Population and Public Health Branch
Atlantic Region

Policies for Aging Populations: An International Perspective

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Prepared for
Population and Public Health Branch
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Canada

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The opinions expressed in this publication are those of the author and do not necessarily reflect the views of Health Canada.

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INTRODUCTION

Over the course of the last decade, population aging has slowly captured the attention of both policy makers and the public in Atlantic Canada. By population aging, we mean a change in the age structure of society – a society in which a far greater number of people than ever are in their senior years and proportionally fewer than ever are being born. *Shifting Sands: The Changing Shape of Atlantic Canada* is a 1999 Health Canada publication that examines both demographic and economic trends in the region. According to this report, if present trends continue, by the year 2011, 15% of the population of Atlantic Canada will be 65 or older and by 2036, nearly one out of every three people will be in that age group. Low birth rates, out-migration, longer lives, and a large population of aging baby boomers are expected to make Atlantic Canada one of the oldest populations in the world.[1]

Far from being a crisis, however, population aging has been recognized as human civilization's greatest achievement – the result of improved living conditions and medical advances. It is also recognized as one of our greatest challenges. The two major policy issues presented by population aging are providing older people with opportunities for independence, health, productivity, and protection while at the same time maintaining economic prosperity in society as a whole. These two interrelated challenges will require a broad range of economic, financial, and social changes.

> *"Active ageing is the process of optimizing opportunities for physical, social, and mental well-being throughout the life course, in order to extend healthy life expectancy, productivity and quality of life in older age."*
>
> World Health Organization 2001

While policy makers in Atlantic Canada increasingly recognize the importance of planning for population aging, they have not yet identified priorities nor set targets, and few attempts have been made to develop the infrastructure to meet the increased need for health and social services.[2]

This report is designed to stimulate action among policy makers concerned with population aging. It introduces a wide variety of approaches that three countries have taken to prepare for an older population: Finland, Japan, and Australia. The report is based on a document search of the policies and programs adopted in these three countries, with a particular focus on the determinants of active aging.

"Active ageing" is a term adopted by the World Health Organization (WHO) in the late 1990s. It refers to continuing involvement in socially productive activities and meaningful work during

later life. According to *Health and Ageing,*[3] the WHO discussion paper for the Second United Nations World Assembly on Ageing, active aging depends on the following factors, or determinants, of active aging:

- *social factors:* education, literacy, human rights, social support, prevention of violence and abuse
- *personal factors:* biology, genetics, adaptability
- *health and social services factors:* health promotion, disease prevention, long-term care, primary care
- *factors in the physical environment:* urban/rural settings, housing, injury prevention
- *economic factors:* income, work, social protection
- *behavioural factors:* physical activity, healthy eating, cessation of tobacco use, control of alcohol abuse, inappropriate use of medication.

Gender and *culture* are considered cross-cutting factors because they influence all of the above determinants of active aging.

These determinants of active aging provide the analytical framework for this report.

The first purpose of the report is to examine the experience of selected countries as they address the impacts of an older population and by so doing, shed some light on our own way forward. Finland, Japan, and Australia were selected for this purpose based on three criteria:

- the age of their population
- the extent of reform that has taken place to address population aging
- the availability of detailed information about the reforms.

The Organization for Economic Cooperation and Development (OECD) document, *Reforms for an Ageing Society,* was instrumental in this selection process.

The second purpose is to provide policy makers and senior leaders in Atlantic Canada with a variety of specific examples of reforms to support active aging.

The final purpose is to provide readers with resources for further study. Due to the abundance of measures adopted in the three countries examined, only brief descriptions of these initiatives are possible in this paper. However, many of the reforms described have been the subject of much national and international attention and numerous progress and evaluation reports. For this reason, this report is widely endnoted and includes an extensive bibliography.

The information contained in this report was found through a search of both academic and Internet-based literature on reforms for population aging. Most of the Internet-based literature was produced by federal government departments and found on government Web sites. Wherever possible, an attempt was made to verify the accuracy of the material by both consulting multiple sources and searching for evaluation reports. However, inclusion in this report does not imply that a reform has been flawless. The intent is to show the wide variety of measures that can be taken, not to guarantee that every measure has been entirely successful.

Section one of the report provides an introduction to each of the three countries studied. It provides an overview of both demographic trends and health and social systems in each country and describes the inter-sectoral policy frameworks that have been developed to address population aging.

Section two describes a myriad of mostly nation-wide policies and programs that have been implemented in these countries to support active aging. It is organized around the WHO determinants of active aging.

The concluding section highlights some common elements of the reform measures in Finland, Japan, and Australia and discusses their implications for policy in Canada and the Atlantic region.

