*[44] exercise class for whole body movement, aiming to enhance muscle movement and utilisation of the brain for the elderly. The community centre had asked a professional trainer to come. The attendees could stand or sit according to their physical situation. This activity also helped to reduce the feeling of loneliness, facilitating friendship among attendees, in addition to all the other events conducted in the community centre.

The centre also organised such exercise classes across the community, called '*iki iki kinryoku kyōshitsu*'[45]—these are designed with the preventative-care purpose of slowing down the physical weakening process in old people. These exercise classes are conducted in 24 public halls (*kōminkan*) or assembly halls (*syukaiba*) in the community. Their aim is to improve muscle flexibility and stretch the body for sustaining daily function; the classes also act as social opportunities for this group of people in the community.

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[44] *Kotsu kotsu kyōshitsu*,コツコツ教室, *kotsu kotsu* describes someone does something steadily with effort.
[45] *Iki iki kinryoku kyōshitsu*,生き生き筋力教室, training class for building sturdy body, *ikiki* means healthy, sturdy, lively, vigorous.

K-san attended the event, but rather than chatting with the elderly attendees all the time, *K-san* talked to colleagues working in institutions providing dementia care in the community. They exchanged ideas on services in some beneficiaries' cases.

After the *'Yuzu kafe'*, I was able to interview *K-san* in the meeting room. She gave me approximately one hour to talk about my research questions. She also shared insights into many aspects of being a centre-based care manager, beyond my research questions. I will include the factual information in the next section of empirical findings. After the interview, official work hours were finished, and the consulting window closed. However, *K-san* still stayed in the office to do her work, since she had not completed all documentation that had arisen that day. I sincerely appreciated her making time for me during such a busy schedule.

In conclusion, this case study explores the community centre-based care manager by looking at the work conditions of *K-san* alongside the interview with her. In the same way as in previous case studies, I did my field observation and interview together. The process was similar to the first case study of the facility-based care manager. I observed without participation in the workplace, and conducted interviews afterwards. However, in contrast to the research process in the case of facility-based care manager (in which I watched the work situation for the whole day, and did interviews with the care manager and her colleagues afterwards), in the case of the community centre-based care manager, I observed without participation first, then was allowed some limited participation to experience their work, and then finally undertook the interview with the care manager. The non-participative and participative observation created a good foundation for me to understand the role of the centre-based care manager, and the semi-structured interview after that helped me understand it in a more profound and broad way.

6.1.3 Interviews and Empirical Findings

K-san scheduled my interview as part of her work that day, which I appreciated deeply. Although I had already read some articles and reports regarding the role of community-centre based care manager, getting in touch closely, using my eyes and ears, was a vivid way to experience the detail.

A centre-based care manager confronts two groups at *individual-to-individual* level: the beneficiary and local care managers. The centre-based care manager is responsible for making care plans for *assistance required* elderly people, and at the same sharing advice with local care managers when they face complex cases without proper solutions. In regard to work relationships at the *individual-to-institutional* level, *K-san* mentioned her experiences and dilemmas across three layers: with the affiliating institution; with the municipal institution; and with other related institutions (including containing care management agencies, medical institutions and service providers).

6.1.3.1 Summary of Interview questions and answers from K-san

インタービュー問題と回答のまとめ

<table>
<tr><td colspan="2">Past career experiences before becoming a care manager and the impact on the present work ケアマネジャーになる前の仕事経験及び影響
Female Direct Care Manager in the community centre, 21 years of history in the care industry
Consulting cases over 10,000
Care Worker > Care Worker + Social Care Worker > Agency-based Care Manager > Centre-based Direct Care Manager</td></tr>
<tr><td>Individual-to-</td><td>issues extracted from the relationship with the beneficiary and their family members 利用者・</td></tr>
</table>

<table>
<tr><td rowspan="2">Individual</td><td>家族との関係
• Various problems beyond elderly care
• Taking time to give detailed / specialised advice
• Managing complex cases</td></tr>
<tr><td>• issues extracted from the relationship between centre-based direct care manager and agency-based care manager
• 主任ケアマネと地域における居宅ケアマネ
• Providing valuable guidance
• Avoid hierarchic attitude between senior and junior</td></tr>
<tr><td rowspan="3">Individual-to-Institution</td><td>• issues extracted from relationship with their affiliation 包括センターと
• The challenge in tackling complex family cases</td></tr>
<tr><td>• issues extracted from relationship with municipal office 市役所との関係
• Lower payment for each yōshien care plan than yōkaigo, but same time-cost almost same
• More effort from municipality in construction integrated care</td></tr>
<tr><td>• issues extracted from relationship with medical institution and service providers
• 医療機関・サービス提供者との関係
• Enhance collaboration in treating dementia
• Reduce the communication time-costs if possible</td></tr>
</table>

K-san took two examinations to become a certified care worker (*kaigo fukushishi*) and social care worker (*shakai fukushishi*), before becoming a care manager. When she worked as a care worker, she felt she wanted to learn more about the whole system of the care industry in Japan, and to learn how care staff connected to sustain the operation of the LTCI. Therefore, she trained as a social welfare worker

at the same as she trained to become a certified care worker. After working as a licensed care worker for seven years, she became an agency-based care manager. Although she did not work as a facility-based care manager, she worked as a care worker and served the elderly at home and the facility, so she understood the facility-based care manager role. Her training in social care helped her pass the exam as a care manager. *K-san* said working as an agency-based care manager enabled her to utilise her social welfare worker knowledge. She had already become familiar with community resources and related institutions before becoming an agency-based care manager. After working as an agency-based care manager for six years, she became a direct care manager in the community centre after the previous manager retired.

Regarding the work relationships at the individual level, she indicated that a significant difference (compared to the other two types of care managers) was the variety of consulting cases. For the facility or agency-based managers, most cases were directly related to elderly care and utilisation of the LTCI system. As a centre-based care manager, she received all kinds of questions from the community if they were related to the elderly. Replying to all these needs in a timely fashion was her responsibility. I asked her to give me some concrete examples to understand what kind of cases she received:

> *From my work experiences, the question being frequently asked is whether their parents need the LTCI service right now. For example, yesterday, a 58-year-old housewife (A-san)—her father had already passed away, her mother then had a stroke and became partially physical disabled. Her mother was discharged from the hospital after one-month medical treatment. As an outpatient, A-san wondered whether her mother needs the service from the LTCI. In this case, I have to explain my knowledge and detail of the LTCI to her, such as how to apply for the LTCI and the difference between home-based care and facility-based care. Also, I have to teach her*

how to search for care homes online, and gave her pamphlets about the care management agencies in this community. After deciding what service is best for her situation, I will contact a care manager who can take charge of her case.

*[Another kind of case is similar to today's, in which]… the welfare commissioner came for consultancy for an old man who might have early dementia symptoms and lives in her district. Yesterday there was a woman in this community who came to ask me the same question. She lives in a collective apartment (*shūgō jūtaku*)[46]. She did not see her neighbour as usual for a week. In this case, we immediately contacted his family and arrange a visit next week.*

As well as family members and neighbours, many elderly people themselves come to consult with me. For example, a 78-year-old woman came to ask me how to adapt to her life in this community. Her husband passed away several years ago and then she chose to live independently. Her son was concerned about her, and asked her to move to this area to live with him and his wife. She came for the first time to live in this community and did not know anyone. She wondered how to make friends, and so she came to the community centre. Her question was similar to the one from the welfare commissioner today. I introduced her to the different events we hold for the community.

Another example was a 75-year-old man, he fell from the stairs of his home and fractured a thigh bone. He received surgery and rehabilitative treatment in the hospital. As an outpatient, he found he could not manage by himself in many ways. Therefore, I suggested he immediately use the LTCI. He began to use a home helper the following week after consulting with me.

[46] Independent living in private rooms with some shared communal spaces.

*… Another older woman noticed she felt sleepy continuously for several days. She asked the family doctor (*kakaritsukei*) and the doctor suggested having more rest. However, she still felt a bit concerned and asked me—I recommended to her to go to the hospital. On the same day, she was diagnosed with vascular malformation in the brain. Fortunately, she found it in an early stage and received timely surgery. She has fully recovered now.*

(K-san, 48, Female, Centre-based Direct Care Manager, Tokyo)

I asked *K-san* about the reservations many elderly people have in Japanese culture about publicly expressing their needs. Her response:

Exactly, people definitely have personal characteristics, but the Japanese 'enryo'[47] *culture is rooted in people's hearts. Our job is to find if there is an elderly person living alone who will not go outside (*hikikomori).[48] *If so, we will visit them in person, and convey the message that we care about them, there are still people giving them attention. At first, they might refuse on surface, but gradually, they will open a space for connection.*

K-san, 48, Female, Centre-based Direct Care Manager, Tokyo

I asked whether *K-san* had experienced any extreme case in her work. She told me about abuse cases:

I cannot say it is extreme. However, what I want to say is not so unusual: the abusive case. Intentional abuse is rare. But it often happens when the care provider is overwhelmed by the care burden. For example, once a lady came to consult, she heard the sound of breaking plate and bowls at her

[47] *Enryo* 遠慮—the literal meaning is holding back, reserved, discretion. It represents a common cultural sense in Japan to keep personal boundaries, not to cross other people's boundary causing trouble, and maintain a discreet attitude or hold back from other people.
[48] *Hikikomori* 引き籠り is social withdrawal, shutting oneself inside home and avoiding contact with society. This phenomenon not only exists in elderly care, it is also widely seen among young people.

neighbour's. She found it strange, and came to the community centre. We investigated and found the elderly person's daughter was too stressed to take care of her mother every day at home, so she threw out all the plates and bowls. Ultimately, we arranged a meeting with her care manager and transferred the old lady into a facility.

K-san, 48, Female, Centre-based Direct Care Manager, Tokyo

A centre-based care manager usually tackles the complicated family cases, and therefore they confront a large variety of personal traits in their work. *K-san* said she already tackled many people when she worked in the agency. However, the agency-based primarily dealt with the cases of care level at *care required* level. When she faced a complex issue, she asked for help from the direct care manager and could avoid the final responsibility of making a decision. As a direct care manager, she cannot throw a case to anyone else anymore. She must be the person to decide. This was a challenge for her during the early years of her career.

Again, differently to the facility-based and agency-based care managers, the centre-based direct care manager not only deals with beneficiaries as individual interactions, but also interacts with local care managers. *K-san* said they held the local care meeting (*chiiki kea kaigi*) several times each year with other care managers, gathering the local care managers together. In this meeting they analyse and exchange ideas on a specific case or project. Discussing the solution by combining local resources, this approach also helps local care managers become familiar with the local resources, and broadens their sight in considering a particular case. In addition to these gatherings, *K-san* also responds to care managers daily, if they have any difficulties in dealing with beneficiaries.

I felt helpless when I did not know how to give an appropriate answer to a

difficult case. Whenever I was called 'shunin'[49] *by the younger care managers, I felt a little bit guilty. For example, in the last local care meeting (*chiiki kea *meeting), some care managers said 'I don't see what* 'hōkatsu' *(the community centre) is doing in this case. I replied, 'that's why we get together today to discuss'; the care manager said 'we (agency-based care managers) are already very busy, this is your centre's responsibility... I felt frustrated when I faced such a situation. It is impossible for a direct care manager to reply to any case perfectly. I know there is also space for my development in my career. When I was an agency-based care manager, I was already overwhelmed by the cases in front of my eyes, and thought the community system did not relate to me much.*

K-san, 48, Female, Centre-based Direct Care Manager, Tokyo

K-san also underlined the realities of the direct care manager compared to the agency-based care manager:

*Agency-based and centre-based [managers] are practically different regarding the core tasks in work. Although, to be honest, the government wants us to set up a local comprehensive care system or integrated care (*chiiki hōkatsu shisutemu*) in the community, this relies strongly on the agency-based care manager. They get in touch with beneficiaries more than us in the centre; they are the professionals in the agency, and they are also closely connected with the local service providers. However, the current problem is that they are already exhausted in completing the care plans at hand.*

Maybe you think the direct care managers have fewer care plans and do more management. They still do the same amount of care plans but have to

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[49] *Shunin*,主任, means direct, senior.

> *do more administrative work in reality. When I was an agency-based care manager, my work situation was like this… when I went to a beneficiary's home who lived alone, on the way to his home, I confirmed with a pharmacy that they delivered the medicine to another beneficiary's home, and got a registration ticket*[50] *from a hospital because the location was on the way. These things happened quite often…I was not an obedient (*goyōkiki*) type of care manager, but it would be [more] effective to give a hand like that instead of calling a helper, arranging the time and waiting until the helper could come… what I experienced as an agency-based care manager helps me understand what other agency care managers are thinking right now... I understand their low incentive in getting involved in the construction of the integrated care system—actually they want it, they think it is a meaningful thing, but they don't have enough energy and time.*
>
> *K-san, 48, Female, Centre-based Direct Care Manager, Tokyo*

As a centre-based care manager, *K-san* pointed out the two layers in work relationships at the *individual-to-individual* level. The first layer is the connection with the beneficiary. The significant characteristic here is the variety of the problems. It requires adequate experience and the ability to respond quickly. (The need for this characteristic is the real challenge). The second layer is the connection with the local care managers. *K-san* faced an emotional dilemma in her work. On one hand, she felt helpless when she could not find the perfect solution. On the other hand, she had to encourage the care manager to be more active in building community as the direct care manager. She understood other care managers' positions because she had the same experience as them. But when she

[50] Registration ticket 診察券: the personal profile contains the information of a patient, such as phone number, the previous time of visiting the hospital or doctor, and other record related the person's medical information. The purpose is to help the hospital or clinics to reduce administration time. They were paper records long time ago, right now they are IC cards or in other digitalized forms.

took a leadership position, she had to balance her professional relationship with them, with this in mind.

Regarding the individual-to-institutional level of work connections, *K-san* firstly mentioned the same problem emphasised by other care managers about the complicated paperwork required for submission to the municipality. In addition, she said the biggest problem for the centre-based care manager was the low payment for creating care plans at the *assistance required* care level. For one such case, the payment was approximately one third of[51] the payment for a *care required* case—however, making an *assistance required* plan took almost the same amount of time as a *care required* plan. Creating an *assistance required* plan requires an initial visit, assessment, monitoring, service provider meeting, and records of the assistant process. In addition, a centre-based care manager also needs to respond to the consultancy at any time if the elderly person needs them; assist the elderly person to visit hospital if necessary; adjust service if required; finish forms for the internal administrative work in the community centre; correct the plan and re-submit it. *K-san* said that a lower payment for almost the same amount of work is a challenge most centre-based care managers feel.

Considering *K-san*'s case as an example, she can receive around 4,000 JPY for each *assistance required* care plan. For other service items, 4,000 JPY can pay for:

- *Up to one hour of personal care (shintai kaigo) from a home helper;*
- *Up to thirty minutes of visiting nursing assistance (hōmon kango);*
- *Between 3-4 hours of day-service.*

K-san said the payment for each *care required* plan was around 10,000–20,000 JPY.

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[51] In Japan,介護報酬 (payment for service delivery) in LTCI system, the calculation standard of each level of care service varied according the type and scale of the facility, but the payment gap between *yōshien* and *yōkaigo* was large regardless of other factors. According to the latest data from 2021 version of payment calculation 改定 2021 版介護報酬ハンドブック, *yōshien* was 438 units 単位、level 1 of *yōkaigo* was 1076 units 単位, one unit costs 10JPY, then *yōshien* was 4380 JPY, *yōkaigo* level costs 10,760 JPY (the number of unit varies according to area, type of agency, scale of agency).

Therefore, no matter how much the municipality wanted to reform policy to reduce the burden on centre-based care managers, agency-based care managers responsible for *care required* care plans will be reluctant to receive *assistance required* cases. The agency are likely to reject these, since even the present payment for *care required* care plans is not enough — but it is sufficient to sustain agency operation.

From *K-san*'s perspective, several aspects of current policy need reform, for centre-based care managers to achieve better work efficiency: first, the *assistance required* form is too complicated. The care manager has to fill in the same points repeatedly on different blank columns in the file. Making the conditions concise and simple is crucial. *K-san* returned to her office and brought one paper form back to me, a green sheet. She pointed to the blank columns and said:

> *See? Regarding the intention of the beneficiary's family (honnin kazoku no ikō), here and here, in two places, actually it is not necessary to separate it like this... Regarding the issue (kadai), two columns, they can put together originally…and the purpose (mokuhyō) has four places on the same page, it is totally not necessary…*
>
> K-san, 48, Female, Centre-based Direct Care Manager, Tokyo

When I looked at the sheet, the different columns indeed include repeated meanings. Categorising the columns is helpful to look at the information; however, overly-complicated categorisation is unnecessary, since many similar purposes of columns could be combined together. Simplifying the form could vastly reduce unnecessary work for the centre-based care manager.

Regarding connections with the medical institution and service providers at *individual-to-institution* level, *K-san* explained more about the integrated care in the community. The local comprehensive care/integrated care system (*chiiki hōkatsu*) has been a buzzword for elderly care in Japan. *K-san* explained '*Hōkatsu'*

to me, using her mother's example.

> *My mother was diagnosed with fourth stage Malignant Lymphoma in 2010. At the time, the doctor told me he was not sure she could survive through that year. Before she got the malignant lymphoma, her kidney had partly lost function and she had angina pectoris. She was 90 years old and diagnosed with terminal cancer—level 4 of care required. However, she insisted on staying at home. She was afraid of dying in an unfamiliar place. Therefore, I tried to create a home-based care plan for her. I was an agency-based care manager already at that time.*
>
> *At first, she even resisted the home helper. She did not feel comfortable when a stranger visited her house. However, the home helper was very careful and assisted her with a footbath that helped her swollen leg. Gradually, she began to accept the home-visit services. The welfare equipment specialist counsellor came and refurbished the home… they renovated the toilet so that she could sit and stand by herself. In addition, because Japanese houses are usually much smaller than in other countries, I put several chairs in specific positions. Thus, she can move from bed to toilet and kitchen by herself.*
>
> *In this community, our* 'hōkatsu' *system contained* 'kakaritsuke yakyyoku' *(family pharmacy) and* 'kakaritsukei' *(family doctor). The pharmacy sent the medicine necessary for my mom every two weeks. The family doctor came for blood collection and sent it to the hospital.* 'Hōkatsu' *also included the visiting dentist (*hōmon hakai*) and visiting dental hygienist (*hōmon haka eiseishi*). They helped a lot with my mom's dentures, enabling her to eat something delicious by herself in the last stage of life, which was a boon. The family doctor had learned the German language when he was in college; my mom had also learned German when she was young. They sang German songs together, which made my mom so happy. There is a medical treatment called musical therapy—it was the first time I realised the purpose of this*

therapy. Everyone has several musical pieces that hold meaning for their life.

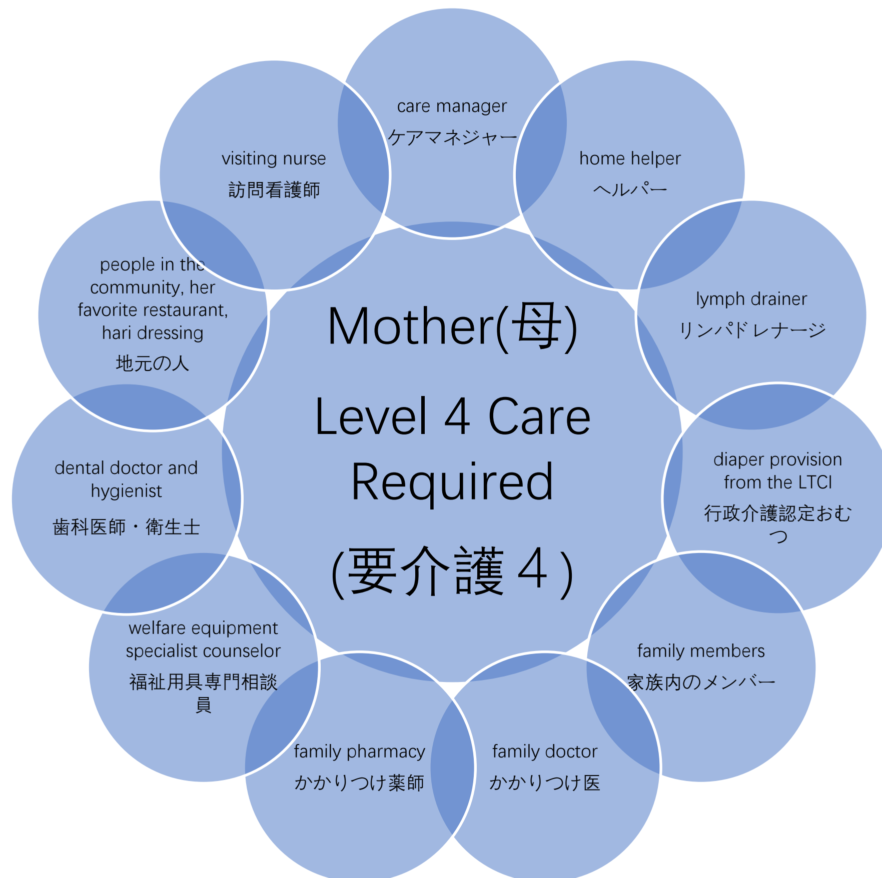
*My mom's catchphrase (*kuchiguse*) was always 'I don't want to die in hospital'. The family doctor pasted a paper of the emergency phone numbers on the wall. The first line was the doctor's number, the second line was the ambulance number. It was touching to see it. The family doctors always responded to my mom anytime when she had any problems. The family doctor himself puts effort into building visiting medical care structures. This component in the* 'hōkatsu' *system benefitted my mom significantly.*

Four years and ten months passed after my mom was diagnosed with fourth stage Malignant Lymphoma—she survived much longer than the doctor's prediction. In the eleventh month in the fourth year, her appetite reduced suddenly. After eating her favourite smashed mango and avocado, she could not defecate by herself anymore. She said her belly was painful. Then the visiting nurse in the 'hōkatsu' *system came home and did the stool extraction (*tekiben*) twice each week. My mom felt released so much. I was very grateful for this service. Three months later, my mom passed away, as her wish, at home instead of the hospital.*

K-san, 48, Female, Centre-based Direct Care Manager, Tokyo

According to *K-san*'s description, I created the chart below to show the local comprehensive system (*hōkatsu*) in her mom's community:

Figure 2: Example of a comprehensive community system (hōkatsu)



Source: Author

K-san said that the ordinary people living in the community were also vital to creating the whole *hōkatsu* system. *K-san* arranged for her own daughter to see her mother (her daughter's grandmother) at least once a month, and let them have a meal together. She also invited other family members to visit her. In addition, she brought her mother to eat outside (*gaishoku*) once a week. They visited their favourite restaurant in the community. The chef had known her mother for a long time. They could have a chat, to make her mother feel she still lived in the community, and that she was not just a *hikikomori*[52] elderly person at home.