SECTION ONE: THREE NATIONS, THREE PERSPECTIVES

Finland, Japan, and Australia are geographically, politically, culturally, and economically diverse. Demographic trends in each country are also different. Yet each of these countries is remarkably similar to Canada in many ways. Together, these three countries provide a kaleidoscope of perspectives for understanding the challenges we in Canada will face and the kinds of reforms we must consider as our population continues to age.

	Canada	Australia	Finland	Japan
Life expectancy at birth, male/female (1960)	68/74	68/74	65/73	67/72
Life expectancy at birth, male/female (2030)	79/84	79/84	78/85	80/86
% of population 65+ (2000)	12	12	15	17
% of population 65+ (2030)	20	20	25	27
% of population 80+ (2000)	3.1	3	3.4	3.7
% of population 80+ (2030)	5	5	8	10
# of employed people for every person 65+ (2000)	3½	4	3	3
# of employed people for every person 65+ (2030)	2	2½	1½	2
% of total population employed (2000)	47	45	42	53
% of total population employed (2030)	44	47	35	50

Table 1: A comparison of population aging in four countries (with projections based on current trends)

Source: Organization for Economic Cooperation and Development, 2000

FINLAND

Finland is a sparsely populated northern country with only 17 inhabitants per square kilometre. Like Atlantic Canada, geographical distances and weather conditions are key factors influencing everyday activities. In rural communities, municipal centres and services can be a long way from home. Finland's welfare state provides excellent social services. However, the country currently has a high level of public debt and high unemployment. By North American standards, taxation is very high. Most Finnish women work full-time, and as in Canada, they also continue to carry the prime responsibility for household tasks and caregiving.[4]

The population of Finland is growing older somewhat faster than that of Canada. The proportion of people over 65 is about 15% today and is expected to reach 25% by 2030. The number of people over the age of 80 is growing very rapidly and is expected to reach about 8% of the total population by 2030. (See Table 1.)

In Finland today, there are nearly three employed people for every person over the age of 65. By 2030, if existing trends continue, there will be only 1½ people employed for every older person. About 42% of the total population is employed today. Taking into account both demographic and labour-market trends, this proportion is expected to fall gradually to 35% by 2030 if these trends continue.

Health care in Finland is funded out of national and local taxation, with some user fees paid by patients. The system is administered at three levels. At the national level the Ministry of Social Affairs and Health is responsible for legislation. At the provincial level there are 12 departments of social affairs and health, and at the community level there are health boards in 461 municipalities. These municipalities have the main responsibility for delivering health care services. Each municipality receives a lump sum of funding for education, social services, and health care. The size of the sum is based on six criteria: size, density and age structure of the population, morbidity, and the surface area and financial status of the municipality.

The key feature of the Finnish health system is the municipal health centre, which is staffed with doctors, nurses, dentists, physiotherapists, and social workers. It provides a full range of primary-care services. There is a high emphasis on nursing care, with a much higher number of nurses per 1,000 people than in most countries. The ratio of nurses to doctors is the highest in Europe. Most nurses work in public health care and have a defined catchment population. Nurses traditionally make home visits, and home care is well developed for children and the elderly.

In addition to the network of community health centres, employers are obliged to organize health-care services for employees and their families. Large companies have their own health centres, and smaller companies share a health centre or use the municipal centre. Occupational health services are the main source of medical treatment for the working population.[5]

The Finnish government has two comprehensive national frameworks to prepare for population aging: the National Ageing Policy up to 2001[6] and the National Programme for Ageing Workers 1998-2002.[7]

The National Ageing Policy co-ordinates a comprehensive range of targets and actions across government departments under five main headings:

- Flexibility and Equality in Working Life
- An Adequate Income Level as a Basis for Independent Living
- Housing and Environment
- New Social and Health Services
- The Right to Participate and Learn.

The National Programme for Ageing Workers was created in 1997 to respond to a rapid increase in unemployment in the 55-64 age group. The severe depression in the early 1990s led to the introduction of early retirement and other measures to reduce the size of the work force and to create employment for younger people. Subsequently, it was recognized that these measures had positive short-term effects but were devastating in the long term, as changing demographics shrank the work force.

The aim of the National Programme for Ageing Workers is to support older people in their efforts to seek jobs, become employed, or remain employed. It is a comprehensive inter-sectoral program coordinated by the Ministry of Social Affairs and Health and operates jointly with two other ministries: Labour and Education. The program includes activities aimed at maintaining the ability to work, improving occupational health and safety, helping older workers obtain employment, renewing legislation and labour policy, increasing opportunities for on-the-job training and lifelong learning, and increasing public understanding about both the value and needs of older workers through research, pilot projects, and social marketing.

Although the program focuses on employment, it is publicly referred to as the National Age Programme without reference to working life in particular. “Experience – a National Treasury” is the slogan by which the program is advertised to the public. The image the slogan tries to achieve is that its purpose is to rally Finns around a critical national issue: the aging population.[8]

JAPAN

Japan’s population is nearly five times greater than that of Canada, condensed in an area roughly the size of the Atlantic provinces. The country has one of the world’s highest population densities, with an average of 336 people per square kilometre. Three-quarters of Japan is mountainous, and two-thirds is covered with forest.

Politically, Japan is organized in 47 prefectures and over 3,300 municipalities. Since World War II, Japan has become the second most powerful economy in the world after the United States. Following three decades of unprecedented growth, Japan experienced a major economic slowdown during the 1990s, and since then, unemployment, still low by Canadian standards, has become a concern.

The population of Japan is said to be the oldest in the world. Life expectancy at birth was 67 years for men and 72 years for women in 1960 and is expected to grow to 80 and 86 years respectively by the year 2030. The proportion of people over 65 is about 17% today and is expected to reach 27% by 2030. The percentage over 80 has been increasing very rapidly. By 2030, one out of every ten Japanese is expected to be over the age of 80.

In Japan today there are nearly three employed people for every person over the age of 65. By 2030, if existing trends continue, there will be only two employees per older person. About 53% of the total population is employed today. Taking into account both demographic and labour-market trends, this proportion is expected to fall gradually to 50% by 2030 if these trends continue.

Traditionally, families have provided care for older people in Japan. A common pattern is for the woman to take care of her husband's parents, who frequently live with their oldest son and his family. The rapid industrialization and urbanization of Japan since 1945 and the accompanying demographic changes have produced a rapid change in family structures, making it increasingly difficult to maintain this system of elder care:

- As in Atlantic Canada, young people have moved to urban centres to find employment, while elders prefer to stay in rural communities, resulting in a trend toward independent living by older Japanese.
- Increased work-force participation by women has made them less available to provide care.
- A rapid decline in fertility has resulted in fewer adult children to provide care.
- Longer lives mean that children providing care for their elderly parents may themselves be in their 70s.

As a result, the proportion of seniors living alone more than doubled between 1975 and 1995. Even so, almost 55% of Japanese over the age of 65 still live with their children, and 85% of caregivers in Japan are female.

The Japanese medical-insurance system guarantees access to medical services for the entire population. It is provided through many different insurance plans primarily managed by employers. Municipalities manage insurance plans for those who work in small businesses, are self-employed, or are unemployed. The health-insurance schemes are financed by employee/employer premiums, general government taxation, and user fees paid by patients.[9]

"Hyper-aging" (*cho-koreika*) has been a popular term, as well as a policy issue, in Japan for nearly 20 years. In 1995, the government issued the Basic Law on Measures for the Aging Society.[10] This law stipulates basic objectives, mandates an annual report to the national parliament, and established an Aged Society Policy Council chaired by the prime minister. It

was followed a year later by a statement of general principles issued under the law. These include an emphasis on the independence, participation, and choices of the elderly population; systematic implementation of measures throughout the life cycle; and specific measures in five areas:

- employment and income
- health and welfare
- lifelong learning and social participation
- living environments
- research.

Together, these two legal documents provide a broad policy framework that unifies the many policies and measures adopted to address population aging in Japan.

AUSTRALIA

The Australian federation consists of six states and two territories in a land mass roughly the same size as the United States (excluding Alaska). Its population is just under 20 million, with an overall population density of 2½ people per square kilometre. More than four-fifths of the population is concentrated in 1% of the land area, and about 80% of the population live in cities. Distance has always been a defining challenge for Australians. Like Canada, there are large regions that have only small, scattered settlements or that are unpopulated.

Australia has had one of the most vibrant economies in the world in recent years, with strong growth, low inflation, and low interest rates. Employment has grown by more than 2% per year in the last two years. The unemployment rate in December 2001 was 6.7%.

Cultural diversity has become a touchstone of the country's national identity. Australia's multicultural society includes indigenous peoples and settlers from more than 140 countries around the world. Although English is the official language, over 100 different languages are in common use.

The age distribution of Australia's population is similar to that of Canada. Both Australians and Canadians are living longer than in the past. In both countries, life expectancy at birth was 68 years for men and 74 years for women in 1960 and is expected to grow to 79 and 84 years respectively by the year 2030. Both Canada's and Australia's populations are growing older at a rate that is about average for developed countries. The proportion of people over 65 is about 12% today and is expected to reach 20% by 2030 in both countries. The number of people over the age of 80 is expected to make up about 5% of the total population by 2030.

During the 1990s, Australia experienced a very rapid growth in the absolute number of very old people. Another important change was the doubling in numbers of non-English-speaking elderly to approximately 22% of the 65+ population.