After her mother passed away, *K-san* decided to become the centre-based direct care manager, because of the end-stage experiences of her mother. She wanted to

[52] *Hikikomori*,引き籠り social withdrawal, staying at home without contact with society.

contribute more to constructing the local system, since she felt she received great assistance from this system. *K-san* hoped it could become better for more people in the community. She then indicated the improvement in care provision regarding dementia is necessary.

> *People in the community gradually began to [understand] what dementia is. We also organised events in high school to let the young students know about dementia. As a result, either in their home or on the street, they could recognise that this elderly person seems strange, or it allowed them to have more patience towards the elderly people in their home. For the next step, we wanted to involve convenience stores into the* 'hōkatsu' *system, and activate a meal service delivery for the physically disabled people.*
>
> *K-san, 48, Female, Centre-based Direct Care Manager, Tokyo*

K-san mentioned it was not difficult to connect other institutions from her position as a community centre-based direct care manager. It took time to make contracts among different institutions—allowing all sectors to collaborate efficiently requires a significant amount of time in conversation and negotiation.

6.1.4 Case Study Summary

This case study explores the community centre-based care manager, by exploring *K-san*'s work through field observation and in-depth semi-structured interview. I visited her workplace to watch her work routine. For half of the day, I stayed out of the official work area and made non-participant observation. The rest of the day, I participated in the event held by the community centre, which gave me a direct opportunity to understand more about *K-san* and her team's work. I also conducted an interview with *K-san* with prepared research questions; she also shared much more information, beyond my expectation.

In the same way as the facility-based and agency-based care manager, a centre-based care manager confronts two layers of work connections. At the *individual-*

to-individual level of interactions, a centre-based care manager interacts with both the beneficiary and the local care managers. At the *individual-to-institution* level of connections, a centre-based care manager deals with not only the municipality, medical institutions, and service providers, but they also deal with more institutions than facility-based and agency-based care managers.

In *K-san*'s case, the challenge at *individual-to-individual* was the vast variety of people including beneficiaries and local care managers. She felt guilty if she could not offer good advice on complex cases, and at the same time, she had to be a senior guide to new care managers. At the *individual-to-institution* level, she suggested the thorough and innovative policy reform to reduce the work for *assistance required* care plans, and how to distribute the tasks in a constructive way, to allow more time in establishing the local '*hōkatsu*' system. She saw that the municipality could take more responsibility in forming the networks from local institutions, practically promoting the local care system, instead of relying on the community-centre for everything.

6.2 Facility-Based Care Manager Interviews

K-san has worked in the care industry for 21 years—almost the same length of time that the LTCI system has been in place. She worked as care worker, welfare social worker and agency-based care manager before taking her present position. The length and variety of her working experiences assists her current work. In addition to studying her, I also undertook in-depth semi-structured interviews with other two centre-based care managers. *M^2-san* is a female direct care manager from Miyagi Prefecture and another is *W^2-san* working in Tokyo:

- *M^2-san, 46, female, Direct Care Manager, Miyagi Prefecture*
- *W^2-san, 41, male, Direct Care Manager, Tokyo*

6.2.1 Additional Interview Findings

M^2-san (46) was a nurse before becoming an agency-based care manager. She had

two reasons for transferring from the hospital to the care agency: to take care of her young children at night, she could not work at night; the other reason was her personality. When she was a nurse, she used to work together with the care manager. She found she quite enjoyed the process of getting touch with different people and moving around in the community. Therefore, she finally took the exam and became an agency-based care manager, and then worked as a centre-based direct care manager.

Looking at the work relations at *individual-to-individual* level, *M^2 san* (46) also indicated the variety of beneficiaries she had to face. She joked that the community centre was like a general trading company (*sōgō shōsha*) for complex cases. Easy cases did not come to the centre. At the same time, she also had to deal with a large amount of *assistance required* cases. There was a saying that the community-based centre was virtually a preventative care plan centre.

In addition, regarding the work relations with local care managers, she pointed out that 'sharp eyes and soft attitudes' were vital in promoting local projects with them:

> *I worked as an agency-based care manager, so I understand their thoughts and concerns. Care managers are from different backgrounds; their intellectual ability and practical experiences varied. Therefore, when I gave the guidance, I had to understand the personality well, otherwise the other person might easily feel I was taking a position of looking down at them (*ue kara no mesen*); [I had to avoid] being authoritative, instead being like a big sister would be more helpful in communication.*

M^2-san, 46, female, Direct Care Manager, Miyagi Prefecture

In terms of the work contents at *individual-to-institution* level, *M^2-san* mentioned the same problem as *K-san* in regard to the necessity of reducing the workload of creating *assistance required* care plans. When she looked at the problems of her

position regarding municipal policies, she said:

> *There is always a gap between the slogan of the policy on surface and the difficulty in promoting them in reality. The policy suggested our roles in the community: zero rate of people leaving the care industry (*kaigo rishoku zero*); enhancing the local comprehensive care system; not rejecting any person's consulting case. They all sound beautiful on the surface. However, the workload soared way beyond our limited time. If we cannot extend the current time length, it is inevitable that we must reduce the time spent on each case, and thus impact the work quality.*
>
> *For my job, I also have to tackle: building the local network; comprehensive consultancy; local care meetings; individual guidance towards specific care managers; response and assistance for complex cases; organising exercise classes for elderly people's health; a communication salon for local people; and collective assistance for primary-stage dementia patients. At the same, I am pushed by many assistance required care plans. Genuinely, it is impossible to finish each task perfectly.*
>
> *You perhaps already knew that right now in Japan, the care industry work force is far from enough. Especially with the number who are becoming care managers reducing year by year, against a background of depopulation in society. Young people are also reluctant to become involved in the care industry, unless they really like this job. To the secular eye, it is a 3K (*kiken*: dangerous;* kitanai*: dirty;* kitsui*: stressful) job in Japan.*
>
> *M^2-san, 46, female, Direct Care Manager, Miyagi Prefecture*

M^2-san also highlighted the workload in creating *assistance required* care plans:

> *It is impossible to distribute the assistance required plans to agency-based care managers. I was there and I know how busy they are. They will not*

accept assistance required because of the low payment for each case, and also the lack of time during an already busy schedule.

*Consequently, from my point of view, there are only two solutions: increase the payment for each assistance required care pla,n from the present average 4000 JPY - 8000 JPY ~ 10000 JPY, or reduce the work amount of the assistance required care plans. In addition, try the best to cut down unnecessary work. For example, we could organise a service provider meeting (*tantōsha kaigi*) only once at the beginning—discuss and make clear decisions. We [then] only need to contact each provider to adjust if there have been subsequent changes. Also, the documentation for the care plan can become more concise and simpler, so that we can reduce by half the time needed on filling in repeated messages.*

M²-san, 46, female, Direct Care Manager, Miyagi Prefecture

M²-san also suggested bold and innovative reform is needed for centre-based care managers:

We do not have enough time to create a comprehensive system well if we continue to keep the current situation. Every year, new care managers decrease, and current care managers are getting older. Many people know the Japan is ageing and is a low-fertility society. Actually, what is going on in the Japanese care industry is just the epitome of the larger society.

M²-san, 46, female, Direct Care Manager, Miyagi Prefecture

M²-san did not feel many challenges when she worked with the medical institution and service providers. She said patience and time were needed to build up the collaboration required for a local *hōkatsu* system. She was a nurse, and therefore she could utilise and connect with the medical team better than other care managers. Her job as a direct care manager was to make other care managers

easily connect with medical staff, and find proper service providers for their beneficiaries.

W^2*-san* (41) worked as a home helper, a care worker in a facility, and as an agency-based care manager before becoming a centre-based direct care manager. Regarding work at *individual-to-individual* level, W^2*-san* also mentioned the same problems as *K-san* and M^2*-san* in relation to the beneficiaries and local managers respectively. In regard to giving guidance to other care managers, W^2-san emphasised the importance of accumulating actual experience as a care manager. The backgrounds of care managers may vary from medical staff to care workers, such as nurses, facility care workers, or nutritionists. They pass their exams by learning from books. However, this is not enough for practical cases.

> *Responding to cases fast and flexibly is vital for us. I mainly assisted new care managers in abusive cases… For example, once, a care manager and I visited a family where we suspected there were abusive actions… when the door opened, the son of that household showed an impatient (*iraira*) attitude, [and I perceived an] unusual atmosphere… We cannot give an evaluation from someone's facial expression only, but if we have accumulated enough sensibility from similar cases, we still can sense something in very short interactions—not just 'reading the air' (*kūki o yomu*), but also the nuances between the family members…*
>
> *In addition to cases of possible abuse, I also assist junior care managers in* 'hikikomori' *cases. In such cases, even waiting for [beneficiaries] to open the door takes time and patience… For example, first, when we knock at the door, we only expect that they might open the door and just said hello. The next time, maybe we can say hello standing at the entrance with the door fully—step by step. The [beneficiary] may gradually think: 'this is not a bad person'. Then they slowly open their space for us. All of these issues need courage, patience and flexibility.*

W^2-san, 41, male, Direct Care Manager, Tokyo

In terms of individual-to-institutional level relations in his work, *W^2-san* also complained about the excessive *assistance required* care plans and unfair payment. In addition, he shared his insights into building a local comprehensive care system *hōkatsu* based on current local resources, which I found meaningful for the present institutional structure, as well as possible innovations for the LTCI in future.

Firstly, *W^2-san* thought that increasing the number of welfare social workers would be useful to building up a more efficient local care system. There are several social workers working in the community-centre or related medical institutions in the community at present. *W^2-san* said this was not enough. Home-based care management agencies, especially, seldom have connections with social welfare workers. *W^2-san* perceives the situation right now to be close to 'all the work is loaded on the care manager's shoulder' (*nandemo keamane*). *W^2-san* identifies welfare social workers as the group of people most familiar with local resources. Therefore, activating their role would help agency-based care managers utilise local networks more effectively, and no longer have to seek the resources by themselves, or come to consult with the community-centre every time. *Hōkatsu* needs connection and collaboration. Encouraging the development of social welfare workers might become a possible approach to build the local elderly care system most effectively.

Secondly, *W^2-san* indicated one of his sincere wishes was to improve the collaboration on the home-based terminal care. He said most elderly people would like to stay at home for their last stage of life. Some may live in the hospitals or facilities in their last moments; but some may get weak quickly and not have time to transfer to other places already. A timely response to the elderly person who might pass away at home is necessary. It costs time to combine different actors (such as family doctors, family pharmacists, visiting nurses, helpers, social workers and care workers), to form a team to respond 24/7. How to weave these

different positions with limited budget, yet create a high impact, is a challenge. However, from his perspective, *W^2-san* thought it is worth conducting such a project in the long-term for the community.

6.2.2 Interviews Summary

Interviews with *M^2-san* and *W^2-san* supplemented the data in regard to centre-based care manager’s work. They conveyed their personal stories, and helped me grasp a clearer and more complete picture of this group of care managers. In the same way as *K-san*, they both raised their hopes for future reform on *assistance required* care plans, including a more concise administrative process and possible increase regarding payment. They also discussed the personal challenges in supporting junior care managers regarding guidance and cooperation. In each community, the centre-based care manger is expected to have the ability to gather various local resources effectively. Therefore, they also need to have an overarching view of local resources and consider the proper approach to activate each sector. The care manager is seen as the bridge between LTCI system and the beneficiary—the centre-based care manager acts like many bridges, including the bridge between the community centre and various local institutions.

6.3 Conclusion

This chapter explores the community centre-based care manager in the LTCI system through a case study on *K-san* accompanied by in-depth semi-structured interviews. The purpose is to explore the centre-based care manager’s work, to understand the role and examine the practical problems therein, and to understand their dynamics within the LTCI operation.

In the case study of the centre-based care manager *K-san*, participant and non-participative observations formed the overarching background to seeing her role inside the centre. From field observation and attendance at an event, I obtained a vivid picture of *K-san*’s working environment and tasks. Before visiting and seeing

by myself, I had only heard about '*hōkatsu*' through the media and books, and did not understand how it really worked. Introduced by *K-san* mother's case, I began to have clearer image of this concept. *M*[2]*-san and W*[2]*-san* received my interviews outside of their workplaces. They replied to my questions and mentioned even more than I had originally asked. The informal environment of the interview (instead of being in the centre) perhaps allowed them to feel more relaxed and enabled me to perceive more of their personal traits.

The care manager works both like a bridge, and as a director in a movie. They arrange different actors to play together for the drama on the stage. The centre-based care manager is the director of the directors. As a servant to individuals, they deal with diverse *assistance required* level beneficiaries, and also provide guidance to the local managers in complex cases. As a servant to institutions, centre-based care managers are responsible for transforming the institutional structures by improving the local *hōkatsu* system. However, they suffer from the problems existing inside these institutional structures. The overly complicated administrative forms make care plans unnecessarily time-consuming, but with only low payment. Moreover, overwhelming complex and urgent cases coming to the centre require them to take the responsibility on behalf of other more junior / less experienced care managers.

In 2025, the baby boom generation (*dankai sedai*) will exceed 75 years old, and the elderly living with dementia who need daily assistance and care are predicted to increase to over 7,000,000 (Baba. T; 2015). It is impossible for all the elderly in their last stage of life to be cared for in a facility or hospital, due to these large numbers. Therefore, home-based care and even terminal-care provision will become extremely important for future development in the LTCI. In ideal terms, elderly people living in the community should receive any necessary service within 30 minutes, according to government policy. However, the practical construction of a local fully integrated care system need time and planning. This is

a main purpose of the centre-based care manager.

The concepts of ‘living’ (*sumai*), ‘iryo’ (*medication*), ‘elderly care’ (*kaigo*), ‘assistance in life’ (*seikatsu shien*) and ‘preventative care’ (*kaigo yobō*) form the package for building the *hōkatsu* system. The centre-based care manager has an important function in knitting the networks for this package, using various threads. However, most of them are immersed in formulating *assistance required* care plans, and supporting other complicated cases for consultancy, with insufficient financial compensation. As a consequence, reducing their work burden in these areas, or redistributing their workload in a constructive way might be the key to speeding up the process of building a complete local comprehensive care system. *K-san,* M^2*-san* and W^2*-san* cannot represent all centre-based care managers. But from their problems and concerns, we can see the gaps between the policy and reality, and the relationship between individuals and institutions. Their roles and dilemmas in the LTCI will also become a reference point to analyse Chinese elderly care, in regard to establishing community-based elderly care under the LTCI. I will shift the attention to Chinese context in the next chapter.

Chapter Seven: The Transferability of the Japanese Care Manager Role into the Chinese Context

7.1 Background to the Chinese LTCI and Labour Market for Elderly Care

In the same way as Japan, China is undergoing a demographic shift at present. The first of the Baby Boom generation, born around the 1950s and 1960s, will move into old age in 2030. According to the China Development Report 2020, people over 65 will make up 14 per cent of the population. It is predicted that by 2050, around 500 million people will have surpassed 65 years old in China. This process of becoming an ageing society has taken just 22 years in China, compared to France and Sweden in which the ageing process took 115 years and 85 years respectively; other developed nations have also been much slower in making this transformation.

However, despite repeated government reforms of reproductive policies to allow the 'one-child' generation to have two children or even three children since 2021, this policy change has not changed younger generation's attitudes towards family planning much. Most young people are retaining a conservative approach towards marriage and children. This is unavoidably leading to a fertility rate which keeps decreasing, similarly to what is happening in Japan. Against a boosted rate of ageing and decreasing fertility rate, China is urgently seeking an approach to solve the welfare agenda of elderly care.

The development of elderly care in China has been through several phases after the establishment of the current government. In 1953, elderly care was legally included in the welfare for the urban population, after the commencement of the Labour Insurance Regulations of the People's Republic of China. The publication of 'The Outline of Rural Development from 1956 to 1967' confirmed these same welfare considerations for rural elderly people. This was the primary stage of terms of state-supported elderly care in urban and rural areas. From 1999 to 2005,

the government focused effort on building nursing homes. For the first time in 2006, the importance of building up a comprehensive system in society to face the ageing issue of the whole population was highlighted. In the Government's 12th Five-Year Plan (2011-2015)[53], in the outline paper released by government, the '90-7-3' strategy was encouraged in China—meaning that home-based care should occupy 90 per cent of care towards older people; community-based care, seven per cent; and the remaining three per cent would be delivered through institution-based care. In 2016, China adopted the long-term care insurance system (LCTI) in the provinces of Shandong and Jilin, along with other 15 designated cities. The Chinese LCTI is in a trial phase and has not yet developed at a national scale.

With the initiation of the trial LTCI, integrated care (*yīyǎngjiėhė*)[54]—combining medical treatment and elderly care—began to draw wide attention in public sphere. Older people's need to mobilise support / care from family, the community, care centres and medical staff (hospital/doctors) frequently, especially for those people whose physical condition does not need to be hospitalised but still needs medical treatment and care services, resulting in strong calls to establish a comprehensive elderly care system in the community.

The general practice service or 'integrated care' has become a buzzword in the Chinese care industry in recent years. This concept arose to support the demographic of older people with chronic illness from ageing. Accommodating this group in hospital in the long term is a waste, in terms of medical costs and resources when there is already a shortage of beds for others needing hospital

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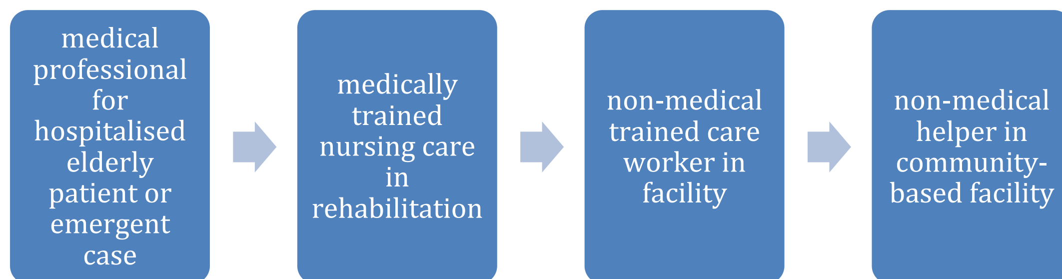
[53] The 12th Five Year Plan outline,第十二个五年计划纲要,
http://www.gov.cn/2011lh/content_1825838.htm
FYP is the blueprint released every five years, listing the goals and emphasis of the next five-year development of economy and society. The 12th FYP gave more attention to quality instead of growth rate, aiming to secure and ensure the improvement of quality of life for ordinary Chinese citizens.

[54] *yīyǎngjiėhė* 医养结合: in 2016,The National Health and Family Planning Commission and Ministry of Civil Affairs released the document of《关于确定第一批国家级医养结合试点单位的通知》initiated the first group of national-level standardised integrated care trial institutions.

treatment. On the other hand, current nursing homes do not have qualified medical equipment for dealing with emergent cases. As a consequence, hospitals are constantly facing an overload, similar to the 'social hospitalisation phenomenon' in Japan, whilst there is a large number of empty beds in nursing homes. (Li. D and Li. L P; 2022)

As noted previously, sustainable financial resources as well as an effective workforce are indispensable for elderly care delivery. It is labour-intensive work, and requires interdisciplinary collaboration between medical and nursing care providers. To construct an integrated care system, Li. D and Li. L P (2022) and Yang. X P, et al (2022) organised four stages comprising the whole picture of *yīyǎngjiėhė*; the former two stages focus on *yī* medical aspects, and the latter two on the *yǎng* nursing aspect.

Figure 3: Four Stages of Yīyǎngjiėhė Integrated Care



Source: Li. D and Li. L P (2022); Yang. X P, et al (2022)

Corresponding to the four stages, different qualified workforces are needed for each type of care. The research attention here mainly focuses on the latter two group: facility-based care and community-based care, in which the workforce is largely composed of uneducated or under-educated migrant workers and lay-off workers, as described in Chapter Four.

Unlike the viable career path seen in the Japanese LTCI system, from home helper

to direct care manager, the Chinese workforce for elderly care has not yet formulated a nationally standardised career path, according to the literature review and first-hand understanding from visits and interviews in China. Neither is there a mechanism like the Japanese care manager in the system yet. Therefore, my research curiosity was piqued to explore the possibility of establishing such a mechanism into the Chinese socio-economic and socio-cultural context. Although the two countries are varied in many facets, regarding political and social structures, there appeared to be a valuable discussion to be had on the functionality and transferability of Japanese facility-based, agency-based and community-based care managers to the Chinese system. Since the Chinese LTCI is operating within limited geographical areas, which cannot form a national-wide standardised service calculation, there is no home-based agency in the market yet as in Japan. Consequently, my focus is on the possibility of establishing care managers within community-based care and facility-based care in China. The discussion on institutional design considers the care manager's function in Japan, to discover whether the same function can be achieved within the Chinese system, and present an open-ended analysis of the potential for developing home-based agencies or other forms of home-based care provision.

7.2 Transferability of the Care Manager Role into Chinese Facility-Based Care

This section will reveal the present state of facility-based elderly care in China, and the situation of care workers working in the facility—posing the questions of whether it is necessary and possible to establish the position of care manager in a facility under Chinese specific context—by examining care worker role and dynamics inside the facility. My field observation and interview comprised first-hand data, using literature research for supplementary reference. After one year of fieldwork in Japan, I returned to China and contacted a facility that allowed me to visit and undertake interviews with the manager and care workers.