Australians have universal access to health care and subsidized medication under Medicare, a tax-funded national health-insurance program. The Commonwealth, or national government, plays a leadership role in policy making, research, and national information management. The state and territorial governments are primarily responsible for the delivery and management of health services, which are delivered through a mix of public- and private-sector providers. As in Japan, there is a large and vigorous private sector in Australia's health services.[11]

Only 15% of older people in Australia live with their adult children, and an increasing number live alone (30% of those 65+ and 46% of those 80+). Families are still the largest source of support for older people. Due to the diverse ethnic and religious backgrounds, there are many different attitudes toward family support for aging relatives.

Australia has been an international leader in the development of social programs to support the elderly, beginning in 1909 with the development of the first old-age income-security programs. More recently, it has developed a broad range of public programs to support older people.

Early in 1999, the Commonwealth government launched the National Strategy for an Ageing Australia, aimed at developing a broad and comprehensive framework to address population aging. The Department of Health and Aged Care has used a consultative approach to inform and engage all Australians in a national debate about measures to address population aging. Five discussion papers were written and widely circulated, one on each of five critical themes related to population aging:

- Healthy Ageing Discussion Paper
- Attitude, Lifestyle and Community Support Discussion Paper
- Independence and Self Provision Discussion Paper
- Employment for Mature Age Workers Issues Paper
- World Class Care Discussion Paper.

After widespread input into the strategy from all interested stakeholder groups, a national strategy document was released early in 2002, specifying goals in each of these five content areas.[12]

Meanwhile, the Commonwealth, State and Territorial Ministers of Health and Community Services have produced the Commonwealth, State and Territory Strategy on Healthy Ageing.[13] The document, which is intended to form the basis of planning until 2005, identifies actions in seven result areas:

- community attitudes
- health and well-being
- work and community participation
- sustainable resourcing
- inclusive communities
- appropriate care and support
- research and information.

This broad framework is intended to provide national co-ordination for the considerable work already undertaken in individual jurisdictions to promote healthy aging in Australia.

SECTION TWO: REFORMS FOR ACTIVE AGING

The previous section was intended to provide the broad social context for the many reforms adopted in Finland, Japan, and Australia. While the culture, economy, experience, and approaches have been profoundly different in each of these countries, the issues addressed in their policy frameworks for population aging are remarkably similar, and reflect all of the determinants of active aging. The following section describes many of the specific initiatives implemented as part of these frameworks.

ECONOMIC FACTORS: INCOME AND EMPLOYMENT

Income

Australia, Finland, and Japan, like Canada, all provide stable social-security benefits to pensioners through three routes: national pensions that provide a basic minimum income to all seniors, employment-related pensions, and various schemes of voluntary retirement savings. In all three countries, recent pension legislation has been aimed at ensuring the viability of pension plans as ever more people reach pension age and live to collect pensions for more years than ever before. These measures include raising the age of entitlement to pension benefits, increasing contribution premiums, and creating disincentives to early retirement.

The overall approach in Australia has been to encourage Australians to be less reliant on national pension plans. The ability of public pension plans to support an aging population has received a great deal of public attention and is the topic of the Independence and Self Provision Discussion Paper, one of the five discussion papers in the National Strategy for an Ageing Australia. Recent changes to pension legislation have been aimed at encouraging older workers to remain in the work force and at encouraging self-financed retirement plans.

The Australian Commonwealth government provides free financial information for people who are either retired or planning their retirement, through both the Department of Veteran’s Affairs and the community-based Centrelink Financial Information Service (FIS). FIS officers provide information over the telephone, meet with individuals, and also hold seminars and workshops across the country. Since 1998, FIS officers have been encouraging the baby-boom generation to plan for their future financial independence while they are still working. An increasing number of seminars have been aimed at people 10-15 years away from retirement.[14]

Centrelink also offers home visits to pensioners over the age of 80 to ensure that they are aware of and receiving their correct entitlements. As well, FIS officers visit pensioners whose partners have recently died to offer assistance with financial, housing, and lifestyle issues.

Recent legislation in Finland has restricted access to the national pension scheme to those people who have very little or no employment pension. A range of pension changes are aimed at keeping older people in the work force.

To improve the financial viability of the Japanese public pension system, the government passed a package of pension reform bills in 2000. One of these reforms reduced employee pension benefits for new recipients by 5%.

The primary motivation for Finland's National Programme for Ageing Workers and a similar program in Japan is to reduce the strain on overburdened unemployment and pension programs. At the same time, these programs are intended to increase incomes and reduce social exclusion among older people.

Employment

The aim of the Finnish National Programme for Ageing Workers is to maintain the ability and desire of older workers to stay in the work force and to maintain the interest of employees in remaining employed until retirement age. The program includes a wide variety of measures to reduce unemployment and improve workplace conditions for older workers, many of which are described elsewhere in this report. Several of the legislative changes adopted as part of this program are incentives to remaining in the work force:[15]

- The employers' responsibility for unemployment and disability pension costs has been increased to make it more attractive for employers to retain aging workers.
- To reduce layoffs and retirement due to disability, employees aged 58-59 are now entitled to an early rehabilitation plan paid for by the employment pension system.
- The age limit for individual early-retirement pensions has been raised from 58 to 60.
- The age limit for claiming a part-time pension has been lowered from 60 to 56 to provide an alternative to early (full-time) retirement.
- The basic retirement pension has been reduced by 4-6% for every year of early retirement, and earnings-related pensions have been reduced by 5.6-6% per year of early retirement.
- The basic pension has been increased by 12% for every year in which retirement is deferred, with a 60% ceiling.
- The long-term unemployment pension has been reduced by up to 4% as an incentive for aging workers to seek re-employment rather than take early retirement. (However, it has been increased for certain cases in which there is no alternative.)
- Tax relief for voluntary pension plans has been reduced, as this is believed to promote early retirement.
- The period on which the earnings-related pension is calculated has been increased from the last four years of employment to the last 10 years.
- New legislation states that the pension of an unemployed person over the age of 55 is not reduced if he or she accepts low-wage temporary work.

The Finnish National Age Programme carried out a service-needs assessment among the long-term unemployed aged 50-58 throughout Finland, and employment centres and agencies have been reorganized to better meet these needs.

The National Age Programme promotes flexible working arrangements, such as part-time employment and alternating periods of work and leave, and the improvement of working conditions to reduce stress and prevent burnout. An Age Management Campaign promotes management practices that make full use of the strengths of older workers. The campaign was implemented through training provided to consultants, business managers, and the personnel of Employment and Economic Development Centres, as well as through articles in business publications. Practical age-management tools have been developed for use by small- and medium-sized employers.[16]

The National Age Programme is scheduled to end and be finally and fully evaluated in March 2002. Early evaluations suggest that both the employment rate of older workers and the average retirement age have increased; however, this may be due to an economic upturn and a reduction in unemployment overall. Attitudes toward older workers and older people in general are said to be improving. A growing number of employers are adopting programs to maintain work ability, and the number of people claiming a part-time pension has risen sharply.[17]

In contrast to Finland, many people in Japan work after retirement, but usually they have jobs that are less demanding than their previous careers. Like Finland, however, mature-age unemployment has been growing in Japan and the number of people reaching early-retirement age is straining pension systems.

In 1994, the Japanese government passed a bill to increase the age of eligibility for social-security benefits for seniors from age 60 to 65, a change that will be implemented gradually over two decades. At the same time, the government has enacted laws encouraging the hiring of older workers and has created incentives for firms to raise their mandatory retirement age. Assistance for older workers in obtaining employment is provided through a program designed to match older workers with appropriate employers, training programs offered through Silver Human Resource Centres (SHRCs), and financial assistance for people over the age of 60 who start a business.

The SHRCs were established to help revitalize community life by providing temporary jobs to retired workers who wish to remain active in the community. Any worker over the age of 60 may become a member of a SHRC. Members are paid a set wage for short-term and light jobs related to community life. As of September 2000, approximately 630,000 seniors were members of close to 800 SHRCs.[18]

The SHRCs are created by local communities and serve a specific geographical area. Funds from the national Ministry of Labour are matched by local governments to pay for core staff, equipment, and administration. The jobs are generated through contracts negotiated by each centre with businesses, government agencies, and individuals. Earnings received by SHRC

members are not counted under pension-earnings tests and do not trigger any pension penalties for retirees.[19]

Japan's Basic Policy on Employment Security Measures for Older Persons in the Fiscal Year 2001[20] builds on and expands earlier measures. A few of these measures include:

- instruction, counselling, and assistance for employers to encourage them to increase the mandatory age of retirement
- assistance for employers who raise the mandatory retirement age
- cooperation with local economic organizations to secure employment for the elderly
- incentive grants for improving workplaces for the elderly
- assistance for employers who re-employ retired people
- assistance for the self-employed elderly
- a benefits package for continued employment of the elderly
- expansion of SHRCs
- projects for promoting voluntary work among retired people
- research into the promotion of a future society in which the elderly can continue working regardless of age.

Mature-age unemployment is also an issue in Australia, and the government has begun to phase in measures to encourage people to defer their retirement and to provide people who are retired with incentives to work:

- The minimum pensionable age for women is currently being raised from 60 to 65 – the age at which men are now eligible to receive a pension. This change is being phased in over a 20-year period.
- A Pension Bonus Scheme enables people of pensionable age to accrue a bonus if they choose to continue to work and defer claiming the pension. Those who work at least 960 hours per year (an average of 20 hours per week for 48 weeks) can claim this as a tax-free lump sum when they retire.
- Since 1997, the Australian government has allowed individuals to contribute to a registered retirement fund until the age of 70, provided they maintain a bona fide link with the paid work force; before this change, the age limit for contributions was 65.
- The Workplace Relations Act of 1996 states that an employer may not terminate a person's employment because of age.