7.2.1. Current Situation of Facility-Based Elderly Care

Strongly impacted by Confucianist culture, the Chinese society has long considered that elderly family members should be taken care of at home (as part of a cultural principle of filial piety). Although modern industrialisation has gradually shaped cultural understanding, family-based care provision has remained the primary expectation for many families (Gui T H and Koropeckyj-Cox. T; 2016). Knowledge and research on facility-based institutions is increasing too slowly. Therefore, this discussion on the applicability of the care manager role into the Chinese context is meaningful both within academia and the care industry.

The need for facility-based care provision has become prominent since the whole population is ageing rapidly, whilst the workforce to support the elderly group are insufficient, mainly due to China's one-child policy. This has created a requirement for the development of facility-based care, as well as community-based care provision. Liu. C, et al (2015) states that, under the long-term familial culture sphere, several factors are making residential care facilities necessary for Chinese people: the increasing dependent older people due to loss of their partners, diminished family sizes due to the one-child policy, the rise of the 'empty-nester' family due to population mobility, and an unbearable care burden for the one-child carer, based on the '4-2-1' family structure.

According to Song. Y, et al (2018), the number of residential institutions has increased, and the rate of institutionalisation has risen from 0.5 per cent to 0.8 per cent respectively in 2002 to 2005, and 2008 to 2011. Song. Y et al suggests several aspects lacking in systematic design that has made the service quality of facility-based institutions in China questionable: a lack of regulation, insufficient funding, low staff-to-resident ratio, and a lack of training for care staff. Song. Y et al (2018) also indicates that most of the research on Chinese elderly care focuses on and elaborates three critical problems: the lack of standardised control in service quality and scope, staff training, and certification.

In past decades, facility-based care provisions were only allowed to admit the elderly who were childless, mentally disabled, or physically disabled without any support (Liu. C, et al; 2015). They were usually governed by social welfare institutions similar to Japanese social welfare corporations. With the rapid rising of the ageing group, the government encouraged the private sector to build residential facilities using different form of funding (such as PPP, PPI etc.). Local government may adopt various policies, including financial aid to the private sector, tax exemptions to some, and bed subsidies. Consequently, the private sector appears to be primarily responsible for the increasing rate of residential institutions for elderly care (Liu. C, et al; 2015).

Privatising elderly care in China has also brought 'hybridisation' in regard to service provision, according to Maags. C (2021). Maags. C points out that care providers might misidentify their ownership for financial and political reasons. Seemingly, privatisation spurred more autonomy in care provision. However, specifically in a Chinese party-dominated context, government still controls many aspects of the administrative process. This is agreed by several domestic scholars that it is necessary to research the privatisation in micro-level cases, rather than research to date, which has focused on gathering macro-level policy analysis (Wang. X, et al; 2020; Du. Y B and Tian. Y X; 2019).

On the other hand, in the public sphere, there were two-pillar systems: the social welfare system, governed by the department of civil affairs, and the medical care system that supported elderly care in China (Wu. B, et al; 2008)—which was quite similar Japan's situation of before the establishment of the LTCI. The department of civil affairs operated the care homes and veteran care facilities. The medical insurance covered related geriatric services in geriatric hospitals, rehabilitation wards and mental health hospitals, run by the medical system. The finance and workforce in social welfare system and medical system paralleled respectively before adopting the LTCI in China. Government expected that resources will

combine more efficiently after adopting the LTCI for developing institution-based long-term care.

In regard to the development of facility-based care in China, Wu. B, et al (2008) emphasise that a gap existed between urban and rural China, focused on institutional care in rural areas. Feng Z L, et al (2011:738) concentrate on institutional care in urban areas, using ‘growth, ownership, financing, staffing, resident characteristics’ as measures to depict development and pinpoint Beijing, Tianjin and Nanjing as focus for primary research (Nanjing was the city I visited for my fieldwork in China). Ownership and financing were seen as salient factors that defined the nature of Chinese institutional care, and these have significantly transformed in the past two decades (Feng Z L, et al; 2011).

Regardless of the rapid development of institutions for elderly care, many institutions faced a shortage of care staff due to the long working hours, heavy workload, low payment, and the emotional pressure associated with the work (Zeng. Y H, et al; 2019). The shortage of qualified care worker is the present major problem. Liu. T and Sun. L (2015) indicated that only 30 per cent of care staff had professional training in long-term elderly care. Especially in the western area of China, more than 60 per cent of elderly care institutions had no professionally qualified staff, and more than 50 per cent were not equipped with medical doctors. Additionally, there was a strong tendency for the facilities to reject elderly patients with a mental disability. Wu. B and Caro. G F (2009) point out the main reason for dismissing frail beneficiaries, or those living with dementia, was the severe lack of professional skills of the workforce in the care market. Despite the Ministry of Civil Affairs requiring each facility to hire care workers with a college degree, it has been almost impossible to reach this standard in reality. Zeng. Y H, et al (2019) investigated the situations of care workers in Zhejiang Province and discovered that most care workers were middle-aged women with educational degrees below middle school; only a small number had professional training before taking the job.

After reviewing 45 articles regarding the conditions of Chinese staff and nursing homes, Song. Y T, et al (2014) emphasise the importance of standardised regulation on the qualification of care staff and suggest an educational programme for care staff with lower levels of education.

Since the LTCI is still a relatively recent development and remains at a trial stage in many places, there is scant literature updating the situation after the LTCI was established. However, the lack of quantity or quality for care workers remains a significant problem after adopting the LTCI. To understand more about the current situation, I personally visited facility-based elderly care institutions in China to investigate further.

7.2.2 Facility-Based Care Fieldwork

This section will introduce the case studies of facility-based care institutions in Nanjing (Jiangsu Province) and Bengbu (Anhui Province). Nanjing is the capital city of Jiangsu Province. Bengbu is an inland city, which has lagged behind in economic development as well as societal constructions, compared with Nanjing. The main analysis is conducted around the case study in Nanjing, while the investigation in Bengbu supplements information regarding facility-based care.

Jiangsu province is located near Shanghai and belongs to the famous Yangtze River Delta, containing Shanghai, Jiangsu province and Zhejiang province. The Yangtze Delta is a triangle-shaped megalopolis, representing the economically developed area in China. In 2018, the Yangtze Delta had a GDP of US 2.2 trillion (comparable to Italy). In 2017, when I visited the facility, Nanjing had not yet operated the LTCI. However, they had initiated the construction of integrated care in some districts. The facility I visited can be seen as a representative case regarding the newly developed integrated care in China. Although integrated care in China differs from Japan in various aspects of development, they share the essential ethos of maximising medical care, specialised elderly care and other social resources to

establish a comprehensive care provision package.

When I was in Japan, I contacted Professor Zhang of Nanjing University, affiliated to the Nanjing University Business School, and who was working on solutions for the advancing ageing society in China. She came to Japan for research when I was in Tohoku. I was the translator for her trip, and since then we have maintained our connection as we have similar research interests. She let me know about a facility operating integrated care (*yīyǎngjiéhé)* and introduced me to Dr Zhou, the facility's founder, in order to conduct an interview and visit the facility.

This elderly care facility is composed of six floors, located in the *Saihongqiao*[55] community. This facility functions as a combination of a small-scale hospital and a nursing home, accommodating terminally ill elderly patients, and elderly people with physical disabilities, additionally providing primary medical treatment beyond nursing care. The district community health centre is located on the first floor. The community centre's function is to provide the elderly-care service within the neighbourhood, and assigning a family doctor to local inhabitants (similar to the Japanese *kakaritsukei*). Once a family has been assigned a doctor and paid the contract fee (50 RMB, or around 6GBP), they can receive the following services:

- *one free holistic annual health check for persons over 65 years old;*
- *one core health check for persons of any age;*
- *20 per cent discount for CT scans, holter monitoring, ambulatory blood pressure checks, colour doppler ultrasound;*
- *one appointment with a specialist doctor.*

The second and third floors comprise the medical examination centre, equipped with basic medical machines to provide health checks for residential beneficiaries and people living in the community. There is also a rehabilitation hall for elderly

[55] Saihongqiao community 赛虹桥社区 belongs to Yuhuatai District 雨花台区, one of the main eight districts in Nanjing.

patients. The third floor accommodated two particularly impressive features: an oriental medicine treatment clinic providing acupuncture, cupping therapy and massage; and an interfaith complex to provide for spiritual support to treatment; this formed from several rooms for prayer within different religious beliefs. The Christian room is decorated as a small church; the Buddhism room is equipped with Buddha statues, and the Hindu and Muslim rooms are similarly equipped with appropriate decor. This is a space for the elderly patients and their families to pray, meditate, or just be at rest when facing terminal illness and the accompanying complex emotions. Such a space is rare to see in a nursing home in China.

Figure 4: Interfaith Meditation and Prayer Rooms, Nanjing Facility

Source: Author

The fourth, fifth and sixth floors are for elderly patients' accommodation.

Dr Zhou is both the founder of the facility and a medical doctor. He noted that elderly patients, having reached the terminal stage, usually needed both nursing and medical care; few facilities could meet such requirements. Therefore, he left his job in a large hospital, and established this facility with local government support, supplying 80 beds. Dr Zhou's medical training provided him with an understanding of the necessary equipment for basic medical treatment, and the

required knowledge background for staff suited for different positions in the facility.

After touring the facility with Dr Zhou and Professor Zhang, I interviewed Dr Zhou, with Professor Zhang in attendance, providing her experience of visiting nursing facilities in Japan, and her understanding of the background to my research questions. Firstly, I introduced what I had learned, heard and saw in Japan, helping Dr Zhou understand the role of the Japanese care manager, and the reasons for my research. Dr Zhou introduced the facility, and the situation from his perspective, sharing his opinions on my research questions.

7.2.3 Nanjing Facility-Based Care Discussion and Findings

As already discussed, I analysed the functionality of the Japanese care manager by looking at the types of work they perform, and considering work connections at *individual-to-individual* and *individual-to-institution* levels, in three case studies of facility-based, agency-based and community centre-based care managers. Therefore, my exploration on the potential for transferability of the role needed to be considered in accordance with these same types of institutions in China, applying similar functions from one system to another. The Nanjing facility was the epitome of Chinese facility-based elderly care. Through in-depth interviews and facility visits, I came to understand the whole work team and the respective roles of each position.

In Japan, facility-based care managers take charge of making and adjusting care plans for the elderly facility residents. They are also partly involved in care provision along with other care staff, when the work amount is high and the workforce insufficient. Therefore, there is an ambiguity in the care manager's position within the facility, which can become a noticeable problem. Another dilemma for the facility-based care manager is their bilateral identity between the LTCI and the facility. They are supposed to scrutinise whether the care service is

being satisfactorily delivered by the facility according to the care plan; they are simultaneously affiliated to the facility, and thus occupy an invidious position if problems are discovered within the facility's processes.

Regarding the role of connecting with beneficiaries at *individual-to-individual* level, Dr Zhou explained that currently in Chinese facilities, administrative staff are responsible for collecting the patient information. When a patient comes to the facility, they bring their identity card and medical records. Since there is no national LTCI system in China yet, it is impossible to make a national standard to designate the necessary level of elderly care. There is a provisional standard to regulate the service standard and entry requirements. However, when it comes to specific individual patients, it is hard to make a clear ruling on whether or not to accept them.

> *Our facility [also] combines with the function of a small hospital and therefore can administer timely services for elderly patients. For most nursing homes, that do not have a direct association with a hospital, it takes time to decide a proper care plan. Rather than setting up the care manager role, the standardised evaluation of the elderly patients and pairing this with the corresponding regulations of service items are most urgent in the Chinese care industry.*
>
> *Dr Zhou, 52, Male, Facility-based Care, Director and Doctor, Nanjing*

Dr Zhou indicated that the difficulty in establishing a national standard in terms of service items was that there are vast gaps in the medical resources and eligibility of workforce in different provinces. In metropolitan cities, such as Beijing, Shanghai or Nanjing, it is relatively easy to gather various resources together to form a standard, and roll this out, because these cities have adequate financial resources and enough people activated in the care market. In the central and west parts of the mainland, there is a constant shortage in the labour force,

because large numbers of young people move to more economically developed areas to find opportunities; many inland cities are less economically developed than coastal areas. Consequently, it becomes harder to maintain a single universal standard, and thereafter, the development of elderly care depends more on the practical circumstances in the province.

In regard to being the coordinator between the facility and other service providers (in the same way that a Japanese care manager functions), Dr Zhou confirmed the necessity of having a role linking medical institutions and service providers. His facility already combines the medical and rehabilitative services, so this factor works well for those needing services beyond basic elderly care. However, most nursing homes do not have a direct connection with medical services. A coordinator providing timely interactions between the facility and medical institutions and service providers is important for any facility, and especially when the facility only can provide basic nursing services.

> *For nursing homes, the timely connection with the medical institution is crucial, because the elderly might be weakening physically in a very short time. Moreover, it would be better to have some services completed within the facility, such as some rehabilitative exercises, meaning the elderly person does not need to transfer to another place. The role of building up such connection with medical resources is basic for each nursing home. According to what I have known, each facility is asked to equip one staff member to do this work. However, most of them are not well-educated, or lack sufficient communication skills, or do not really have a strong incentive to promote such collaboration due to the time-costs [of doing so]… I would suggest the utilisation of care worker in facility-based care. Care workers have more experience in social work in the community; if they cannot work full-time, at least, they can work part-time in facility, which helps the facility to use all possible social resources to the maximum…*

Dr Zhou, 52, Male, Facility-based Care, Director and Doctor, Nanjing

The Japanese care manager's role of connecting with the municipality, medical institutions and service providers has been more or less fulfilled by the administrative staff in the facility in China, and the social worker from the hospital also assists in some cases. According to the existing macro and micro social environments and resources in the literature, as well as my personal fieldwork, referring to the opinions from Dr Zhou operating as a frontline worker in facility-based care, I would argue that it is possible to set up a care manager in the facility, bearing in mind its current limitations.

A care manager is a position requiring relatively high professional skill, experience in taking care of the elderly on site, and as being familiar with local resources. In fact, it is pragmatically difficult to establish a care manager in the facility in the short-term, since the care worker career path is not clear (unlike in Japan). Establishing an experienced care worker in the facility increases costs; additionally, there is no standardised system to qualify a person as a care manager. A person with a medical and nursing background and as social worker skills can be evaluated only from the professional resumé they themselves provide. These limitations challenge the possibility of applying the Japanese care manager role, nonetheless, Dr Zhou indicates that it is still worth trying to do so, in order to have a professional mechanism for facility-based care in China, and thereby making the role responsible for collecting personal information, linking local resources, and increasing more focused and efficient collaboration between different institutions.

Regarding facility-based care, I also visited a facility in Bengbu (the city where I was born) in Anhui Province in central China. An ordinary inland city, Bengbu significantly lags behind Nanjing in economic terms.[56] Due to the limitations of

[56] Nanjing GDP in 2021 was CNY 1635.532 bn, around GBP 196.264 bn; GDP per capital was CNY 174500, around GBP 20,940; Bengbu GDP in 2021 was CNY 198.9 bn, around GBP 23.868 bn; GDP per capital was

this thesis, I will not detail this visit in depth. I visited one nursing home that claimed to be the best equipped facility in the city—I was shocked by my findings.

The most obvious problem I noticed was the shortage of care workers. When I worked into a room, with the commode (see figure below) close to the door, I saw a lady was waiting for a care worker to change her diaper. She told me she had waited over half an hour for assistance.

Figure 5: Interior of Care Facility, Bengbu

Source: Author

On her right hand, there was another bed, occupied by another lady. Since the resident could not move, she could not use the commode; she told me that she and her neighbour in the next bed would do so if they were able to move independently or with assistance. However, there were not enough workers in the facility, so they

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CNY 60338, around GBP 7240. (National Bureau of Statics)

had to wait long periods of time for help, and the room became smelly, in particular in the summer months.

Figure 6: Exterior of Care Facility, Bengbu

Source: Author

As captured in

Figure 6, I was shocked to observe an old lady excreting outside the building, in front of a group of old men and women close by. Perhaps two metres in front of her was a window, through which I could see a worker preparing food for facility

residents. Having anonymised the identity of this person, I have included this image to illustrate the status of the residents in this facility. The worker inside the kitchen making meals; the lady outside on the commode; the group of old people several metres away, who appeared oblivious to the scene—these three groups seemed to be living in parallel universes, gathered as they were in a geographically small space, but living distantly from the world in front of them, without emotional connection to their surroundings.

If resources allowed, this research could expand to a wide-ranging project analysing the diversity in service provision across different areas in China. But to refocus on the research question of the transferability of the Japanese care manager role into Chinese facility-based care, according to my facility visit and conversations with its care workers—it is both possible and necessary to establish such a social mechanism. However, many issues are required to be resolved to create an effective policy package. Unlike Nanjing, with an adequate workforce in the care market, inland cities such as Bengbu first require a sufficient volume of adequately certified frontline care workers to sustain the basic operation of the facility. Thereafter, refining the quality of service delivery and management could only be considered once the fundamental needs are in place.

7.3 Transferability of the Care Manager Role into Chinese Community-Based Care

7.3.1 Current Situation of Community-Based Elderly Care

Against the previously mentioned '90-7-3'[57] policy background, seven per cent of care was set up to be delivered through community-based care in China. Although there would appear to be a wide gap between 90 and seven per cent, however, the

[57] 90 per cent of care towards older people delivered through home-based care, 7 per cent through community-based care; and the remaining 3 per cent would be institution-based care.

necessity of developing community-based care increased greatly after social transformations in the society, such as the growing 4-2-1 family structure[58] after the one-child policy decreased fertility rates, a large number of migrant workers moving into urban areas, and more female participation in the workplaces (Yang. Z Y, et al; 2020).

In addition, facility-based care has been mainly provided to old people on the basis of qualifying through the 'Three Nos'[59] in China. Along with the privatisation of elderly care, facility-based care was opened to larger range of people. However, facility-based care normally accommodates frail and physically disabled people. Community-based service delivery which includes more medical treatment but suitable for older people who can still live at home with some assistance is increasingly demanded by the market. The concept of community care is relatively new (Yang. Z Y, et al; 2020), and research related to the topic is increasing, but not yet sufficient (Wang. J and Wu. B; 2017).

Chen. H L, et al (2017) point out the community-based care workers have not been deeply researched. These group of people who delivering community care ought to draw wide attention, but the identity of this group is ambiguous according to Chen. H L, et al (2017), since the definition of home-based and community-based is not currently clear enough. They usually combine together some service items, such as distributing meals to old people's homes. Wang. J and Wu. B (2017) researched domestic care givers in mainland China and Hong Kong, raising the dilemma of their identity when facing legal issues and also the challenges they faced in their working process. Wang and Wu suggest promoting educational training to upgrade skills, and also provide a more comprehensive system to provide workers with legal support.

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[58] four old people, two young people and one grandchild in the family.
[59] Three Nos: no children, no relatives, no home.

As introduced in Chapter Four, due to urbanisation and economic reform, a great number of migrant workers and lay-off workers became *'baomu'*, similar to the Japanese home-visit helper. They provide home-based care or assistance with other housework. It is difficult to categorise these workers as home-based or community-based care workers; from the literature and my fieldwork, I would conclude that the boundary is still blurred in elderly care in China. However, this fact does not impact my analysis of the possibility of applying the role of Japanese care manager into community-based care, from a functional perspective.

7.3.2. Community-Based Care Fieldwork

Following the visits in Nanjing and Bengbu, the third destination for my fieldwork in China was the city of Shenzhen, in Guangdong Province. Shenzhen was the first city to open up to the international market through the reform and opening-up (*gǎigékāifàng*)[60] policy since 1979. This policy, promoted by the previous president Xiaoping Deng, brought enormous economic development into the domestic market and vastly improved the quality of life for the whole nation. Shenzhen was the first trial city for this process (and also my second hometown, after being born in Bengbu). Shenzhen developed from a fishing village to become the leading financial centre of the Asia-Pacific region. According to the global financial centre index, Shenzhen was identified as the eighth most internationally competitive financial centre, and ranked fourth highest city for number of billionaires, following Beijing, Shanghai and New York.

With its outstanding economic development, Shenzhen has enough financial resources and workforce to form and test the model of community-based elderly care. I visited a community centre which had linked the home-based care provision

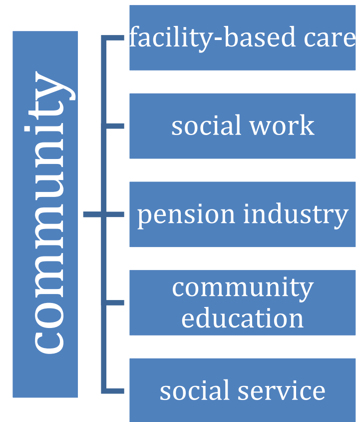
[60] *Gǎigékāifàng* 改革开放: the Chinese economic reform or 'reform and opening-up', indicated the opening of Chinese markets to the world, initiated in 1978, and practically developed since 1992, after Deng Xiaoping's visits in southern China.

together, putting its efforts into innovating various new models for local elderly beneficiaries. I visited the office and interviewed the establisher of the organisation, Ms Liang, who had been a social worker in her early career. At first, she trained a group of people redeployed under the reform and opening-up policy, allowing this group of people to return to economic contribution. Before Chinese economic reform, the Government had adopted the egalitarian practice of distribution of social resources (*dàguōfàn*[61]). The new policy introduced market-based principles that focused on efficiency and competition, resulting in the collapse of many factories and enterprises under egalitarian distribution, and causing the social phenomenon *xiàgǎng*, which formed a group of lay-off workers. At this point, many of them became home-visit care providers or housework assistants.

Ms Liang established the community-based centre to train people who had lost their jobs in this way in the 1990s. Along with the gradual ageing process, she noticed that taking care of the elderly at home in the community was becoming an urgent issue. Most elderly people prefer to stay at home rather than live in a facility. The gap between the demand of the home-based elderly care and supply from the market gained Ms Liang's attention, and her work shifted gradually to developing networks in the community to provide the requisite elderly care. After two decade's work, the community centre now links five sectors together, working for the elderly:

Figure 7: Liang's Five-Pronged Community-Based Care Structure

[61] *Dàguōfàn*,大锅饭: literal translation from the characters is 'cooking all the food elements in one big cauldron/pot'. It was a metaphorical description of the egalitarian model in the distribution of social resources.