The Australian Return to Work Programme[21] helps both parents and caregivers get back into the work force after their caregiving responsibilities have ended. It is aimed at people whose main activity during the previous two years has been as an unpaid caregiver of a child under 16 or a person who is disabled, frail, aged, or chronically ill. The program offers career guidance, help with skills assessments, training plans, confidence building, access to training, and an introduction to computer technology.

The continued participation of older workers in the work force is the topic of two of the goals in the National Strategy for an Ageing Australia, and the issue is expected to receive more coordinated attention as the plan is implemented.[22]

Coordinated action plans to address mature-age unemployment currently exist in some Australian states. The New South Wales Mature Workers Programme has been operating since 1990. The program has two strands: employment (operated through community-based organizations) and training. Evaluation after five years showed that 50% of past clients were still employed at the time of the survey, and most attributed this to the program.

In 1999, South Australia and Western Australia introduced their own programs. In South Australia, the program includes the Mature Age Employment Incentive Scheme, which provides incentives of up to $2,000 to firms that employ older workers, and the Mature Age Support Programme, which provides advice, training, and employer-awareness programs to improve both job opportunities and the employability of older people seeking employment. These programs supplement the work of Don't Overlook Mature Expertise (DOME), a voluntary organization funded by the state government to support aging job seekers, and DOME Inc., a recruitment agency specializing in mature workers. The Western Australia program, Profit from Experience, has a network of access officers, a career-restart program, a skills-redirection program, a "cyber job link" for remote communities, and a skills-recognition program.[23]

LIFELONG LEARNING

"Education in early life combined with opportunities for lifelong learning can give older people the cognitive skills and confidence they need to adapt and stay independent. Studies have also shown that employment problems of older workers are often rooted in their relatively low literacy skills, not in ageing per se. If older adults are to remain engaged in meaningful and productive activities, there is a need for continuous training in the workplace and lifelong learning opportunities in the community." World Health Organization, 2001.

Japan and Finland have made lifelong learning a national prioity - both to maintain people's ability to work and to promote overall well-being.

Since the 1990s, adult education has been a priority in Finland, where almost half of those over the age of 45 have no basic vocational training. The rapid change from a resource-based to a knowledge-based economy, advances in information technology, a high unemployment rate, an aging population, and differences in literacy and education between generations have contributed to the challenge.

For these reasons, lifelong learning is a central component of Finland's National Programme for Ageing Workers. The Ministry of Education is responsible for 10 of the program's 40 objectives. The starting point is to develop adult education so that it will better meet the needs of those over the age of 45. Some of the specific measures to promote lifelong learning found in the National Age Programme include:[24]

- an information-technology strategy (information society skills for everyone)
- the development of guidance and counselling services for adult learners
- monitoring and evaluation in the area of adult education and training
- programs to develop adult-education skills among teachers and trainers
- a variety of incentives and financial supports for older workers who choose to further their education.

Finland has also rapidly expanded open-learning environments, including distance high schools, open universities, and networks of liberal education, to facilitate the access of older workers to ongoing education and training.[25] But lifelong learning in Finland is not limited to older workers. Third Age Universities (UTA) have also rapidly expanded and are now offered in 19 universities and colleges. UTA lectures at the University of Helsinki are tape-recorded and published for senior students who are unable to attend because of distance or disability. Study groups around the country meet with tutors in service homes and other seniors' facilities to listen to and discuss the taped lectures.[26]

Japan, a country in which education is treated with a respect bordering on reverence, has a longer history of lifelong learning. For over 50 years, "social education" has been a national priority. This term is used to describe non-formal, out-of-school programs designed for people of any age, but held mainly for the benefit of the community.

In 1990, Japan's Lifelong Learning Promotion Law set up a national Lifelong Learning Council and increased the responsibility of prefectures for lifelong learning. As a result, all prefectures established departments responsible for lifelong learning and most prefectures and municipalities developed lifelong learning councils and action plans. Opportunities for lifelong learning have grown rapidly since that time. Universities and colleges have facilitated the access of the general public by adopting special admission criteria for mature learners. School facilities at all levels have been opened to the public for access to gymnasiums, sports facilities, classrooms, and lectures. In addition, the country is promoting the use of proficiency tests as a way to recognize non-formal learning.

The 2000 National Framework for the Creation of a Lifelong Learning Society[27] has four major areas of action:

- development of a structure to promote lifelong learning
- dissemination and public-awareness activities
- expansion of adult learning opportunities
- assessment and recognition of prior learning achievements.

An interesting component of Japan's lifelong learning strategies is the University of the Air, now used by more than 81,000 learners, 10,000 of whom are over the age of 60. The University of the Air was created in 1983 to bring higher education to the wider public, and became available nation-wide in 1998. Lectures, broadcast 18 hours a day, are supplemented with correspondence study materials and assignments. Face-to-face instruction and examinations for students who wish to obtain a college diploma are provided in 49 regional study centres. These centres also offer academic counselling and access to the university's library collection.[28]

Inamino Gakuen – A University for the Elderly

Inamino Gakuen is a Japanese university created for older adults. Located in a natural, forest-like setting within a 10-minute walk of a railroad station, *Inamino Gakuen* provides a four-year undergraduate program and a two-year graduate program. Most of the students are between the ages of 65 and 74, with some students over 80.

The construction of a university for the elderly was proposed in 1968. At first, only a one-year program was offered, but soon it grew into a four-year college. The graduate program was added in 1977. There are three main objectives to the curriculum: to challenge the ways in which students think, to develop students' mental abilities, and to promote a healthy lifestyle.

In addition to choosing a major area of study, students are required to take a number of prerequisite liberal arts courses: literature, philosophy, history, economics, religion, and current events. Participation in clubs is also encouraged for socialization and the development of new hobbies.

A typical day in the life of a student at *Inamino Gakuen* begins at 9:30 a.m., usually following a commute that can be as long as two to three hours. Throughout the day, students participate in calisthenics, lectures, and club and social activities. Classes are conducted one day a week for each grade level (e.g., freshmen attend on Monday, sophomores on Tuesday, etc.). Fees, required since 1977, are kept to a minimum.

A correspondence program was developed as interest in the college grew, and this eventually became the University of the Air. Because of *Inamino Gakuen,* there is a heightened awareness of the importance of education for the elderly in Japan. With its goals of lifelong learning, the school has had a major impact on citizens in the Hyogo Prefecture as well as throughout Japan.
Source: Mary Eva Repass, 1999

THE PHYSICAL ENVIRONMENT: HOUSING AND TRANSPORTATION

"Physical environments that are age friendly can make the difference between independence and dependence for some older people. For example, older people are more likely to be physically and socially active when they can safely walk to a neighbour's home, local transportation and parks. Older people who live in an unsafe or polluted area are less likely to get out and therefore more prone to isolation, depression, reduced fitness and increased mobility problems ...

... Safe, adequate housing is especially important for the well-being of older adults. Location, including proximity to family members, services and transportation can mean the difference between positive social interaction and isolation." World Health Organization, 2001.

Older populations in Japan, Australia, and Finland have focused national attention on housing and transportation issues, and several innovative best practices have been identified. Both Finland and Japan have recognized the need for barrier-free design in all new buildings and transportation systems.

Housing

Japan has had 40 years of experience in housing policy for older people. Over the years, a variety of policies developed by different ministries (Health, Welfare, Construction) have favoured the development of seniors' apartments, larger dwellings that can be easily subdivided, two-generational dwellings, and adjoining dwellings. In 1985, the Ministry of Construction established a Housing Plan for Senior Citizens in the Local Regions. This policy required every local government to establish a plan for housing elderly people. At the same time, the Silver Housing program was launched to subsidize the construction of seniors' housing.

For many years, the construction of special dwelling units for the elderly was favoured. However, it has now become apparent to policy makers in Japan that special buildings will never meet the demand of the rapidly growing elderly population. This has given rise to the concept of "design for all ages." Design Guidelines of Dwellings for the Ageing Society were issued in 1995 after thorough research into the housing needs of older adults. Because new construction alone is not enough, the government is also renovating all public housing stock to be barrier-free.[29]

Universal Housing – Design Guidelines for an Ageing Society

The many changes in floor level in a traditional Japanese home are a hazard for older people. At the entrance, shoes are left one step below the floor level of the dwelling. The tatami room, in which people sit directly on woven straw mats, is raised five to ten centimetres above the level of the wooden floor. In the bathroom, in which the body is washed before immersion in the tub, the floor is also raised by about ten centimetres to allow drainage beneath, and requires a step up and over. There is strong resistance to changing these design features, which are embedded in Japanese culture. However, in anticipation of an older society, building codes and standards have been developed to encourage a more elder-friendly housing design.

In 1986, when the National Institute of Population Studies first forecast that one-quarter of the population would soon be over the age of 65, the Ministry of Construction initiated a process to ensure appropriate housing for elderly residents. Recognizing that all housing should be suitable for people over 65, the Ministry invested in research to develop housing-design guidelines aimed at providing universal solutions, rather than solutions specifically for older people. The resulting Design Guidelines of Dwellings for the Ageing Society were issued in draft form in 1992, and officially adopted in 1995.