Source: Author

The first sector is facility-based care. In the community, beside the community-centre building, there is a two-floor accommodation facility, providing facility-based care. The second sector utilises social workers to assist the elderly in the transitional period moving from hospital back to home. The third sector, the pension industry, is a project to facilitate the establishment of nursing homes for the elderly who have insurance programmes to finance this. The fourth, community education, is aimed at identifying and linking people who can work in the elderly care, and at the same time providing them with professional training. Additionally, community education also arranges the more active older people in support the senior older people, conducting activities or visiting their homes. The last sector is social service, is mainly focused on digitalising the service, to allow people to connect and communicate with greater efficiency. The centre has developed an online service programme for people in the community to access appointments or services online.

Initially, I visited Ms Liang and her team in the community office, where she introduced the team's work on elderly care in the community. Having just finished my fieldwork in Japan, Ms Liang invited me to talk to her team about Japanese elderly care, after which, we talked about the current situation in China. I asked the team their thoughts on the possibility of introducing the role of care manager,

and we exchanged ideas in detail. After our discussion, Ms Liang guided me around the community nursing home, and then briefed me on the situation of community-based care and her thoughts on transferring the Japanese model to China.

On our arrival at the nursing home in the community, a care worker came out to greet with me, and then led me around the facility. It was lunch time when I visited there; many elderly residents were gathered in the hall, and they greeted me. The care worker then explained to me the structure of their team. There are three groups: the administrative group, nursing group and logistics group. The administrative group are responsible for reception, administrative issues, records and information, and project planning. The nursing group worked on the day-service, accommodation, rehabilitation, mental support and recreation. The logistics group monitored food supply and property management. The care worker also showed me the daily record sheet of each elderly person. These recorded the mental condition, the nutrition and water intake for each time period, toileting, bathing/washing, exercise, personal hygiene, room cleaning, evening care and quality of sleep.

After my tour, I asked the care worker my research questions regarding the application of Japanese care manager. She shared her opinions from the perspective of a care worker, and mentioned potential improvements she could see in terms of community-based care. After visiting the facility, I met Ms. Liang again and had a conversation with her in the community-centre.

7.3.3 Shenzhen Community-Based Care Findings and Discussion

Unlike other ordinary facility-based care, this facility was located within the community, and was connected with a community centre for elderly care delivery. Therefore, different to Japanese nursing homes (that usually specialise in one type

of elderly, such as *tokuyō*[62] for the terminally ill, or group homes[63] for those living with dementia), the facility provided diverse service items towards the local elderly population. In the facility, they offered a day service, short-term accommodation and temporary accommodation. Outside of the facility, they offered home cleaning, hairdressing, accompanying support for hospital visits, bathing assistance, meal ordering and delivery, and had connections with the community-centre.

Table 8: Shenzhen Facility Service Items

Service Item	***Level of care required***	***Daily charge***	***Monthly charge***	***Note***
Day service	*Independent*	45RMB	*1350 RMB*	*Includes lunch, daytime only, return home at night*
	Partially independent	55RMB	*1650 RMB*	
Short-term Accommodation	*Independent*	65RMB	*1950 RMB*	*Includes three meals, 24/7 in the centre*
	Half Independent	80 RMB	*2400 RMB*	
	Dependent	100RMB	*3000 RMB*	
Temporary *Accommodation*	*Half-independent*	*25RMB per hour*	*n/a*	*Additional payment for meal*

[62] *Tokuyō*,特養:特別養護老人ホーム: facility/nursing home for elderly designated at *care requirement* level, publicly owned, and therefore cheaper compared to other types of facilities.
[63] Group home,グループホーム: facility for elderly people living with dementia, usually 5-9 residents.

Home-visit cleaning		*30RMB per hour*	*n/a*	*Laundry& clothing repair*
Hair dressing, hospital visit accompaniment, social visiting		*35RMB per hour*	*n/a*	
Bathing Assistance		*40 RMB per hour*	*n/a*	*Physically disabled or partially physically disabled*
Meal Order		*Breakfast 5RMB Lunch 15RMB Dinner 15RMB*	*n/a*	
Meal Delivery Service		*18RMB each time*	*n/a*	*Two meal dishes One veggie dish One soup*

(1 RMB = 0.11 GBP, 30 June 2021)

Source: Extracted from pamphlet of the facility, collated by author

The care worker told me the facility provides the accommodation as well as visiting care. Regarding the idea of establishing a care manager, she agreed that in reality, this needs a person with a medical background as well as nursing knowledge, to evaluate the type of service needed. Since most elderly people prefer to stay at home, a care manager could help in deciding the services according to the local resources, with a medical understanding.

From the perspective of community-centre care, Ms Liang presumed that the Chinese system functions in a similar way to the Japanese direct care manager role. Community centres bridge diverse resources, and try to build a local integrated care system. Additionally, community centres conduct various training courses, for example, raising awareness dementia for elderly people. However, there is no professional position responsible for doing this. Normally, a member of the administrative staff or a social worker is appointed to plan and promote events. The problem with this approach is that, without an official position set up in community centre to fulfil these functions, staff turnover makes it hard to designate one person to take responsibility for building up an integrated care system. It is necessary to have a stable position in the community centre to promote this project.

The model in this community cannot represent all the communities in China. It is epitome of the structure in general, regarding community-based care. For the construction of integrated care, it is necessary to mobilise all the accessible local resources. The facility in the community also provides home-visit services, as one project promoted by the community centre. The community centre, according to Ms. Liang, to have a position like Japanese care manager, who is able to pinpoint the service provision with basic medical knowledge, and also link with social workers more.

7.4 Transferability of the Care Manager Role into Agency-Based Care

The Japanese agency-based care manager is affiliated to the home-based care provision management agency under the LTCI system, and hence the standard of care service and the level of care requirement are uniform across the whole country. Therefore, it has nurtured the development of diverse care service providers, as well as a professional workforce in the industry. Like China, Japan is also facing a severe shortage of labour in the care industry, because the job has been deemed 3K, and many graduates will not choose work within elderly care

even if they graduate into this profession. Despite the shortage in the number of people, however, it is easier to standardise the codes of elderly care within the LTCI structure in Japan.

On the other hand, China is in the primary stages of trialling the LTCI, and only within a limited area. There are provisional regulations thus far, and it is almost impossible for to create a uniform standard regarding service provision and employment qualifications for the people providing the service. As a result, establishing a care manager agency and hiring care managers working within it is nearly impossible in the current Chinese market. Ms Liang told me that usually, a function similar to the Japanese agency-based care manager role has been undertaken by staff from insurance companies in China. When the customer has insurance, staff in the company would take responsibility for the elderly person's case, from medical records to service items. These caseworkers generally come from private insurance companies, hence their plans for customers are biased according to financial benefits for certain service providers. Despite the potential for affiliated agencies to influence Japanese agency-based care managers, the standards designating care requirement levels and service quality do not vary too much under the national LTCI structure.

It will take time for similar care management agencies to appear in the Chinese market. Service providers are scattered in scale and quality, and labour resources are unevenly geographically distributed. The fundamental success of the operation of the home-based care manager agency in Japan lies in the LTCI structure, which regulates a standardised market supply. Practically speaking, regarding the transferability of the agency-based care manager, it is impossible at this point to have such role in the Chinese socioeconomic context.

The Chinese care market workforce varies in quantity and quality across regions, and it has not yet formed a clear career path. It is therefore difficult to exactly apply the Japanese social mechanism of agency-based and community-based care

managers in China. However, in the practical promotion of integrated care in the Chinese context, it seems certain that a good approach would be to establish a stable mechanism that can make connections amongst the various resources and provide efficient suggestions for service items for the elderly. From my point of view, instituting a community-based manager similar to the Japanese direct care manager is a necessity. It does not need to be named 'care manager', but it should be possible to set up a position carrying out the same functions. The agency-based care manager is currently impractical for the Chinese market, due to many structural elements currently lacking.

7.5 Chapter Summary

This chapter examines the practical situation of elderly care in China, and aims to discuss the possibility of transferring the Japanese care manager mechanism into the Chinese context. Staying in China, visiting institutions and meeting people personally gave me a direct and vivid understanding of the current reality of elderly care. This chapter is not a comparative study regarding elderly care systems between the two countries, but rather an exploration on the transferability of the social mechanism of 'care manager', to discover what is missing in the current system, what are potential future possibilities.

China has the largest population in the world at present. The imminently vast ageing population is not only an issue for Chinese people—such a demographic change influences the worldwide market and environment. Therefore, a stable and effective approach to confronting this shift is vital. This is an opportunity to reflect on current social structures, and suggest improvement after referring to the operation of the LTCI in general, as well as the specific function of the Japanese care manager. However, due to many variables in the socio-economic and socio-cultural contexts between Japan and China, I have not conducted comparative research, due to the time limits and scope constraints of this thesis. The discussion here is on the transferability of the social mechanism, conducted through the

perspective of functionality. Such discussion is not exhaustive; however, such a perspective provides a practical and efficient angle to analyse current structures at macro and micro levels.

Proximity can inspire conflict. China and Japan are geographical neighbours, sharing a long history of communication at all levels. Previous President Deng Xiaoping visited Japan in 1978, during the diplomatic visit, he took the bullet train (*shinkansen*). He was impressed by the technological development in Japan and felt deeply that the egalitarian mode should no longer operate in China. Encouraging efficiency and openness into the Chinese market was critical for its economy. After returning, Deng Xiaoping conducted the famous 'Third Plenary Session of the 11th Central Committee of the Communist Party of China', and decided to open the door to the international market. Since then, Japan and China have cooperated closely in various economic aspects, in spite of the coldness of political conflict at times over recent decades.

According to my fieldwork investigation, the Japanese elderly care industry is actively trying to expand their market into China. In the process of 'glocalisation' (globalisation+localisation), Japanese models face many challenges in practical operation. Alongside my search for the answers regarding the transferability of the care manager role, I also uncovered various challenges to localising the Japanese model in China.

A primary consideration is that Chinese older people and their families have a different approach to the core principles of elderly care. The Japanese LTCI aims to maximise self-assistance (*jiritsu shien*)[64] for older people, using peripheral assistance as a support. In general, Japanese elderly people accept this principle, from my visits and conversations with people who work in elderly care industry,

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[64] *Jiritsu shien*,自立支援介護: respecting the elderly's independence, provide elderly care for promoting physical independence in life.

whereas the concept of self-assistance in elderly care is gradually receiving attention in China, but yet not enough. According to my conversations with care workers in facility-based care in China, old people tend to think facility staff are best placed to do provide all their service within care provision. Take a very small detail for example: one Japanese care worker told me how he assisted an old man to put on the clothes, in the spirit of *jiritsu shien*. The man's right arm functioned well, but his left arm only could move within certain angles. Therefore, he would help the old man to put on the left sleeve and let him put on the right sleeve himself, to practice movement and function in his right arm as well. In China, if a care worker did the same thing, the beneficiary would think it was not polite to help them only halfway. Hence, in future, a patient explanation of the purpose and the promotion of recognising self-assistance will be important in practice.

Secondly, for the higher economic strata of Chinese society, luxurious design and glamorous interior decoration is of a high cultural value. In general, the Chinese perception of Japanese-style nursing homes is that they are frugal and simple-designed. This does not apply to all affluent Chinese people, nevertheless, the luxurious style of nursing home has indeed captured a large group of the higher economic band of elderly people. In recent years, the more expensive Japanese nursing homes have tried to adapt to Chinese society and transformed the aesthetic design of their facilities (JB press; 2021). It is difficult to place an absolute evaluation on such value orientation, or perhaps this reflects a short-term social reorientation in China, after enormous economic growth from the reform and opening-up policy. The efforts of Japanese nursing institutions to adapt to Chinese people's cultural preferences are noteworthy.

Thirdly, Japan has much more than China in regard to the types of welfare equipment available [65] (Jetro; 2017). Since there is no mutually recognised

[65] Welfare equipment,福祉用具 in Japanese. 福祉用具 is the welfare equipment for multiple purposes,

standard regarding welfare equipment, importing Japanese welfare equipment into the Chinese market is complex and time consuming. In Japan, welfare equipment does not fall into the medical equipment sector, and items may be circulated on the market once they have received the welfare equipment JIS logo. In China, welfare equipment—be it from a foreign country or from a local market—belongs to the medical equipment sector, and thus requires higher-level certification that takes longer to approve.

Finally, a significant difference is in the quality of people found in the industry. In Japan, a care worker has usually graduated from a professional school or university, whereas care workers in China currently come largely from the rural migrant demographic. Many of them even have not even been trained in basic notetaking, and hence training them as qualified service providers is a huge task. In addition, in China, the number of people that one care worker has to take care of is usually two or three times higher than the care worker in Japan. As a result, it is hard to achieve a similar service quality in China.

From my investigation and reflection, a uniform social structure is paramount as a starting point, to regulate and improve the workforce market. A clear career path in Japan was formed and facilitated by the operation of the LTCI. Although the LTCI has been conducted in limited areas at present in China, the enhancement of provincial standardisation regarding regulation will benefit the career formulation of those involved in care. Government plays the most useful role in promoting the whole industry, despite the privatisation of many welfare services.

The Japanese care manager is rooted in the LTCI, and has flourished as a career through its operation. Regarding the transferability of this social mechanism into

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such as help the older people living independently, rehabilitative practice, build a safer environment, reduce potential risk of falling down; for example, setting the handrail at home. They belonged to LTCI services (MHLW).

the Chinese context, I have explored the potential from the perspective of examining functions within societal structure. Regarding the facility-based care manager, the same function has been attained via administrative staff or social workers thus far, and hence the answer to whether it is possible to set up this mechanism is neutral, either yes or no with premises. Regarding the agency-based care manager, since the labour market has not yet formed into a broadly recognised standard, it will be difficult to establish the different care manager agencies to provide uniform services; therefore, the answer to the possibility of transferring this role into the current Chinese market is no. The community centre-based care manager has a pivotal function in building up the integrated care system. In China, it would seem that the system is destined to develop integrated care, due to the lack of beds available for the forthcoming ageing population, as well as the deeply ingrained filial piety that results in a culture where elderly people prefer to stay in a family environment with loved ones, if at all possible. As a result, the position of the direct care manager, bridging the gap between home-based services and community-based resources, is indispensable for developing integrated care. Since there is no consistent career progression in Chinese care industry yet, a possible approach would be to establish a stable role that focuses on combining resources and building networks. Therefore, the answer to the possibility of transferring the centre-based care manager into the Chinese context is yes. It will be required by the market, and it can be established in current local networks. The role may take another name (not necessarily care manager) but must achieve the same contribution as the centre-based care manager in Japan.

Chapter 8: Theoretical Analysis on Research Question

This thesis includes two main research themes: the Japanese care manager in the LTCI, and the possibility of transferring this mechanism into the Chinese elderly care system. After the analysis of the case studies from an empirical perspective, this chapter aims to provide theoretical analysis towards the two major research questions. In this chapter I choose the theory of body and the theory of policy diffusion to analyse them respectively. The first question is the investigation of Japanese care manager role, including its function, and challenges within the LTCI system. I use Foucault's theory of the body to comprehend the Japanese care manager from the social identity and individuality, and incorporate the analysis into a sociological explanation. The second question, and even more intriguing exploration, is the examination of the possibility of transferring the care manager role into Chinese elderly care system, to attain a similar function regarding elderly care provision, also as a policy solution to the upcoming ageing population challenge. For discussion on the possible approaches for adoption and diffusion of care manager's mechanism in Chinese society, I use the policy diffusion theory to analyse the potential pathway, as well as potential barriers for applying the Japanese care manager role into the Chinese specific political and socio-economic system.

8.1 Analysis on Japanese Care Manager Role—The Body Theory

8.1.1 Literature Scoping

A small phenomenon can represent a wider social issue, or an incident can indicate a structural flaw—the care manager role can mirror elderly care from the system to the person. Elderly care requires diverse efforts in all social aspects. If the care manager is the epitome of the care provision system, then the care manager's problems are indicative of the problems of the system. A small element can influence the whole process in policy practice. This point of view resonates with

research by Nishioka. S (2017), in an investigation into the causes for policy failure regarding *taikijidō* (children on the waiting list to nursery) in the Japanese *hōikuseido* (childcare system). This research indicates that the shortage of *hōikushi* (nursery teachers) gave rise to the policy failure. The Japan NPM (new public management), under a neo-liberal ideological background, privatised the child-care sector and reduced the proportion of *kōmuin* (public civil servants) in nursery teaching, resulting in a workforce deficit, notwithstanding the increase in equipment and buildings for nursery schools.

A jigsaw cannot be complete without a missing piece. As an important piece in the puzzle of the LTCI is the care manager, who functions as a frontline care provider, as well as holding symbolic meaning, reflecting the state of elderly care in Japan. Although I have analysed the role at *individual-to-individual* and *individual-to-institution* levels, I was impressed by the way personal traits (*kojinsei*) strongly impacted the work relationships of each individual care manager, and how they view their existence. As a result, when looking at the dynamics the care manager exerts on the elderly care structure, there are multiple layers interacting with one another. For example, at the *individual-to-institution* level, in essence, it is still a person-to-person conversation. The personality of the individual representing the institution is one of the deciding factors of work progress, despite the fact that they represent an institution. Thereafter, my curiosity shifted to multiple theoretical perspectives of a social mechanism within a structure, and how they mutually influence and shape each other. Thereafter for this purpose, I read scholarly articles regarding identity, individuality, institution, agency, environments and so on.

Wahl. H and Oswald. F (2010) examine person-environment interchange processes, and point out that the environment is always infused with 'subjective' factors, i.e., social norms, cultural interpretation, and implicit symbolisation. Hence, it is hard to find an 'objective' environment in any surroundings; this theory

can be applied in analysing the care manager—their work is also a person-environment interchange. The smaller social environment represents their connections with beneficiary at the individual level, and the larger social environment is the LTCI structure, within which they associate with institutions. In addition, a life-long environment—including factors such as family, education or work experience—have also shaped the care manager at a personal level, influencing their values and attitudes in work and life.

The bioecological theory from Bronfenbrenner. U (1999) differentiates the layers of the person-environment analysis as:

- *the microsystem (interpersonal interactions within the immediate environment);*
- *the mesosystem (two or more microsystems affect the individual directly);*
- *the exosystem (linkage between the mesosystems that affect the individual indirectly); and,*
- *the macrosystem (given factors from society: value, norms, convention, etc.).*

This theoretical structure can be adopted for the analysis of the relationship between environment and individual development. It also can be applied to understand the care manager in this research. The care manager interacts with colleagues or beneficiaries at microsystem level, and forms the mesosystem based on the work within the microsystem. Their work also interacts with institutions, and results in effects on the exosystem, fulfilling their social identity as the key role in the macrosystem of the LTCI.

Despite all kinds of disagreements and controversies, this fertile topic incurs continuous discussion in sociological study. Among many descriptions depicting elusiveness with respect to the concept of 'structure', Giddens (1993) argues that social structure is constructed by social actions; meanwhile social actions activate social structure. Other theorists assert that 'social structure' and 'social action' interact and have effect mutually—dualism of the structure (Berger. P L and Luckmann. T, 1967; Giddens. A, 1993).

Interpretive theories from phenomenology, cultural anthropology and symbolic interactionism argue that social structure places constraint, but is not a decisive factor affecting individual behaviour (Marshall. V and Clarke. P; 2010). Structural functionalism sheds light on the conventional and cultural facets of social structure, whilst factors such as transformation, reform, and innovation draw attention to symbolic interactionism, to discover the how those factors affect a response to a problem in practical circumstances (Chappell. N L and Orbach. H L; 1986).

Dawe. A (1970) asserts that society is constructed by members, via various meanings imposed on the construction per se, from an interpretive perspective. Weber. M (1978:7) defines sociology as 'a science concerning itself with the interpretive understanding of social action', and the social action per se entails the 'subjective meaning' within its course. Marshall. V and Clarke. P (2010) underline the 'temporality' of the agency presented by Emirbayer. M and Mische. A (1998). They conceptualise agency as a temporary structure, engaged by actors interplaying with ritual, convention and habits. This inter-play shapes and reconstructs the structure itself.

Incorporating macro and micro variables using one theory is complex. Marshall. V and Clarke. P (2010) review Marshall. V W (1995)'s earlier research about the impact of social structure on individuality, and vice versa. This theme resonates with Waitzkin. H (1989), who agrees that the macro and micro interplay, mutually impacting upon each other.

Scoping the macro and micro perspectives in the course of life, Cain. L D (1964) states that a person's life course is itself just a social structure. Elder. G H (1997) argues that agency is embodied in a human being's existence. Deeming a person as a structure itself, within a social structure, is reminiscent of the discourse in Foucault's theory of the body—the 'body' developed under certain 'powers' that entails social narratives.

Concisely speaking, the above-mentioned theories are abstracted contestations for research on the interplay and interactive dynamics between the individual and the institution—or microstructure and macrostructure, actor and agency, person and environment. In addition to the articles listed above, there is a large number of articles striving to differentiate these definitions, which is not my research focus in the analysis of the care manager. The essence of the investigation lies in the mutual dynamics, i.e., the care manager and the LTCI system—rather than fitting a phenomenon into a pair of nouns.

8.1.2 Zooming into the 'Body' Perspective

Choosing Foucault's *theory of the body* in interpretation is partly influenced by my personal research interest. The 'power-body' conjunction runs throughout Foucault's research, sharing intriguing perspectives in looking at a micro-level existence, such as a body, or a social role, and how this micro-level entity interacts with a grand macro-level structure. According to Foucault's ideas about relationship between body and power—considered in modernisation processes since the 17th century—the human body has been regarded as a 'machine' (Foucault; 1978:139) that is an object of power to control and regulate through discipline, optimising its capabilities, exerting its forces, increasing its usefulness as well as its docility, and integrating into an efficient and economic system. Thus, power here can be characterised as the power of discipline, which Foucault calls 'an anatomo-politics of the human body' (Martin. B; 1982:7). Foucault himself, nevertheless, does not see the relationship between body and microscopic power as a negative one, because power can render the human body active and productive in the same way (Foucault 1978: 23; Martin. B: 1982:7).

The body theory entails fertile philosophical domains (for theorists and scholars to apply to their research genres), such as the analysis of the maternal body, by referring to Foucault's Panopticon in Discipline and Punish (LeBlanc. S S; 2020); its applicability in history, philosophy and psychology (Line. J; 2016), an

exploration between public administration and public protest (Eagan. L J; 2014); the comprehension of the sexual body in the experiential body from a feminist perspective (Oksala. J; 2004); or a philosophical discussion on rationality (Paulle. B and Emirbayer. M; 2016). Under significantly diverse descriptions in this research, I do not intend to expand the 'body-power' conjunction into an overwhelmingly complicated explanation, but instead to focus on the essential meaning that Foucault created to analyse the care manager as the *body* per se.

> *The body is moulded by a great many distinct regimes; it is broken down by the rhythms of work, rest, and holidays; it is poisoned by food or values, through eating habits and moral laws, it constructs resistance.*
>
> *Foucault; 1994:380*
>
> *This new object is the natural body, the bearer of forces and the seat of duration; it is the body susceptible to specified operations, which have their orders, their stages, their internal conditions, their constituent elements. In becoming the target of new machines of power, the body is offered up to new forms of knowledge.*
>
> *Foucault; 1995: 155*

According to Foucault, the body is a product of social discourses—bodies directly located in political power (Carlos. J M and Jorge. A J M; 2019); the body has been constructed, moulded, normalised, disciplined and subjectified in history, infused with value, information, orthodoxy, etc. These elements constitute the body for the production purposes, and hence the body is one 'subjected, practiced, productive and docile' (Paulle. B and Emirbayer. M; 2016:47). From the narrative of 'body-power', the *body* seemingly fell into an abyss and has been unable to escape from *power* since its very existence. However, from my point of view, jumping out of the genres of political and historical critiques, the 'body-power' narrative can be understood in plain form in daily life.

For example, we were born into a certain culture and family, and we received information from surroundings since we were born. Then we went to school, we were taught from current knowledge, values and understandings. We interacted with people, may have experienced trauma from family members, may go through value conflicts with partners, may find connections with friends who share similar backgrounds and interests; we may become influencers, outputting value, or subscribers to an influence, accepting a value. All these elements have their *power*, or even represent *power* per se, which shape the cognition of 'I', which forms this *body*.

More precisely, this *power* existed since we were born, almost everywhere, noticed and unnoticed, to define this *body*. We cannot escape from the *power* when we are the *body* per se*;* and at last, become the subject for productive purposes, as Foucault describes: '…the notion of 'docility', which joins the analysable body to the manipulatable body. A body is docile that may be subjected, used, transformed, and improved.' (Foucault; 1995:136)

Foucault established the disciplinary body under power structures. His critiques and philosophy yielded significant impact in history, politics, sexology and criminology. In my research, when putting the lens of the 'power-body' framework onto the care manager, their existence (namely, their *body*) is subjected to or 'tamed' by two forms of *power* within the structure. The first *power* structure exists in their social identity in the work. Their social *body* was trained and shaped by external *power* structures, i.e., policy, exams, work codes, past experiences. These external components drive the social *body* as a care manager, to fulfil the expectations of the power structure. The second *power* structure exists in their self-identity, the internal *body,* or *body* as it is. This *power* structure shapes the self-cognition, personal traits, inner values, and emotional patterns which form the foundation of the *body*: a human being and a care manager. The first and second *power* structures, in fact, interactively impact upon one another, as well as on the

body. The *body,* as a result, in turn exert its functions on the *power* structure, as the care manager works within the LTCI.

Scoping the work progress of care manager through the 'power-body' narrative more closely, a care manager obeys the work codes, moral standards and regulations in actual work processes, and hence formulates the *body* in social identity, to respond to the beneficiaries, municipality, medical staff and service providers. At the same time, the essential part of care manager's work is face-to-face conversation, which involves the individual. The self-identified *body* decides the responsiveness, attitude, flexibility, and empathy of its work to a certain extent—under the guidance of work codes, under *power* structures at both social and personal levels.

In this sense, I am also subjected to the power influence right now. My analysis and interpretations are 'tamed' by the frames of education, cognition, and life experiences so far. These pre-destined factors that decide a person's reactions, choices, attitudes and emotion I will name as pro-active mechanisms. This resonates with the spirit of Foucault's body narrative. The 'docile, tamed, disciplined' body expresses itself, with proactive mechanisms, under omnipresent power structures in the world.

8.1.3 The 'Body' of Care Manager

Using a pragmatic approach, I analysed the problems existing in the care manager's work, from two layers of relations, at *individual-to-individual* and *individual-to-institution* levels. Using a theoretical approach, corresponding to Foucault's 'body-power' narrative, I choose to interpret these problems as a dilemma under the *power* structure, detecting the flaws of structure per se, and suggesting solutions from personal understanding.

In the practical workplace, there were several dilemmas in the care managers' work. For example, the care manager is paid through the LTCI system, and is

supposed to contribute their best in organising beneficiary care plans. However, their working time is calculated by unit slots; each beneficiary is allocated limited slots, meaning care managers do not have enough time for effective communication. Instead of time for consultancy, they have to spend much of their time on administrative documents for bureaucratic purposes (evidencing that money has been used properly, which is a reasonable aim), but which eclipses the original purposes of elderly care. Another example is the conflict for facility-based care managers, as occupying both the function of service provision inspector and internal team member.

In the above-mentioned issues, social and personal levels of *body* are influenced greatly by the *power* structures, and *power* in these circumstance acts in an obvious form. For example, at the individual level of interactions: flexibility, interpersonal and communication skills play a large factor in establishing mutual trust with beneficiaries, especially in complicated family cases. Although care managers all receive standardised training and examination, the diversity of their individuality certainly impacts on their work performance. The pre-active mechanism, as explained in last section, i.e., *power* influences, is derived from the person's former life. This type of *power* structure is unseen, but affects people in their response to the external world.

The *body* is a window for Foucault to describe the world as seen. In a timeline, if historical and current events are repeatedly imprinted on the body, thus, the body is reflexive, reflective and changeable. The body intervened by power and subjected to power is the result of power. *Power* for Foucault (unlike for Karl Marx, who indicated political or economic superiority supported by structural 'entities', i.e., ownership, hierarchy) is formless, omnipresent, without structural 'entity'. For example, a teacher is teaching in a classroom; he can ask a student to come to the front to answer his question. In this circumstance, towards the students, the teacher possesses invisible *power* endorsed by the symbolic implication of

educational institution, which offers an evaluation of a person's intelligence. Therefore, the student obeys the invisible *power* from the teacher to do what she has been instructed. Similar invisible-but-omnipresent power structures prevail in every corner of life.

In this research, the care manager is the *body* working in the LTCI. They are influenced by *power* structures in work and in life. Their existence comprises a producible disciplinary body under visible *power*, and a self-identified pre-active body under invisible *power*. Their dilemmas confronted at institutional and individual level can be traced back to the original definitions of their identity and role, the *body* under *power* structure.

Researching elderly care enabled me to communicate with old people as well. Unlike the care manager, who stands in the position of service provider, old people as the service receiver are also the *body* per se. Taking care of older people is not only about the physical body, but also the body as a package of information, shaped, moulded, formulated by power. A care worker from one facility I visited told me that everyone has a story. Although they now need help to take off their clothes, these people perhaps were once active football players, doctors, or travelled to many countries in their lives. Right now, they need basic assistance for physical function—but their memory is there, the past is there. Hence, knowing their life stories—pride and sorrow—is necessary in the process of taking care of them. Elderly care under the LTCI is not only a legislative and administrative process, but rather a face-to-face care delivery process. The human, the body, is located in the centre of elderly care: either it is a physical body or a socially identified body. The elderly person's body is the service target, whilst the care manager's body is an essential mechanism enabling the LTCI to work well.

It is certain that other sociological theories can be applied into the analysis of Japanese care manager. This section is a personal interpretative venture after reading related articles. The next section will explore the possible applicability of

care manager between two nations who have distinct features in regard to the political structure.

8.2 Analysis on the Transferability of the Care Manager Role into China—Policy Diffusion Theory

8.2.1 Literature Review of Policy Diffusion Research

8.2.1.1 General Review of Policy Diffusion

Policy diffusion theory analyses the process via which the idea, practice, and innovation of policy spreads into different geographic regions and socio-economic contexts. According to Roger. E M (2003:5), diffusion is defined as the process through which 'an innovation is communicated through certain channels' along with time among the participants within a social system. It explains the reason for successful or unsuccessful results of a policy by examining the factors—i.e., political-economic context, regional culture, bureaucratic operations—that facilitate or hinder the diffusion process. The policy diffusion occurs by various channels, such as inter-governmental organisations, professional networks, advocacy groups, or the media. It can happen either in the intentional approach, such as policymakers deliberately looking for policy solutions, or in an unintentional approach, such as the media or civil activities helping to formulate certain policy ideas.

There is abundant literature regarding policy diffusion. The early and classic studies start from such as Crain. R L (1966), examining the factors that led to the spread of water fluoridation as a public health measure in American cities, shedding light on the social and political factors that contribute to the diffusion of innovations in public health; Gray. V (1973) analyses the diffusion of four policy innovations across the US states (state-level minimum wage laws, no-fault automobile insurance, state-supported community colleges, and state-level health planning agencies), stressing that the diffusion process tends to follow a

predictable pattern, i.e., states in the Northeast and West Coast adopt new policies earlier than those in Midwest and South. Gray suggests this was caused by regional differences in political culture and institutional structures, and different social and economic conditions for policy decisions. Walker. J L (1969) formulates his research based on the diffusion of six policy innovations across the US states (civil service reform, public utility regulation, worker compensation, income taxation, old-age assistance, and state aid to education), finding that the diffusion process was influenced by factors such as the perceived benefits, cost for innovation, the complexity in implementing the policy, the presence of interest groups for / against the policy, and the coordination and cooperation among policymakers across the country. Walker also argues the innovations follow a predictable pattern, spreading first to states which contain similar political and cultural structures, then gradually disseminating to other states over time.

Regarding the definition of policy diffusion, Marsh. D and Sharman. J C (2009) point out that policy transfer and policy diffusion are used interchangeably, but they have distinct features: *policy transfer* refers to the direct replication of a policy in a new context, while *policy diffusion* refers to the indirect influence of a policy. Policy transfer occurs when a policy is adopted from one jurisdiction to another with little or no modification. This can happen through mechanisms such as emulation, and learning. In contrast, policy diffusion occurs when a policy idea, instrument, or institution spreads from one jurisdiction to another, but is adapted to local contexts and conditions. Marsh. D and Sharman. J C (2009) argue that policy diffusion is often more effective than policy transfer, because of its flexibility and adaptation to local circumstances. However, policy transfer can be important in cases where there is a need for quick solutions or where the original policy has been proven to work effectively.

Unlike policy transfer and policy learning, policy diffusion not only contains intentional and institutional promotion, but also involves self-dissemination and

self-expansion in the process; secondly, policy diffusion includes adoption and promotion by policymakers, not only the direct policy transfer; thirdly, policy diffusion relates to macro and micro operations together; last but not least, public diffusion is more associated with structural issues; meanwhile the policy transfer relates more to agency emphasis (Marsh. D and Sharman. J C; 2009).

Literature on policy diffusion can be categorised into three types: result-oriented diffusion research, process-oriented diffusion research, and mechanism-oriented or cause-driven diffusion research. In order to explore decisive factors for policy innovation—i.e., whether the government / department has decided on an innovation or whether it has occurred in the dissemination process of a policy—Walker. J L (1969) and Berry. F S (1994) conducted theoretical research on state policy innovation. They found that the speed of innovation in some states was much faster than other states, suggesting the inter-state communication is an essential reason behind policy innovation diffusion. Based on this research, Berry. F S (1994) adopted Event Historic Analysis[66] to summarise three modes that explain innovation: the internal determinants model, the regional diffusion model, and the national interaction model. Berry focuses on the result of diffusion process, i.e., the adoption and practice of the public policy.

In the 1980s, scholars began to pay attention to the processes of policy transfer and diffusion. Rogers. E M (2003:5) defines innovation diffusion as 'the process by which an innovation is communicated through certain channels over time among the members of a social system.' It can be understood as the process through which policy innovation is conducted and spread to different level of government or

[66]Event History Analysis, EHA: a statistical method used to analyse the timing of events, such as policy adoption, organisational change, or other significant occurrences. It is also known as survival analysis or duration analysis. The concept was first introduced in the 1980s, by Paul D. Allison who is a prominent sociologist and statistician known for great contributions to the development and application of statistical methods for social science research. His work 'Event History Analysis: Regression for Longitudinal Event Data' (Allison. P D; 1984) has become a widely cited and influential work for this analytic method.

political contexts, whilst policy transfer is understood as a package of public policy, where an administrative system in one time-space has been applied into another time-space (Dolowitz. D and Marsh. D; 1996). Based on this, Simmons. B A and Elkins. Z (2004) extend the definition of policy diffusion as the process of how one nation's policy options influence another nation's policy decisions, through finding the temporary and spatial cluster of liberal economic practices due to policy diffusion in their hypothesis. Lucas. A (1983) focuses more on the concrete content in policy diffusion, by identifying policy diffusion as a process whereby a policy practice diffuses from one department or area to another department or area, combining with the adoption and adaption processes of the new policy practitioner.

Wejnert. B (2002) emphasises policy diffusion as a process for distribution and innovation of policy, discussing how policy is distributed by social networks and other communication channels, and moreover, how it is innovated and adapted as it is adopted by different actors and institutions. Wejnert's framework incorporates aspects of different diffusion models, providing a more nuanced understanding for the policy diffusion process as the policy is diffused, adapted and transformed within different social systems. Charles R. S and Craig. V (2012) define policy diffusion as the process by which one government is influenced by another, and hence absorbs the external political experience, information and concept to localise into its own practical circumstances. Takao. Y (2014) examines policy diffusion as a policy transformation process through policy goal-setting, design and decision, by conducting a case study about the implementation and diffusion of cap-and-trade policy in Tokyo's metropolitan area, arguing that that policy learning and diffusion play an essential role in the successful adoption and evolution of the policy which relates to a complex network of actors at different levels of governance. Takao demonstrates how policy learning and diffusion help to overcome political and institutional barriers via local government initiatives and stakeholder engagement. At the same time, research on policy diffusion

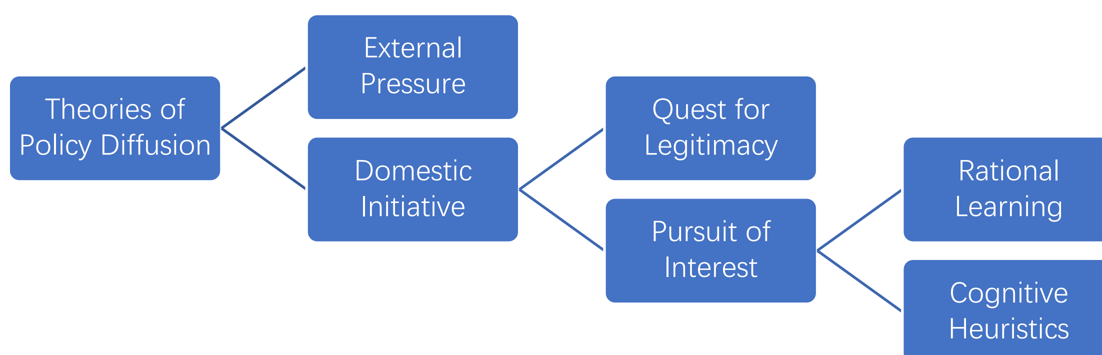
processes at time, space and institutional level were also developed in academia. Brown. L A and Cox. K R (1971) discover three regularities in diffusion: The S-curve in a temporal context, the 'proximity effect' in a spatial context, and the 'hierarchy effect' or 'short circuit effect' in the context of a central place system.

Regarding the mechanism and reason for policy diffusion, Charles R. S and Craig. V (2008:840) list four mechanisms for diffusion: 'learning from earlier adopters, economic competition among proximate cities, imitation of large cities, and coercion by state government'. Marsh. D and Sharman. J C (2009) also define these four mechanisms: learning, competition, coercion and mimicry. Dobbin. F, et al (2007) indicate four theories to explain diffusion phenomenon as constructivism, coercion theory, competition theory and learning theory. Karch. A (2007) suggests it is necessary to focus on the geographic proximity, imitation, emulation and competition to analyse the reasons for policy diffusion. Karch. A (2007) also outlines how the national organisation, policy promoter and central governmental organisation play significant roles in driving policy diffusion. Mintrom. M and Vergari. S (1998) explore the importance of the policy promoter and policy networks, which both significantly influence whether the policy can attain its legislative goal. Dolowitz. D and Marsh. D (1996) list six types of actors who form the driving force in policy diffusion: elected officials, political parties, bureaucrats, pressure groups, policy experts, and supra-national institutions. Dolowitz and Marsh also summarise three causes motivating a political entity/department/area adopting the policy of another entity/department/area: *voluntary transfer* (because they see its benefits); direct coercive transfer (one entity diffuses the policy under external pressure); indirect coercive transfer (policy is diffused as an unintentional side effect from a sense of responsibility).

Some scholars discuss causal mechanisms of policy diffusion from a structural perspective. Elkins. Z and Simmons. B A (2005) indicate two causal mechanisms in diffusion as policy adoption, the initiator's activities become the motivation for

diffusion, and policy learning, where the policy adopter confirms the rationality of adopting the new policy based on its expected benefits. Simmons. B, et al (2006) consider four mechanisms for the diffusion of a liberal economy on a global scale: hegemon, competition, learning and emulation. Hegemon means that the diffusion happened under external pressure in a vertical direction. Competition among countries triggers the adoption of liberal economic policy to avoid lagging behind (a horizontal direction). In learning, the effect of policy adoption in a country influences the decision in another country towards the same policy. Emulation is where one country emulates the policy from another country with a similar socio-economic context for external resonation, without analysing the benefits in detail.

Figure 8: Policy Diffusion Framework according to Weyland. K (2005)



Source: Weyland. K (2005)

Weyland. K (2005) uses figure above to summarise this mechanism. External pressure brings about rapid adoption of similar innovations in dissimilar settings, which forms a vertical imposition from the centre of the international system. Domestic policymakers have great latitude to legitimise diffusion and consider its benefits. Rational learning and cognitive heuristics help to approximate

comprehensive rationality for policymakers.

There is also literature shedding light on the process through which the diffusion can happen, factors that influence diffusion (Volden. C; 2006), actors in the diffusion (Balla. S J, 2001; Mintrom. H, 1997) and initiative process (Boehmke. F; 2005). Methodology for diffusion research can be found in Berry and Berry (1990), contributing to the use of event history analysis as a tool for studying the adoption of policy innovations. In this article, Berry. F S and Berry. W D (1990) adopt an event history analysis to examine the timing and patterns of state lottery adoption between 1964 and 1984, to form a detailed understanding of the dynamics of policy diffusion. Berry. W D and Baybeck. B (2005) suggest that Geographic Information Systems (GIS) can be used to study interstate competition. They demonstrate the utility of GIS by analysing competition between states for business investment.

Various topics appear in policy diffusion studies. Haider-Markel. D P (2001) explores how same-sex marriage bans spread in the United States during the 1990s, arguing that policy diffusion crossing different jurisdictions can be seen as an expansion of the scope of political conflict. Haider-Markel suggests policy diffusion as an important factor in understanding how political conflicts expand geographically and gain momentum over time. Mintrom. M (1997) conducts a case study of policy entrepreneurs who successfully diffused new policies, such as the promotion of charter schools and the creation of the earned income tax credit, providing insights into how policy change occurs in a decentralised political system, and the role of individuals and organisations in shaping the policy agenda. Mooney. C Z and Lee M H (1995) investigate how morality influenced the regulation of abortion in the United States prior to the *Roe* v. *Wade* Supreme Court decision, noting that states' decisions to liberalise abortion laws were influenced by moral attitudes towards women's rights and reproductive freedom, and also political and social movements advocating for change—highlighting the complex

interplay between morality, politics, and social change in shaping public agenda. Balla. S J (2001) provides case studies of professional associations, i.e., the American Planning Association and the National Association of Social Workers, that successfully diffused policy innovation such as smart growth and the adoption of licensing standards for social workers, discovering how professional associations drive policy diffusion across different states.

8.2.1.2 Review of Research on Policy Diffusion in China

Policy diffusion research in China is insufficiently developed (Wang. P Q and Lai. X J; 2013); in particular in the analysis of policy practice featured in Chinese social contexts. Lou. W L and Du. H (2022) conducted a systematic review of articles that relate to policy diffusion research in China, where international theories are localised into a concrete context.

In terms of understanding policy diffusion, four themes have been discussed in the research on policy diffusion within Chinese scholars: subject, path, content and process. In terms of diffusion subject, Wang. P Q and Lai. X J (2013) argue that policy diffuses from one area or department to other counterparts. Similarly, Liu. W (2012) and Zhou. W (2012) argue that policy diffusion is policy dissemination from A to B. Regarding the diffusion path, Zhu. X F and Zhao. H (2016) demonstrate that policy diffusion in China depends heavily on the inter-government relationship, whilst Yang. D F and Liu. X (2018) argue that it has been attained by specific social channels. In regard to diffusion content, Zhang. J, et al (2016) state that it incorporates policy knowledge, information and experiences. Meanwhile Yang. Z and Wei. S (2018) point out that the cognition, evaluation and adoption of a new policy are also its diffusion contents. Wei. J R (2021) emphasises how policy transformation can be attained via task set-up, policy design and political judgement. Zhou. Y Y and Huang. C P (2020) suggest that the diffusion process is the process of dynamic spread and communication, characterised by the ongoing exchange and adaptation of ideas and practices between actors and contexts,

leading to a more comprehensive understanding of policy and its effects. Ji. J X and Song. Y F (2020) suggest diffusion process comprises policy transfer, policy mimicking, policy recreation and re-utilisation.

Timelines for the completion of policy diffusion have also been discussed from different perspectives. Some researchers argue that if government launch or legitimised a policy, policy diffusion has been completed—otherwise the diffusion cannot be defined (Zhang. W, 2011; Zhu. Y P and Ding. S J, 2016; Zhu. D G and Hu. Z J, 2017)—whilst other scholars suggest that policy diffusion includes two phases, (i) adoption and (ii) operation. If policy is only publicly issued without practical operation, the policy has not functioned as it was supposed to, and cannot be deemed as successful policy diffusion (Damanpour. F and Schneider. M; 2008). Therefore, the timing of deciding the occurrence of policy diffusion should consider the whether the policy has been practiced functionally (Wu. J N, et al, 2014; Zhu. X F and Zhang. Y L, 2015).

Qualitative and quantitative methods have both been used to research policy diffusion. In qualitative research, case studies have been used for deeply investigating the diffusion phenomenon, and as a mechanism analysing the causal relationship between requirement and effect in policy diffusion (Yang. J W, 2006; Zhao. H, 2015). Comparative case studies can select cases that include similar elements, and analyse the different diffusion modes and innovations that happened in the process (Lin. X F, 2015; Cao. L H and Duan. R, 2017). The qualitative comparative analysis [67] (QCA) method has been used in diffusion analysis, because it can analyse small-scale samples (Xiong. Y and Zhou. J G; 2017) by systematic comparison (Yang. Z and Wei. S; 2020). Based on the logic of this

[67] Qualitative Comparative Analysis, QCA: a method for analysing and comparing cases based on the presence or absence of specific conditions. It is used to identify patterns and configurations of factors associated with a particular outcome of interest. QCA was introduced by Charles Ragin, a sociologist and political scientist, in the 1980s in the work 'The Comparative Method: Moving Beyond Qualitative and Quantitative Strategies', which laid out the theoretical and methodological foundations of the approach.

method, Zhang. G R (2017) utilises fuzzy set QCA (fsQCA), and Liu. X L, et al (2019) and Fan. Z Q (2020) conduct crisp set QCA (csQCA) to analyse policy diffusion process.

In quantitative research, Ma. L (2015) and Zhao. Q (2015) adopt event history analysis (EHA), combined with binomial logistic regression analysis to calculate the extent that policy diffusion has reached, as well as revealing the diffusion process. Zhu. X F and Zhao. H (2016) use causal meditation analysis[68] and EHA to identify the causal meditation mechanism of variables and their complicated inter-effect in policy diffusion. Huang. A S (2020) and Wang. F S and Zhang. H P (2021) combine the EHA and Cox Model[69] to examine the factors influencing policy diffusion and its inner demand. Feng. F and Zhou. X (2018) and Zheng. S M (2019) quantify the texts and then analyse the width, intensity, speed and direction of policy in diffusion process. Wang. X, et al (2021) adopt panel data regression analysis to investigate the diffusion mechanism and factors in the process of new industry policy. Most research defines diffusion by looking at whether or not the policy was adopted. However, the practical process usually is not black and white—there is a distinction between the extent to which a policy was disseminated and applied: widely and strongly or just narrowly and weakly? As a result, Liu. H Q and Liang. Y C (2021) use the Word Embedding Model to establish the coefficient of 'policy re-construction' with refined analysis.

In regard to the diffusion modes in China, Zhu. Y P (2010) summarises four modes in the Chinese policy diffusion process as: national-interaction, area-

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[68] Causal Mediation Analysis, CMA: a statistical method to examine the mechanisms by which an independent variable affects a dependent variable through one or more intervening variables, known as mediators, to test the extent to which the relationship between the independent and dependent variables is explained by the mediators, and to identify the specific pathways through which this occurs. This concept has been developed by several researchers over time, but the most widely recognised contributions have been made by Andrew F. Hayes, a psychologist and quantitative methodologist. He developed a widely used software package for conducting CMA in statistical software programs such as SPSS, SAS, and R.

[69] Cox's Proportional-Hazards Model: a statistical method used to analyse survival data, which is data that tracks the occurrence of an event of interest (such as death, failure, or disease) over time. It was first introduced by British statistician David Cox in 1972.

dissemination, leader follow-up, and vertical impact. Zhou. Y Y and Huang. C P (2020), Yang. J W (2006) and Ma. L (2015) emphasise the innovative and creative space of local government in policy practice. Either success and failure can become a lesson and point of knowledge reference for central government, which helps to strengthen the bottom-to-top diffusion mode. Miao. F T and Ci. Y P (2022) investigated how local policy practice becomes nation policy by analysing the policy diffusion of the New Rural Social Pension Scheme. They indicate the requirements in which the demand for a certain policy innovation widely exists but is not extremely urgent; the policy practice combines multiple political groups involved at local level, and paves the way for central adoption; the government becomes the lead implementer because of the hierarchical political structure in China.

Ma. L (2015) and Zhao. Q (2015) raise the concept of cross-level diffusion in China: central government will bypass provincial government and associate with local government directly in policy operation. Wen. H (2020) points out two paths in cross-level diffusion: from central to local dissemination and from local to central promotion. There is also horizontal policy diffusion from one department to several departments; they admit this policy and work together to promote it (Zhou. Y Y and Huang. C P, 2020; Yang. J W, 2006; Ma. L, 2015). Zhu. Y P (2010) indicates that diffusion occurs from higher demand areas to lower demand areas, or the areas in which the policy operates well, to areas in which the policy does not function well. Zheng. S M (2019) suggest a concentric circular radiation mode of diffusion—the first trial area will drive the areas around it in policy practice. Zhang. W (2011) depicts a sectorial radiation mode of diffusion—the areas closer to central government find it easier and more efficient to adopt the new policy, and the policy diffuses in a sectorial shape. Zhou. W (2016) argues that, after official policy adoption from central government, policy diffuses both vertically and horizontally, and eventually radiates to all areas. Wu. G Y and Wan. Y (2019) define *oblique diffusion,* finding that policy diffusion occurs between two political

districts with no political supervisory relationship. Yang. Z X (2019) suggests a wave-like crossing-level diffusion: policy innovation first happens in the suburb areas of a province, and then radiate to areas in other provinces; ultimately, central government absorbs the local experience and lessons, and promotes the policy at national scale. Wen. H (2020) suggests a multiple-centre and concentric circular radiation in policy solutions for crisis.

Policy diffusion also has different modes in time and space dimensions. Regarding the analysis of diffusion along a time dimension, most policies in China follow the S-shape progressive diffusion path (Yang. J W, 2006; Wu. B and Qi. X, 2020; Liu. Q, et al, 2019)—policy diffuses slowly at first, and then along with promotion from central government and adoption by local governments, the policy expands rapidly; eventually it returns to a stable and slower diffusion. However, S-shape diffusion is not always progressive, but may become a steep S-curve: the first stage of diffusion is slow, the second stage expands explosively, the last stage becomes still (Chen. T and Li. Y K; 2020). R-curve diffusion has been discussed in case studies where policy develops quickly in the first stage, explodes in the second stage, and at last, diffusion slows down, showing exponential rapid growth (Yang. Z and Wei. S, 2018; Lei. X C and Wang. N, 2019). Yang. Z and Wei. S (2018) also mention the inverse R-curve diffusion that the first stage diffusion rate is slow (around 10 per cent until the two-thirds of the way into the process), after that, diffusion explodes to reach 90 per cent diffusion rate in the final third.

In terms of the diffusion path in a space dimension, most policy diffusion in China follows the ‘trial in certain areas—national promotion’ mode, where the policy has been adopted in trial places and then expands to adjacent areas which have resource and information interactions with the trial places (Wang. H T and Wei. S Y, 2015; Li. J, 2017; Zeng. S C and Pian. S Y, 2019). Zhu. Y P (2010) suggests that in the Chinese context, a new policy (either macro reform-open policy for the whole nation or concrete policy innovation) usually launches in one or several

geographic areas. If proved successful, the policy is admitted by central government and then diffused to local government. Wang. J T and Ji. K W (2007) argue that there are gaps regarding social and economic resources among different areas, and hence, along with the policy diffusion, it can promote the communication and mutual learning resulting in the proximity effect in space. Diffusion is influenced not just by geographic distance but administrative level. For example, two cities have different levels of economic development, management capability, and human resources. This may result in 'leapfrog' hierarchical diffusion when these cities adopt the same policy (Wang. J T and Ji. K W; 2007). Wang. J T and Ji. K W (2007) also point out the axial effect in diffusion, which means the policy diffuses following a railway line or public highway. Zhang. W (2011) outlines the 'gathering effect' in policy diffusion, whereby surrounding areas of a policy trial location would potentially learn and adopt the same policy, and then become a gathering space for policy diffusion. Wen. H (2020) summarises the 'centred effect' in policy solutions to the Covid crisis. The policy towards the crisis forms the crisis-centre mode, political centre mode and economic centre diffusion.

Wang. P Q and Lai. X J (2013) summarise the mechanisms that influence policy diffusion in China, which include: learning, mimicking, competition, administrative order and societal formation. The *learning* mechanism means optionally learn from other policy experiences; *imitation* indicates the direct application of a policy from another region or bureaucratic department; *competition* represents the competitive relationship between governments due to the lack of resources, hence leading to policy adjustment; *administrative order* suggests more top-down operation regarding policy innovation and diffusion; *societal formation* identifies the multiple elements, such as politics, culture, economy, that influence the policy diffusion. Yang. D F (2016) suggests a 'tempting mechanism' occurs when lower administrative government attain better results and benefits, which in turn tempt higher administrative government to adopt new

policy. Zhu. D G and Hu. Z J (2017) indicate the importance of incentives given from higher level government to the lower levels, the encouragement or rewards from central to local level accelerate the policy diffusion. Wang. P Q and Lai. X J (2013) emphasise the role of civil organisation or social groups who raise the public agenda and accelerate it into a policy formation process. Liu. H B and Lin B (2019) mentions autonomous decision-making mechanisms—local government has more space in policy decision and practice.

In regard to the factors influencing the diffusion mechanism, from an individual and institutional perspective, Zhu. X F and Zhang. Y L (2015) investigate how the individual factors of government officials, such as age, educational experience, and career path influence the diffusion process. Conti. R M and Jodes. D K (2017) emphasise innovative motivations, and Zhang. K (2015) points out the personal quality of policy decision maker are direct incentives involved in diffusion. Adequate social connections, authoritative quality, and networks with other government officials also strongly influence diffusion (Conti. R M and Jodes. D K, 2017; Zhang. K, 2015; Yang. D F, 2016; Li. Z C, 2019). On the other hand, from an institutional perspective, governments with think-tanks will benefit from diffusion (Mccann P J C, et al; 2015). Centralised power structures incur many problems—but the highly coherent political culture and ideology promote policy to the local level quickly and easily (Zhu. X F and Zhao. H, 2016; Wang. F S and Zhang. H P, 2021; Fox. A M et al, 2017; Balsiger. J and Nahrath. S, 2015).

Regarding the factors influencing the diffusion mechanism from an internal and external perspective for an administrative unit/area or local government, the urgency of policy (Zhao. H, 2015), scale of government (Zhu. D G and Guo. J H; 2016), local economy, industry structure, openness of economy, and development of new technology (Zhu. D G and Hu. Z J, 2017; Zhu. X F and Zhang. Y L, 2015) all decide the adoption of policy for local government. Zhang. G R (2017) and Liu. Q, et al (2019) emphasise the important function of non-governmental and non-

profit organisations (NGOs/NPOs) in promoting policy diffusion. Wu. B and Xu. M (2018) find that economy-related policy diffuses easier and faster than other types of policy in China. If policy brings about comprehensive benefit, it helps diffusion more efficiently (Zhou. Y Y and Huang. C P; 2020). From an external perspective, the vertical pressure from higher government accelerates policy diffusion (Zhang. G R, 2017; Xiong. Y and Zhou. J G, 2017). Liu. Q, et al (2019) note that the pressure does not only diffuse in vertical direction, but also horizontally, as local governments mutually influence and compete with each other.

There is also discussion about the effect of policy diffusion. Liu. H Q and Liang. Y C (2021) separate policy diffusion into deep diffusion and superficial diffusion. Superficial diffusion or diffusion-on-the-surface means the policy has been adopted without much focus on how to localise and develop the policy into a concrete social environment—which is deep diffusion (Wang. F S and Zhang. H P, 2021; Feng. F and Zhou. X, 2018). Deep diffusion represents transformation happening within the diffusion; this can be understood as a process of policy reproduction (Liu. H Q and Liang. Y C; 2021). Yang. D F (2016) divides the effects into full-diffusion, conceptual-diffusion and negative diffusion. Full-diffusion means the policy has been adopted and practiced fully; conceptual-diffusion means the concept of policy has been accepted, but its realistic operation has not developed. Negative diffusion means that either at conceptual or practical level, the policy has not been adopted. One result of diffusion process is when policy innovation happens when local government tries the policy due to central government promotion (Zeng. S C and Pian. S Y, 2019; Wei. J R, 2021). Another result of policy reproduction is implementing a policy into a concrete local context with considering the previous diffusion experience (Meng. J Y, et al; 2020). Compared to passive reception of policy diffusion, reproduction requires more subjective motivation in its absorption and transformation (Wei. J R; 2021). Liu. W (2014) notes that if the policy application stays at superficial level, and is copied without mindful localisation, this is policy-mimicking. Wang. L Z and Pang. R (2018)

argue that when policy followers confront risk of adoption, at same time they lack of openness to the new policy as well as creativeness to localize the policy, the policy variation happens in the diffusion process when they changed the policy or the policy developed in another direction.

Based on the literature review above, I created a theoretical framework of policy diffusion in China, based on its specific political, socio-economic context:

Table 9: Theoretical Framework for Research on Policy Diffusion in China

Definition of Diffusion	Subject, Path, Content, Process	
Mode of Diffusion	Vertical Direction	
	Horizontal Direction	
	Mixed Shape	Sector, Radiation, Oblique, wave-like, multiple centre
Path of Diffusion	Time Dimension	S-shape Steep S-shape, R-shape Inverse R-shape
	Space Dimension	Trial area–national wide Hierarchical Diffusion Axial effect Proximity effect Crisis-centred
Mechanism of Diffusion	Learning Mimicry Competition Hierarchical Pressure Formation by Social Factors	
Influencing Factors for Diffusion	Individual–Institution Internal–External	
	Extent of Adoption	Deep

Effect of Diffusion		Superficial Full adoption Conceptual adoption, Negative adoption
	Transformation	Policy innovation Policy Reproduction Imitation Variation

(Source, author)

8.2.1.3 Review of Research on Policy Diffusion in Elderly Care

Since policy diffusion research is widely developed, and formal long-term elderly care in China only began in 2016, in contrast to the vast number of literatures on policy diffusion, there are only a few articles on Chinese elderly care adopting the perspective of policy diffusion theory.

Luo. X and Wang. R (2021) analyse the development of the LCTI by examining policy diffusion theory, indicating that the LTCI has gone through the localisation in three stages: as pilot-trial phase, partial-trial phase and expansion phase, based on learning foreign experiences. In the pilot-trial phase or pre-LTCI phase, from 2012 to 2016, the cities of Qingdao, Nantong, Changchun and Shanghai initiated an LTCI trial within certain political districts; the trial mainly explored the funding channels. The partial-trial phase from 2016 to 2020 was the official operation of LTCI within 15 cities. The experiences in this stage provided the lessons to policymaking for central government. The expansion stage, after 2020, in which central government slowed down the promotion of expansion based on the previous experiences in local operation, aimed to make more detailed policy design in each trial area.

The diffusion path of policy development in Chinese LTCI suggests three characteristics (Luo. X and Wang. R; 2021): inter-regional diffusion, top-down

hierarchical diffusion, and radiating bottom-to-top diffusion. Luo. X and Wang. R (2021) also point out three factors: a fragmental local insurance system, insufficient policy understanding, and incomplete financing mechanism as the reasons for the restricted policy promotion. As a result, they suggest a national scale of promotion in policy specification and diversity of funding channels.

Lyu. X R and Zhang. X Y (2022) investigate the role of government and the logic behind its organisational behaviour in purchasing home-based care service in 31 provinces in China from 2010 to 2019, through EHA from policy diffusion theory. They discover the degree of ageing is not the main driving factor in the diffusion process; rather, efficiency and legitimacy play essential roles promoting the diffusion. Regional fiscal capability, economic conditions, inter-governmental competition in a horizontal direction, and early signal release of central policy are significant factors influencing the diffusion. In addition, relationship between the age of officials and policy adoption is shown as U-shaped.

Huang. C and Liang. X Q (2021) investigate policy diffusion for a new service mode that combined medical and elderly care together, noting that the competition among benefit groups, the policy limitations, and the specific local context make a 'medical and elderly care together' mode difficult to diffuse at national scale. Che. F and Zhou. Y L (2022), using NVivo software, collected 223 policy documents on elderly care purchased from central and provisional governments from 2006-2020, indicating five phases of diffusion: local government initiation, local policy dissemination, central-government promotion, national-scale promotion, and transformation of policy.

8.2.2 Theoretical Analysis on Transferring the Japanese Care Manager Role to China

8.2.2.1 Is it Possible to Transfer? —The Transferability of Three Types of Care Manager from Empirical Evidence

The discussion on the transferability in previous chapters has been conducted

from the perspective of functionality based on empirical evidence. The main focus lies in the functionality of Japanese care manager within the LTCI structure, and hence the exploration of applying this mechanism into China is also conducted through evaluating the possibility and potential approach of achieving the same function as in Japan, by establishing and localising a path for social systems in China.

In empirical findings, the Japanese care manager role has been examined through work contents, role and challenges; analysis was conducted by looking at the major two layers of work relationship: individual-to-individual and individual-to-institution. Their work has been standardised through regulation in the macro system, and additionally, the care manager has to exert their individual interpersonal attributes to make work smoother with various institutional representatives in face-to-face human interactions.

According to the first-hand data collected from fieldwork, as well as literature, with regard to instituting a care manager role in **facility-based care** in China, I suggested the answer may be either yes or no—the introduction of such a role is not urgent, but it would be possible to set up such a mechanism for information collection and connecting the local resources. These are tasks that the administrative staff and social workers are currently handling, but without high quality or efficiency. The facility needs more effective collaboration with other institutions via a position such as care manager. On the other hand, as the care manager role is a senior position in career path, it requires more time and investment in education and training; therefore, costs may increase through having a facility care manager—but this may bring long-term benefit for the institution.

With respect to **community-based care**, the findings showed both a high necessity and potential for establishing a care manager. The care manager could be a key person to develop integrated care in the community, since more and more

older people prefer to 'age in place', which requires adequate care and medical delivery, both community-based and in the home. In China, the community centre functions similarly to the Japanese centre-based care manager. Usually, the community centre appoints administrative staff or a social worker to build care networks. However, they shift jobs frequently, due to unsatisfactory payment, and it takes time to build a network. Establishing an official care manager position will help to keep the person working stably, and keep the network operating in the long-term, in turn, developing the integrated care system.

Regarding **home-based care**, since the LTCI in China has not formulated a nation-wide standard for service and pricing, it would be difficult to establish a care management agency, as in Japan. Even in the pilot cities testing the LTCI, service providers are scattered in scale and quality, and have not yet formulated a complete market. In addition, insurance companies or home-visit service companies may provide individual-based care delivery through commercial contracts, which partially cover the function of Japanese agency-based care manager. As a result, introducing a care manager would be almost impossible at this point, and will take longer time to have a social mechanism to facilitate a home-based care manager.

8.2.2.2 How to Transfer? Policy Diffusion of the Care Manager Mechanism

In the previous section—whether it is possible to transfer, I discussed whether it is possible to transfer the care manager through investigating three types of Japanese care manager within LTCI system, as well as the special circumstances of counterparts in applying such social role. In this section, I will use policy diffusion theory to analyse—how to transfer? i.e., if China applies a care manager role, how would they adopt and diffuse this mechanism in its specific socio-economic context: what are the barriers, and what is the potential?

The analysis regarding 'how' to diffuse the new mechanism is conducted according

to the inner logical sequence that Weyland. K (2005) created in his theoretical framework (see Figure 8). Since China has its own societal and political features, the analysis will also incorporate the theoretical framework created for the policy diffusion research in China (see Table 9), to form a comprehensive understanding towards the question about the promotion of care manager and related policies for elderly care.

In Weyland's theory, the external pressure may come from international organisation or central government (towards local government). For China, the urgent need for innovating the welfare system is not coming from external pressure, but rather the domestic policy agenda for an anticipated massive ageing population. Central government is seeking appropriate policy by referring to modes operated in other countries, such as Japan and Germany. Learning and imitation is the relationship with the external environment regarding elderly care policy in China.

With strong domestic momentum, Weyland suggests policy diffusion happens through a quest for legitimacy and pursuit of interest. As is well known, the policy diffusion process in China displays a strong top-down tendency, and thus the standard guide and policy from central government is essential for a policy promotion in Chinese society. Because of this hierarchical structure, the quest for legitimacy would not be a problem in the adoption of a new policy for the central government. Usually, welfare policy and other types of policies disseminated in the approach of 'trail areas to national scale' (Wang. P Q and Lai. X J; 2013). The LTCI was launched officially by central government in 2016 and was tested in a few cities. Unlike the Japanese care manager, rooted in the LTCI and receiving payment from the system, there is no complete career path in China, and the source of financial reward for care staff does not have stability even in trial areas. Therefore, there are two directions for solving this: (i) a central policy in the top-down pattern, to stabilise finance and establish a national standard of qualification for

people who work in the elderly care industry, and thus help to accelerate the increase of care managers if applied in the Chinese LTCI, or (ii) diffuse this mechanism in the bottom-up way, stabilising the care manager and related social structure in local areas first, and then central government can absorb local lessons and experience, ultimately creating a nation-wide operated policy.

Weyland then mentions the pursuit of interest is an important driving factor for diffusion, including rational learning and cognitive heuristics. As in empirical analysis previously, the community-based care manager *is required,* and it is possible to have this mechanism in facility-based care; but would be difficult to immediately translate this role into home-based care. The benefits of having a care manager in community- and facility-based care are: gathering social resources to promote integrated care, increase efficiency in connecting various institutions, and reduce costs of care workers and social workers in facilities. However, it is important to invest both time and finance in educating and training around such a social role, legitimising its position in the elderly care system. After attaining policy benefits in diffusing the need for care managers, a successful area/local government may incur the proximity effect, and thus drive the 'rational learning' (Weyland. K; 2005) of another area/local government. Weyland suggests that 'cognitive heuristics' is the most common explanation for the diffusion mechanism. In addition, the mechanism may diffuse from a place with a higher driven force to a lower one. For example, an area with higher ageing rate might need more urgent policy diffusion than an area in which the service provision is not urgently needed. Since there are distinct regional characteristics in each province in China, it is also difficult to promote a 'one-size fit all' policy. Any policy, even from the central level, has to localise into its concrete circumstances, and transform accordingly with the practical conditions of its operation.

In contrast to the national-standardised LTCI in Japan, China has divergent local circumstances. For example, within the first trial cities, their service coverage,

financing approach and designation of health level are greatly different from each other. The cities of Changchun, Guangzhou and Ningbo fund LTCI through a medical insurance pool; the rest of the cities have adopted various different approaches. Since there is distinct economic gap between these cities, social equity also becomes an issue inviting wide discussion. For example, the elderly in the city of Chongqing should pay for 150 RNB per year, in contrast with the 30 RNB per year in the city of Anqing (Luo. X and Wang. R; 2021). Payment for care workers also differs largely according to the local economy. The depth of policy practice responding to central government also differs across areas. The cities of Shanghai, Chengdu, Qingdao and Suzhou established a standard designation for the care level and put them into practice. The rest of the areas still have great ambiguity in applying concrete services from the LTCI (Luo. X and Wang. R; 2021). Charles R. S and Craig. V (2008) point out two natures of policy diffusion mechanism as 'temporal' and 'conditional'. Regarding the conditional nature of mechanism, they suggest larger cities are more capable to learn from other areas, "less susceptible to economic competition" and not be coerced strongly. Indeed, economic-advanced province or cities in China have advantage in different types of resources, i.e. economy, human resource, abundant administrative experiences, etc. However, larger cities do not represent not be coerced due to the central-dominant political structure. LTCI—as the 'sixth insurance'[70]—has not stabilised its funding approaches at present. The cities in the first trial stage mainly take medical insurance as a funding resource for the LTCI. However, since there is large medical gap funding existing between cities, according to their economic abundance, the service ranges and targets also have great differences. The cities of

[70] The sixth insurance 第六险种: before the LTCI, as the sixth insurance, there are 'five insurances and one fund', which is called 五险一金 in China, as the basic insurance system for each employee. 五险一金 refers to five social insurances and one housing fund, which employers are required to provide mandatorily for employees by the government. The five insurances contain endowment, medical, unemployment, work-related injury and maternity insurances, while one fund refers to the housing fund that provides financial support for housing-related expenses. Together, these policies and fund form the basic social security system for employees in China.

Shanghai and Suzhou cover the LTCI for the rural residents,[71] while the rest of cities only provide the LTCI for the urban residents (Luo. X and Wang. R; 2021).

Beside the hierarchical pressure from central government, the diffusion process and its effect on a social mechanism also largely depends on the local context. The adoption and diffusion of care managers, as part of the care provision system, has also varied according to the provisional environment. Referring to the theoretical framework for policy diffusion research in China created previously (see Table 9), possible approaches to adopting and diffusing the mechanism of care manager comprise (i) the widely well-known vertical diffusion from higher governmental level to the lower level. Wang. P Q and Lai. X J (2013) argue that from the previous experiences of the operation of public policy in China, the 'trial place to the whole country' is a basic and common approach in history. It is similar to coercion regarding diffusion mechanism (Charles R. S and Craig. V; 2008) discussed in western studies but with obvious difference because the central government of China has the absolute dominant power over local governments. Therefore, developing the care manager mechanism from central government's official political demand may become the most powerful and effective way for policy diffusion.

On the other hand, (ii) the mode 'from innovation of local government to central government's adoption', i.e., the bottom-up absorption mode, means local government actively uses the creative space to practice new policy, from which to provide lessons and motivation for central government to promote it to a national-scale policy. The care manager is a new concept for elderly care provision, and it needs time to receive social recognition and acceptance, on which basis to form

[71] Rural resident and urban resident: there is a household registration system 户口制度 in China that identifies an individual as a resident of an urban or rural area. This system can track an individual's place of origin, family member, and other personal information. It also relates to various social welfare benefit, including education, medical care, and employment opportunities. Urban residents generally have more access to social services and better economic opportunities than rural counterparts.

the rationale of innovating a national system. For example, the community centre or district centre could initially establish the position in the care delivery system, allowing the beneficiaries and other stakeholders to experience the benefits of such role, and then diffuse this to a larger range of operation, from which it may at last become official, national policy.

As mentioned before, the diffusion also has a 'proximity effect' among the same administrative level of governments/areas in China, such as the Open and Reform Policy, which enabled the east and southern east of China to achieve tremendous economic success, and gradually influenced the middle and west part of China to develop along the same lines. The potential diffusion of care manager might undergo a similar pattern that develops in the first trial areas, or an area in which elderly care system is highly developed, and then expand this practice to other areas once the first cluster of trial places achieved policy benefits from it, , as Charles R. S and Craig. V (2008) note that 'the likelihood' for a city to adopt a new policy becomes higher when it has been conducted in other cities in their learning and imitation hypothesis.

Finally, another social mechanism for the diffusion of the care manager role in elderly service provision may come from the activities of social groups. From investigation in the fieldwork, NPOs and NGOs have become more active in recent years. They organise social workers / care workers, and work with facilities in the community, enabling them to develop new models to provide home and community-based care service, and at the same time, to increase the financial payment for these care workers or social workers through social networks. Although there are no true NGOs in the dominant political culture in China, civil society has been able to raise awareness among local people, and has become an indispensable factor in building a more complete elderly care system. Many social or care workers also expect to have a career potential, instead of an exhausting job with low pay, seemingly without any future potential—they expect to be able to

progress further if they are to continue to serve in this industry in the long-term. The establishment of the care manager, would possibly become such a motivation for care workers or social workers, as well as a mechanism to encourage more educated people to become involved in the elderly care service.

8.3 Conclusion

This chapter has conducted a theoretical analysis on the two major research questions of the thesis, i.e., the role of the Japanese care manager and the transferability of this mechanism into China, through the body theory and policy diffusion theory, respectively. There are abundant theories in interpreting similar research issues. The reason for choosing these two theories lies in the contents of the questions themselves. The first question is centred on the Japanese care manager, using the 'power-body' structure to understand the dynamics interacting between an institutional structure and an individual identity. In the case of the Japanese care manager, the 'body' becomes a socially existential identity—the care manager, the 'power' is embedded in the structure, and hence comprehensively impacts the body. Thereafter, I incorporated Foucault's 'power-body' context into a sociological interpretation. The second question is the discussion on the transferability of the care manager role, as a possible solution to the increasing numbers of the ageing population in China, by learning from Japan. It would not be a policy-transfer process, because the policy design of Japanese care manager cannot be applied directly into Chinese society and its current LTCI system. Consequently, I choose the policy diffusion theory to explore possible mechanisms to adopt and develop the care manager role in the Chinese political context, to investigate the potential for and barriers against so, in order to suggest a policy solution for the serious social issue of caring for the ageing population.

I understand that it is not enough to analyse research questions from two separate theories. There are also other options for explaining them from different approaches. From personal understanding, the meaning of theory is the

summarisation and abstraction of certain phenomena, and discovering the internal regularities/rules based on which to form our explanations and interpretations. Elderly care is an inter-disciplinary topic, both in academia and in practice, and thus understanding towards the care manager role relates to different genres of theories. Care, as a research topic for humanity, naturally has its 'soft dimension' in interpretation when touching the individual level—and inevitably, must also look at the hard structures on which to sustain this soft dimension. In the whole study of care manager, especially when I associate with care managers, care workers, and the elderly face-to-face, I found the soft and humanitarian quality had more influence over the elderly care system, which led me to perceive the care manager as a vivid 'body'. On the other hand, when I travelled from Japan to China, my concern for the accurate and sustainable design of a hard structure—especially when considering the possibility of applying a social mechanism that works successfully in one country into another state's distinct political context—drew my attention towards finding a potential solution to the pressing social agenda of ageing, worldwide.

Chapter 9: Conclusion

9.1 Research Summary

This study explored the role of Japanese care manager in the long-term care insurance system (LTCI) and discussed the possibility of transferring this mechanism into the Chinese elderly care system. In Japan, the LTCI guarantees sustainable financial resources for care provision, as well as the workforce supply to provide this care. The care manager is the pivotal role—in Japanese, the *jiku*. They bridge the institutions and the individual, and sustain the normal function of entire the LTCI. Dintrans. V P (2020) lists the four elements to consider when establishing a long-term care system for the elderly: the beneficiary, the benefit package, the providers and the financing. He also emphasises that the efficiency of an LTCI system not only lies within each component, but also in the way they interact and cooperate with one another. The care manager in the Japanese LTCI system is the service provider; their role interacts with the other three elements: the beneficiary, the benefit package and the financing.

This research examined facility-based, agency-based and community centre-based care managers in the Japanese LTCI system. The care manager provides us with a micro-level image that mirrors that how the macro-level system functions. They are the 'director', allowing diverse actors to play their roles to their maximum effectiveness in the arena. The care manager deals with various relationships, either in personal interactions, or at institutional level, operating by a standardised work code. According to their job description, an analysis of their roles and challenges can be conducted via exploring these two layers of work connections: *individual-to-individual* relationships, i.e., care manager relating to beneficiaries and their families; *individual-to-institution* relationships, i.e., care manager working with their affiliated facility/agency/centre, the municipality, medical institutions and other service providers.

After examining the role of the Japanese care manager through their functionality, the research attention shifted to China. This research initiates a pilot discussion on the possibility of transferring the social mechanism of Japanese care manager into Chinese elderly care. Due to the vast differences regarding socio-political systems between Japan and China, as well as the limitations of time and thesis scope, this research is not a comparative study between two systems—but rather a reflection on the current differences, and an exploration of possible approaches towards a better construction of the system.

This research answered three major questions: firstly, an investigation into the role and challenges faced by the Japanese care manager in the LTCI, to understand elderly care management in Japan; secondly, an examination of the current elderly care system in China, and a discussion on the necessity and possibility of applying the mechanism of care manager into this system; and last but not least, a theoretical reflection on the existence of the care manager, and a discussion on the delivery of elderly care beyond geographical context, based on insights gained from empirical studies in Japan and China.

This research does not confine itself to an empirical perspective, but ventures to provide theoretical reflections. I explore analysis based on policy diffusion theory and body theory to interpret the research questions after summarising the article reviews of other theorists. Regarding the discussion on the transferability of Japanese care manager, the policy diffusion theory has been used to discuss a possible approach to adopting the care manager mechanism in China; whilst the body theory has been adopted to understand the nature of the care manager in the LTCI.

9.1.1 The Role and Challenges faced by Japanese Care Managers in Elderly Care Management in Japan

I stayed in Japan for one year, and in China for several weeks for the fieldwork. This research comprises first-hand data from fieldwork, as well as secondary data from

literature studies. Facility-based, agency-based and community centre-based care managers have been examined via three case studies, comprising field observation, semi-structured in-depth interviews with care managers, and open interviews with people related to the care manager's work. As a supplementary addition to these case studies, a set of semi-structured interviews have been conducted towards the three types of care managers. Following my investigation in Japan, I also undertook visits and interviews with people related to my research. Since there is no role of care manager in China at this point, interviews in China were conducted towards people who are experienced in elderly care, sharing their frontline perspectives towards my research questions regarding the transferability of the specific social mechanism of 'care manager' within care provision.

In the facility-based care manager case study, observation and semi-structured interviews were undertaken towards the care manager *T²-san*, who worked in a large-scale nursing home. Open interviews were conducted towards her colleagues to gain more insight into the care manager's work. Besides this, semi-structured interviews were conducted towards other facility-based care managers, away from their working environments. At *individual-to-individual* level, the conflicts between the care manager and the beneficiary were found to be mainly in making the care plan. The ability to get the *honne* from the elderly person, and harmonise the demand and supply regarding service provision are essential qualities of a successful care manager. Unlike home-based care management, elderly people living a facility utilise both hard and soft resources within the facility. Therefore, optimising people, time, equipment to meet the demand is essential for a facility-based care manager. *T²-san* pointed out very small details, such as assisting an old man in toileting—the patient would accept help from staff to help him sit on the toilet, but not to help him take off his trousers. Also, the service provision the care manager may deem to be necessary might conflict with what the beneficiary and their family might think. People living with dementia may

easily forget they have eaten a meal or done some exercise, and this lack of recall may cause misunderstandings between the care manager and the beneficiary and family.

On the other hand, at the *individual-to-institution* level, being a team member as well as having an inspectorate role within the facility is a challenge for the care manager, both in a practical and psychological sense. They pointed out ‘cross-border’ problems regarding responsibilities in their work. *I-san* indicated that in the facility, other experienced care workers might think they understand their work better than the care manager. *N-san* faced an unclear workload, but rather than finding this to be a negative situation, rather she demonstrated her understanding of the system, recognising the shortage in workforce in current care provision. In regard to their relationship with municipality, all studied care managers expressed the desire to simplify the administrative forms, so as to have more time devoted to increasing service quality for the older people in their care. In the relationship with medical institutions and service providers, T^2*-san* emphasised the potential impact a background knowledge of medical training might have for a care manager in terms of communication with medical staff. O^2*-san, U-san* and *N-san* all indicated the need to improve mutual understanding between the care manager and medical staff, since medical staff usually pay more attention to the medical treatment of a beneficiary, rather than a broader, more comprehensive approach to a person’s care—unlike the care manager’s focus. *U-san* also expressed a hope for improvements to medical assistance for people residing in facility for end-of-life care, especially at night-time, since older people in this period of life may experience any type of emergency, beyond the capability of normal care workers to tackle.

In the case study of agency-based care managers, I undertook a one-day field observation and semi-structured in-depth interview with the care manager T^1*-san*. In contrast to the facility-based care manager, where all data can be collected at

the facility, agency-based care managers have to move around a lot. Therefore, my observations happened in various external locations. In addition, I undertook a set of interviews towards other agency-based care managers, including T^1*-san's* colleague. At the *individual-to-individual* level, T^1*san* accentuated the importance of removing her own personal judgement and framing, and accepting all kinds of personal traits on the beneficiary's side. W^1*-san* resonated with this point, and addressed the diversity in lifestyles she had experienced during her contacts with beneficiaries. M^1*-san* mentioned the dilemma of making care plans when the individual beneficiary and their family members held different opinions. Particularly, for a *care required* level 3 or 4 beneficiary, they are not like *care required* level 5 (top level of care requirement) beneficiary, whose care provision is decided mainly by the care manager. *Care required* level 3 or 4 may not have physical ability in movement, but they tend to have personal preferences in how service is provided to them. For example, a care manager may possibly decide the frequency and time of sending care workers to assist with toileting and hygiene for *care required* level 5—who almost are bedridden without any mobility. However, beneficiaries designated *care required* level 3 or 4 may still want to go to toilet by themselves, but do not have the physical ability to do so without assistance. In such a case, it is difficult to decide in the care plan how and when to send care workers for home-based visits.

At the *individual-to-institution* level, in addition to excessively complex and repetitious administration, T^1*-san* expressed the desire for clarification over the 'grey areas' in terms of service standards and items, when negotiating with service providers. M^1*-san* underlined the time cost on updating beneficiary on the latest LTCI policy changes. *J-san* and Y^2*-san* pointed out that more time is spent on the cases of elderly people living alone, or with complex issues, which renders standardised payments for each case unfair. In regard to relations with medical institutions and service providers, *J-san* mentioned some service providers tend to reject cases where the beneficiary has illness, so that it takes additional time to

find proper service providers in such cases. *Y^1san* and *Y^2-san* highlighted the high time costs of meeting for care managers: firstly, if the beneficiary's designation of care level changes, everything has to be renewed in the care plan; secondly, the beneficiary's children are normally working people with little time for meetings on weekdays, resulting in many meetings at the weekend for the care manager. *T^1-san* noted the phenomena of both the 'egoistical' care manager (*erasōna*) and the 'obedient' care manager (*goyōkiki*) in their interactions with service providers and beneficiaries. A care manager should pay attention to the tendency to become egoistical when service providers 'woo' the care manager, meanwhile avoiding the tendency to perfectionism, accepting all demands made by the beneficiary, and allowing this to override their own professional evaluation in deciding appropriate care provision.

The third case study, of the community centre-based care manager, is known as a direct care manager in the LTCI system. In this case study, I undertook a field observation and semi-structured interview with the care manager *K-san*. During the process, I was allowed to attend an event as a volunteer, which was also a participant observation. In the same way as in the previous two case studies, I also interviewed other centre-based care managers. Differing from the facility-based and agency-based care managers, at the *individual-to-individual* level, the centre-based care manager mostly works on complex cases, and also provides guidance for junior care managers. Their challenge relates to resistance from agency-based care managers regarding training tasks, and also their responsibility to promote the construction of an integrated care system in the community. Regarding the *individual-to-institution* level, the complicated documentation was mentioned by *K-san, K-san, M^2-san* and *W^2-san,* who all expressed their hope of reform for *assistance required* care planning for centre-based care managers. *Assistance required* care at level 3 or 4 takes the same amount of time as *care required*, but managers receive approximately one third of the *assistance required* payment for each case. As the senior role on the career path, they are also expected to have

more connection with medical staff, greater collaboration with social welfare workers, and build a more complete care system, with the assistance of the municipality. Insufficient cooperation in treating dementia, and the high cost of communication were stressed, regarding collaboration with medical institutions and service providers.

The three case studies uncovered the practical dynamics of the Japanese care manager within the LTCI system. To understand their work contents, role and challenges, analysis was conducted by looking at the major two layers of work relationship: at *individual-to-individual* and *individual-to-institution* levels. By investigating such key positions in the LTCI, we may understand the dynamic of the whole system regarding elderly care delivery in Japan. Despite the differences in working situations among the three types of care managers, there are commonalities to be noted in terms of the care manager and the LTCI system: firstly, almost all types of care manager highlighted the overload of paperwork for administration purposes, which left their interactions with beneficiaries rather pressed for time. The initial purpose of the LTCI was to guarantee the appropriate elderly care provision for the aged people. However, they are now so occupied in administrative work much that the initial purpose of the LTCI has been overshadowed. Secondly, clarity in regard to work responsibilities as well as service items in grey areas are important for improving their work efficiency. Thirdly, they expect greater financial reward and stable policies, to encourage more people to become involved in elderly care, instead of the old impression of '3K' work—to build up stronger and brighter vision in this industry by assistance from the LTCI, as well as other social resources. Finally, although care managers have standardised training and exams, all the managers in my interviews agreed that their personalities greatly shaped their work progress, especially in complex cases. Care managers are in touch with diverse people all the time, which requires great flexibility and communication skills, an empathetic heart and strong persistence.

The care manager is rooted in the Japanese LTCI system, bridging the macro and micro mechanisms, and contributing to elderly care provision. Their work has been standardised through regulation in the macro system, and additionally, they have to exert their individual interpersonal attributes to make work smoother, since they communicate with various institutional representatives in face-to-face human interactions. In light of these practical findings, this research suggests several improvements for the higher efficiency of the LTCI system:

Recommendations for the Improvements to the Role and Processes Related to Japanese Care Managers in Elderly Care Management in Japan

i. *Simplify the paper forms, making them more concise regarding contents to reduce administration time-costs and refocus time on work that directly relates to enhancement of service quality.*
ii. *Consider possible reform regarding the nature of assistance required care plans, and to clarify the responsibilities of the facility-based care manager.*
iii. *Against the background of low fertility rates and the ever-increasing ageing population, integrated care in the community is important to maximise social resources and expedite care service delivery. Promoting integrated care needs active and practical policies at the macro-level, to reduce communication costs for the care manager in their work of liaising between institutions.*
iv. *Formulate a series of policies to promote a sustainable and qualified workforce in the elderly care industry, reducing the Kiken, Kitsui and kitanai stigma as perceived characteristics of work in elderly care. Additionally, rates of pay are not equivalent to the efforts they put into the workplace, further reducing the incentive to work in this area. Stimulate human capital through efforts at all policy levels; the fundamental cause of many of the care managers current challenges are linked to the labour shortage in the industry.*

Examining the Japanese care manager helps us to understand elderly care delivery in Japan, as a super-ageing country, and their solution and transferable lessons for this trans-national social issue. As a long-term commercial partner and geographic neighbour, China is also facing an unprecedented ageing rate from a significant population base. Therefore, this research also shared attention to elderly care in

China.

Rather than a comparative analysis of the LTCI between Japan and China, this research conducted a discussion on the transferability of the Japanese care manager role into the Chinese context, from its general functionality within the LTCI. China initiated the LTCI in 2016, within limited areas. Therefore, this discussion is formulated not only in the LTCI trial regions, but nationwide. Unlike Japan, there is no home-based care management agency in China yet. Therefore, I conducted investigations in facility-based care and community-based care, via personal visits and interviews in Nanjing, Bengbu and Shenzhen, across the coastal and inland areas.

9.1.2 Potential for Transferring the Care Manager Model to Chinese Elderly Care

What I learned, saw, and heard in China could have developed into three case studies, had the scope of my research allowed. As the research question is about the possibility of applying the care manager role into Chinese elderly care, thus I retained the original structure of just one chapter devoted to the Chinese case, focused on exploring the transferability of the role from a functional perspective.

According to the first-hand data collected from fieldwork as well as literature studies, in regard to *facility-based care* in China, I suggested the answer to the transferability of Japanese care manager may be either yes *or* no. It is not urgently needed, but it is possible to establish such a mechanism, responsible for collecting information about older people, as well as connecting with local resources—which tasks the administrative staff and social workers are handling right now, but without high quality or efficiency; the facility is expected to improve effective collaboration with other institutions, and hence will either need to use more care workers, or create a position like the care manager. However, the care manager role is a senior position in the care market career path. It requires more time and investment in education and training; therefore, costs may increase through

having a facility care manager, but this may bring long-term benefit for the development.

With respect to *community-based care*, the findings showed both a high necessity and potential for establishing a care manager. Having an experienced role which entails both care knowledge and social networking abilities, a care manager could be a key person to construct integrated care in the community, since more and more older people prefer to 'age in place', which requires sufficient care and medical delivery covering both community-based and in the home. The Japanese centre-based care manager plays a significant role in bridging diverse institutions in the community. In China, the community centre functions similarly to the Japanese centre-based care manager. Usually, the community centre appoints administrative staff or a social worker to build care networks. However, they shift jobs frequently, due to unsatisfactory payment, and it takes time to build a network. Establishing an official care manager position will help to keep the person working stably, and keep the network operating in the long term, in turn, developing the integrated care system.

Regarding *home-based care*, since the LTCI has not formulated a nation-wide standard for service and pricing, there is no possibility of setting up a care management agency yet, as in Japan. Even in the pilot cities testing the LTCI, service providers are scattered in scale and quality, and have not yet formulated a complete market. Thus, there is almost no meaning in establishing a home-based care provision agency. In addition, insurance companies or home-visit service companies may provide individual-based care delivery through commercial contracts, which partially fulfil the function of the Japanese agency-based care manager.

Although different types of elderly care have varied responses to the questions regarding transferability of the Japanese system of care manager, the most pressing policy issue across the whole system is that of constructing a complete

career path for the elderly care workforce in China. In the short term, this may need financial investment and support from social resources to create standardised regulation and training systems and build an early form of workforce career path. Nonetheless, in the long term, a complete career path within the service industry will definitely nurture human capital within elderly care, giving people a vision of social care, social recognition for their industry, and ultimately increase willingness to work in this area.

The first thing that triggered my curiosity about this area of research a is my personal experience. I am from the so-called 'one-child' generation, living distant from my hometown and parents. During a previous decade of living abroad, in Japan and the UK, I missed several important moments during which I felt I should be with my family. I was preparing for an exam in Japan when my mother was having a surgery to remove a tumour; I was in the UK when my father broke both his arms—an accident about which he only told me once he had totally recovered. I think such incidents will only increase in the future. Therefore, the challenge and possible solution for how to manage my parents' ageing—indeed, for older people across China, and on a global scale—drew my attention deeply. I also noted that Japan has more experience in policy testing, based on responding to this problem of a rapidly ageing population.

As a PhD student, and especially as a foreigner, time and resources were limited for collecting data and building trusted relationships with care managers. Accordingly, this research did not reach perfect data robustness—but it reached the maximum of my effort in the process. I investigated the macro and micro levels of the system in Japan and China, tried my best to balance the pros and cons within accessible resources to collect and formulate data, via field observation including non-participant observation and participant observation, semi-structured in-depth interviews, and open interviews. The pandemic brought great changes in elderly care, according to my ongoing contact with the care managers I

interviewed. I hope there will be an opportunity to discover the latest situation on this topic in the future, if time and resources allow.

9.2 Theoretical Reflections

Care is an innate attribute, the same as love. Being cared for or loved by others, and the care and love of others are both important experiences for a human being. Elderly care for a person at the last stage of life embodies comprehensive implications. From the perspective of phenomenological narrative, elderly care in the course of life might be like the last chapter of a story, into which are woven memories, social values and cultural fabrics. From the perspective of cultural anthropology, elderly care might become an interactive space in which exchanging individual concern, vulnerability, and sensitivity are situated in a specific structural context, i.e., the LTCI in Japan. From the perspective of political sociology, elderly care becomes a public policy welfare agenda, finding solutions through the socio-economic environment. From the perspective of gerontology, elderly care links clinical and ethical issues, seeking an approach to minimise pain, both physically and psychologically, for the final farewell.

What is elderly care and how should it be properly provided?

This question haunted me throughout my research journey. Elderly care relates to physical comfort, emotional harmony, and even spiritual serenity at the end of life. It is difficult to define proper elderly care based on only one circumstance—to say, if we do this, this is enough for elderly care. In the same way, at the conclusion of my research, I did not categorize it into a specific discipline, with a '*-gy*'. Instead, I situated my interpretation into theories responding the specific research question.

This research focused on the care manager—the system operator bridging macro and micro levels in LTCI structures. The care manager mirrors the connections between the LTCI as a macro system, and the older people as micro unit. Their active function represents the successful place in the policy design of LTCI, whilst

their challenges in the work indicate what still needs to improve. It provides lessons and examples for another nation in dealing with elderly care delivery.

Establishing an appropriate LTCI structure rooted in Chinese social characteristics has been widely discussed in society and academia. Japan and China share many aspects of subtle internal homogeneities, regarding cultural consideration, filial piety values, and basic life patterns—due to very close long-term interactions in business and culture over the past thousands of years. On the other hand, China also now has a significantly different societal base from which it will operate the LTCI. Since 2016, China has been in the initial stages of the LTCI, conducted only within designated areas. Moreover, there is no mechanism like the Japanese care manager in the Chinese care market. This absence triggered my curiosity to examine the applicability of such a mechanism in a different national environment. The discussion on transferability has to consider the various diversities between the two social systems of Japan and China, and thereafter, for a concise and clear solution, I analysed these systems from the perspective of functionality, trying to explore how Chinese social structures can attain similar functions, and ground solutions in its own way.

In the current Chinese market, it is possible to establish a facility-based care manager, but it will need time to train managers to work differently to social workers, regarding their connection with medical institutions. At this point, it is unlikely that China could institute an agency-based care manager and it would need policy support on a national scale. It is imperative to set up a centre-based care manager within community centres, and this role will help to speed up the formulation of integrated care in the local community. In addition to this conclusion, I also suggest a broader range of policy support. The LTCI is conducted in just a few cities in China. If the whole LTCI system wants to attain more effective and fruitful function, standardised regulation of care levels and provision is needed. If regulation on a national scale is currently difficult, due to economic gaps

within different areas, it will be pragmatically beneficial to have a provincial standard, regardless of whether the region contains an LTCI test city or not. A unified standard at the macro level would provide rationales and work codes for people involved at the micro level.

I stayed in Japan and China for over a year, and travelled here and there in the region for this study. During this long process, I met many kinds of people working in the care industry, as well as many elderly people living in the institutions I visited. From my personal experience, elderly care is—at first glance—a face-to-face intimate interaction between the service provider and receiver, and thus a qualified and effective work force has great significance for the system. In Japan, the care manager is rooted within and has an impact upon the LTCI; in turn, the transformation of the LTCI affects the care manager. They combine together, and function as a package. In the meantime, China remains at the initial stages of applying the LTCI model. One important issue for sustainable development is to build a sufficiently professional workforce of an adequate size within care provision.

The topic of transferability relates to the structural design and formation of a social system; it is not a direct policy-transfer process, i.e., not a copy-paste action. Transferability certainly requires the consideration of the local situation from comprehensive perspectives, and thus I used the policy diffusion theory to interpret applying the mechanism of care manager in China. In fact, Japanese entrepreneurs have tried to progress in Chinese market. Some Japanese elderly care enterprises tried to open subsidiary institutions in China. However, the significant differences inside the structural formulation must also be paid considered; heterogeneity instead of homogeneity has strong effect on the practical formulation of social structures. For example, when the Japanese elderly care subsidiary institutions opened in China, they confronted many challenges in adapting to the cultural and political environments. The *transferability* of the

Japanese care manager works in the same way as any other social mechanism.

As concluded in the previous chapter, there might be four diffusion approaches for transferring the mechanism of care manager in the current LTCI system in China. The first is the vertical promotion from central government to local government. The initiation of the LTCI started in this way, and has been tested in a few cities. At present, the LTCI system has not been formed across the country, and therefore it would be difficult to release a policy to establish the care manager nationwide at this point. The second possible diffusion approach is from central government to central government, through the 'absorption mode'; central government would adopt a successful local policy to promote it as a national-scale policy after the care manager's mechanism is proved to work well in the elderly care system. The third diffusion path lies in the interactive effect, i.e., 'proximity effect' between local governments or areas. Another local government would choose the similar policy approach when they see the benefit from it when conducted in another area. Although there are large gaps in terms of economy, climate, and population among provinces in China, local government can adopt a policy trial based on its own features and form its own version for local people. The fourth potential diffusion path might arise from related social groups. Although NGOs/NPOs have their own political features in accordance with the special political culture in China, they may still exert their powers to facilitate community- and home-based care by building social connections, and associating with people at the frontline of service delivery. Their active involvement may accelerate the development of the care manager mechanism.

After discussion on the transferability looking at the structural factors, another important element in transferability is the care manager's individuality. Even if we assume the Chinese care manager role sits in the exact same LTCI structure as Japan, another inevitable factor—consciously or unconsciously—playing a significant role is the nature of each care manager per se; their personality or

individuality. Japan and China share many cultural homogeneities, yet differ largely in many nuanced places, such as the definition of proper care, the beneficiaries' situations they face, the intuitional spirit, the social ideology embedded—all of these influence the care manager's practical work. On the other hand, the care manager's personal education, life experiences, and work ethic also influence the process. As a result, I chose the 'power-body' narrative to explain the nature of the care manager. It is perfectly acceptable to understand this social role through literature on agency and structure—the reason for choosing the body theory is partly because of my personal admiration for the interpretation of 'power' by Foucault. Foucault's power, unlike the hard power of political and economic structure, is softer, omnipresent, inevitable, inescapable for everyone. It comprises the influences of the hard structure—the impact on the care manager from the LTCI in this thesis—as well as soft structures—the personal environment and personality shaped by environment comprehensively and eternally from birth. Analysis of the Japanese care manager conducted at institution-individual and individual-individual levels attempts to lay out a clear form by which to analyse such a role, and incorporates the body theory into a more sociological explanation.

Beside the main research theme of the care manager in this thesis, another form of 'body' that impressed me significantly in the fieldwork—though without much description in this research—is the bodies of the elderly people receiving care. Especially when I visited facilities, and saw the accomodated elderly people lying on their beds, it reminded me again and again that the last phase of care is truly about humanity. Advanced policy design is not enough for service delivery. The most important factor is the people who locate and practice the policy. An efficient policy structure might provide the motivation for people who work in it. However, the personal features naturally involved in their work directly influence the effect of a policy design.

9.3 Conclusion

This chapter comprises an empirical research summary and theoretical reflections. The three case studies of facility-based, agency-based and community-based care managers enabled me to understand elderly care delivery in Japan, and further to examine its potential for transferability into China in terms of functionality. Elderly care, as a comprehensive project, requires an efficient macro policy design, as well as micro-level operations on the ground. Although structural flaws or operational deficiencies can be found through scholarly research, I would state that there is no perfect policy at initial stages. Every system must transform itself for optimal efficiency and outcomes through its operations.

I travelled in Japan and China for over a year in total, and the strongest impressions I had during that time were my interactions with people working in elderly care. After seeing their actual working conditions, I felt that true passion and interest were the most important reasons for those care managers and care workers to work in the industry over several decades. Certainly, people might come to the sector for financial reasons. But it is indeed difficult to work for a long time in elderly care without a sense of fulfilment; financial rewards were hardly equivalent to these efforts.

The care manager is the key role in the LTCI, mirroring elderly care from macro to micro systems in Japan. Reform of the LTCI would positively influence their work in terms of administration; the preferences of beneficiaries also impacts their work when making care plans. In view of the diversity of their work, this research did not adopt a specific discipline-based theoretical framework, but applied a cross-cutting interdisciplinary lens of analysis, situated within philosophical domain-based interpretations, via three divisions: for structural formulation (reflections on *transferability)*, structural operations (reflections on the care manager), and general structure (care manager dilemmas and beyond), aiming to reveal comprehensive study and understanding on the research question.

In the past two years, I have experienced pregnancy and became a mother, during

a worldwide pandemic. The fieldwork and most readings provided the data before this period. I am therefore curious about the latest situation, during and since the pandemic, in regard to the care manager's work, as well as the whole elderly care system. I hope there will be an opportunity to continue this study in the future.

Appendix 1

The University Of Sheffield.

Information Sheet for Participants

Research Title: Investigation of Japanese Care Manager and Discussion on its Transferability into Chinese Context

Researcher: Jing WANG, PhD Candidate

Address: School of East Asian Studies, Sheffield University

6-8 Shearwood Road Sheffield S10 2TD United Kingdom

Tel: 0114 222 8400

E-mail: jwang106@sheffield.ac.uk

Supervisor in UK:	Supervisor in Japan:
Peter MATANLE, Senior Lecturer	Susumu NISHIOKA, Professor
Address: School of East Asian Studies,	**Address**: Graduate School of Law,
Sheffield University, 6-8 Shearwood Road,	Tohoku University, Kawauchi, Aoba Ward,
Sheffield S10 2TD United Kingdom	Sendai, Miyagi 980-0862, Japan
Tel: +44-114-222-8407	**Tel:** +81-22-795-6173
E-mail: p.matanle@sheffield.ac.uk	

Introduction

You are invited to take part in a research project. Before you decide it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with the researcher and others if you wish. Ask me if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part. It is up to you to decide whether or not to take part. If you do decide to take part, you will be given this information sheet to keep (and be asked to sign a consent form) and you can still withdraw at any time without it affecting any benefits that you are entitled to in any way. You do not have to give a reason. Thank you for reading this.

Summary of the Research

This research is to investigate the Japanese care manager in the LTCI system, via examining facility-based, agency-based and community centre-based care managers. From the investigation of the current work circumstances of care manager, this research aims to discover the status quo and problems in Japanese elderly care delivery, with suggestion for improvement of the system. Further, this research shares insights into elderly care in China, by discussing the transferability of the social mechanism as Japanese care manager into Chinese socio-economic context. At last, this research intends to enrich the perspectives regarding worldwide ageing issue beyond a specific geographic area.

Participation

You are being asked to participate in an individual interview in which you will be asked to share your opinion about the role and development of care manager in general and your personal opinion about this system in Japan. The interview will last between 60 and 120 minutes and will take place at a mutually agreed place upon by yourself and the interviewer. The interview will be audiotaped and/or

videotaped if you provide your explicit permission and they will not be made directly publicly available in any form.

Usage of the Data

The data will be used for PhD dissertation and additional journal publications on the topic, either during or after the completion of the thesis. The data collected will not be directly used as materials for any new pieces of research that diverges significantly from the above, without the explicit and renewed consent of the participants.

Risks and Benefits

Interviewees will remain anonymous in the study. The researcher will minimize the risk by removing identifying information from the data. In addition, all data will be password protected computers and phones. You will be treated with a cup of coffee or tea, even a meal depending on your convenience for this interview.

Questions and Comments

You are welcome to ask questions at any time during your participation in this research study. You can also reach the researcher through mail or phone.

Appendix 2

PARTICIPANT CONSENT FORM

Research Project: Investigation of Japanese Care Manager and Discussion on its Transferability into Chinese Context

Name of Interviewee	
Date	
Location	

YOUR CONSENT

I have read the information about the research and have been given the opportunity to ask questions about the research	
I understand that the data collected will be dealt with in confidence and I have the right to withdraw from the study at any time and decline to answer questions/participate in activities I do not feel comfortable with during the research	
I am happy for the research to be recorded either by voice recorder or video camera. A copy of the recording(s) can be provided upon request.	
I agree that the data collected from me can be used for future research	
I agree to take part in the research and do so voluntarily	

An English, Japanese and Chinese language copies of the consent form will be provided for the participants for reference; only the Japanese and Chinese language copies need to be signed by the participants. Two copies of the consent form will be signed, one remaining with the participant, one with the researcher.

I have understood the above:

Signature: ____________________________ Name: __________________________
(Participant)

Signature: ____________________________ Name: __________________________
(Researcher)

Appendix 3

参加者シート

研究テーマ：日本介護保険制度に根ざしたケアーマネジャーシステムの考察と中国においてこの制度を活用する可能性の検討

研究者：王菁　博士 2 年
アドレス（日本）：仙台市青葉区川内 27−1　東北大学大学院　法学研究科・法学部
宮城県仙台市青葉区三条町 19—1 東北大学国際交流会館 D306 室
携帯（日本）：080−6869−9654
アドレス（イギリス）：School of East Asian Studies, Sheffield University
6−8 Shearwood Road Sheffield S10 2TD United Kingdom
Email: jwang106@sheffield.ac.uk

指導先生（イギリス）：
Dr. Peter Matanle, Senior Lecturer
アドレス: School of East Asian Studies, Sheffield University, 6-8 Shearwood Road Sheffield S10 2TD,
United Kingdom
電話: +44-114-222-8407
E-mail: p.matanle@sheffield.ac.uk

指導先生（日本）：
西岡晋　教授
アドレス: Graduate School of Law, Tohoku University, Kawauchi, Aoba Ward, Sendai, Miyagi 980-0862,
Japan
電話: +81-22-795-6173

紹介事項：
インタービューの協力できるかどうか、判断する事前に本研究の主旨と内容を理解していただくことは必要です。したがって、以下の内容紹介と注意事項を十分理解していただく上、あるゆる質問も大歓迎です。インタービュー途中で何の説明をしなくてもやめられます、ご了承ください。

研究紹介：
本研究は日本の介護保険に根付いているケアーメネジャー制度に注目している。ケアーマネージャー制度の歴史、発展と役割を施設ケアマネ、居宅ケアマネと包括センターケアマネの事例研究によって考察します。日本の状況以外、この制度を中国で生かせる可能性を検討する。中国は政治状況、文化認識が日本と異なるところが

数多くありますが、同じ社会課題を解決するように協力するところが多く、制度を調整してから中国で生かせることが期待できます。

参加事項：
タイトルとして「日本介護保険制度に根ざしたケアーマネージャーの考察と中国においてこの制度を活用する可能性の検討」の研究インタービューに参加していただくことです。一時間から二時間まで時間をかける予定です。ご許可していただく範囲以内の形でインタービューの内容を記録します。

データー保護：
インタービューによる収集するデーターを論文とこの課題に関係ある文章に使われる予定です。この専門と異なる分野においてデーターとして使わないことです。

リスクと利点：
インタービュー対象の名前、所属などの個人情報が匿名化し保護されます。研究者本人が情報漏れないように責任を取ります。並びに、収集したデーターをパスワード設定済みのパソコンと携帯に保存されます。インタービュー参加者の時間より、コーヒ・お茶一杯、あるいは食事を研究者からご馳走します。

Appendix 4

参加同意表

タイトル: 日本介護保険制度に根ざしたケアーマネジャーシステムの考察と中国において この制度を活用する可能性の検討

名前	
日付	
場所	

同意事項

研究内容と主旨を紹介していただいてから理解できること。あらゆる質問が出してもよいこと。	
データーが保護されることが確認すること。途中で理由を持たなくてもやめられること。	
インタービューの内容記録について文面と音声のどちらを自由に選べること、あるいは拒否すること。	
収集したデーターを将来の研究に使われること。	
インタービューの参加が自主的であること。	

以上の注意事項を了承することができた

サイン: ______________________ 名前: ______________________

(参加者)

サイン: ______________________ 名前: ______________________

(研究者)

Appendix 5

参加者注意事项

研究课题：日本介护保险制度下 care manager 制度的历史与发展，以及此制度在中国利用的可能性探讨

研究者：王菁

地址（日本）仙台市青葉区川内 27-1 東北大学大学院 法学研究科・法学部
（英国）School of East Asian Studies, Sheffield University
6-8 Shearwood Road Sheffield S10 2TD United Kingdom

Email： jwang106@sheffield.ac.uk

指导老师（英国）：
Dr. Peter Matanle, Senior Lecturer
地址: School of East Asian Studies, Sheffield University, 6-8 Shearwood Road, Sheffield S10 2TD, United Kingdom
电话: +44-114-222-8407
E-mail: p.matanle@sheffield.ac.uk

指导老师（日本）：
西岡晋 教授
地址: Graduate School of Law, Tohoku University, Kawauchi, Aoba Ward, Sendai, Miyagi 980-0862, Japan
电话: +81-22-795-6173

注意事项：
在进行采访之前，请您了解此次研究的目的与大致内容。关于研究所有方面的问题都可以提出，您除了可以选择是否进行此次采访，也可以决定随时退出采访，不用提供任何理由，也不会影响到您的任何权益。

研究介绍：
本研究着眼于日本长期介护制度下的介护经理人制度的发展，调查了介护经理人在机构养老，居家养老和社区养老中的作用和问题。作为养老问题的社会制度的探索，本研究会就介护经理人制度是否适合中国进行讨论，探讨在当今中国的社会经济制度层面下，如何实现日本介护经理人在养老体系里发挥的作用。中国即将面临大规模老龄化问题，虽然中国的政治文化和社会制度和日本相差很大，但是在求同存异的基础上，探讨制度的活用有其现实意义。

参加事项：

此次采访会进行 1－2 小时，在您许可的方式范围内进行数据记录。

数据保护：
研究者会负责数据的全责保护。数据用于本次论文，以及未来相关领域的研究。不会被用于差异较大的领域研究。

风险和收益：
参与采访的所有情报信息都会采取匿名化，被全责保护。数据会被都是收录在设有密码的电脑和手机内。同时根据参加者的时间，可能会被研究者请客吃饭或是喝茶，喝咖啡作为答谢。

Appendix 6

参加同意书

研究题目：日本介护保险制度下 care manager 制度的历史与发展，以及此制度在中国利用的可能性探讨

姓名	
日期	
地点	

同意事项：

了解此次研究的目的与大致内容，关于研究所有方面的问题都可以提出。	
研究者会负责数据的全责保护。数据用于本次论文，以及未来相关领域的研究。可以决定随时退出采访，不用提供任何理由，也不会影响到您的任何权益。	
在您许可的方式范围内进行数据记录	
数据用于本次论文，以及未来相关领域的研究。不会被用于差异较大的领域研究。	
是自愿自主的参加访谈。	

我已了解所有事项并自愿签署同意书

签名: ____________________ 姓名：____________________
(采访对象)

签名: ____________________ 姓名：____________________
(研究者)

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