Three concepts form the basis of these guidelines: the dwelling should be used 30 years beyond its construction, it should be safe and comfortable for any resident, and it should accommodate adaptation as needed by the resident. Specifically, the guidelines recommend that all dwellings be designed with level floors, handrails in critical places, and wider doors and corridors. These guidelines were tested in both public- and private-sector construction. They were found to be economically feasible (with a cost increase of about 2%), to increase aging in place, and to reduce institutionalization.

The guidelines were a clear departure from previous policies of purpose-built housing for the frail elderly. To encourage the adoption of these guidelines by all builders, the Japan Housing and Loan Corporation provides lower interest rates for those who follow them. They are also required for all government loans for renovation as well as for building or renovating all public housing.

Source: Satoshi Kose, 1997 and 2000

In Australia, many local councils have undertaken studies of the housing needs of older residents and have developed innovative approaches, such as retirement villages and cluster housing. Retirement villages are groups of housing units or villas designed to provide security, companionship, entertainment, and recreation activities for older people. Some retirement villages also offer nursing-home accommodation. Cluster housing is a group of independent housing units, such as townhouses, supported by a network of home support services and shared communal facilities.[30]

Best Practices in Community Housing for Older People – The Abbeyfield Model

The Abbeyfield model, which originated in Australia, provides a unique solution of community-managed shared housing for older people with limited resources who are isolated or vulnerable. It maintains older people within their own familiar community and encourages independence and self-determination.

There are four elements in each Abbeyfield house:

- the local community volunteers, who develop and manage the house, employ the housekeeper and provide support (if needed) for the residents
- the residents, who are often isolated, lonely and in need of a measure of support, but who wish to continue to be independent and in charge of their own life
- the house, which is generally purpose-built and consists of 10 private bed-sitting rooms with ensuite washrooms (residents share the common areas of the house, including the sitting and dining rooms, kitchen, laundry, guest room, and garden; a self-contained housekeeper's unit is also provided)
- the housekeeper, employed by the local volunteer society, who shops, prepares two meals a day, keeps the shared areas clean and acts as a house coordinator.

Together, four elements provide a coherent whole. Residents identify strongly with the house and see it as their own. The Abbeyfield committee, relatives, and friends also provide support, company, advice (if requested), and assistance in decision making. Home and Community Care Services and the Royal District Nursing Service are available when needed. The support available in Abbeyfield houses is relatively low-key, but provides an environment in which residents can rely on a range of options for both security in their day-to-day activities and support for dealing with health or emotional crises.

Abbeyfield's contribution to best practices in community housing lies first, in the model of housing it provides, and second, in the process of restructure and change on which it has embarked to meet established and emerging needs.
National Community Housing Forum, 1999

The Australian government has published two booklets that discuss the range of housing options available for older people: *Moving House: Your Choices* and *Home and Residence Choices for Older People.* These are designed to help older people decide whether to move and also to understand the types of accommodation available. As well, they describe programs that enable seniors to stay in their own homes, including loan and subsidy programs for home repairs, as well as a variety of health and social-service programs aimed at providing in-home support. The Department of Veteran's Affairs operates a Home Maintenance Helpline, to enable veterans to receive property-maintenance advice and referrals, and HomeFront, a free home assessment to reduce the risks of falling.

The greatest change in seniors' housing in Finland in the 1990s was the widespread development of service homes by municipalities and non-profit organizations. Many new service homes were built, and many existing buildings were converted into service homes. Service housing provides obstacle-free living, basic services, and security for people who can manage with relatively little support. A variety of services are provided, either by local home help and nursing services or by the home's own staff, but the housing is not staffed around the clock. Many of the common rooms in service housing also act as social centres for seniors in the neighbourhood. Service housing is arranged in blocks of service flats, in a group of service homes, or in an individual small service home. The number of dwellings in a service home varies, with the average being 20 to 40. The units are usually rented, but ownership is growing.

Group homes, which usually have fewer than 10 residents, are also becoming more widespread in Finland, especially for people with dementia. Residents share a kitchen, sitting room, sauna, and washroom. Staff in a group home usually consist of trained home helpers and practical nurses.

The remodelling of older housing stock to meet the needs of seniors has been a priority for over a decade in Finland, and a variety of government programs are available to help pay for renovations. A serious concern is the lack of elevators in older rental housing, and the Government of Finland has both funded research and subsidized renovations for installing elevators in blocks of older flats.

As in Japan, state subsidies are available in Finland for new housing construction to require that all flats include wheelchair-accessible bathrooms and toilets, and that flats with more than one storey must include an elevator.[31]

The Marjala Model – A City for All

The neighbourhood of Marjala in the city of Joensuu in eastern Finland has been designed to meet the needs of seniors and wheelchair-bound inhabitants. For over 15 years, Joensuu had built special housing for the elderly and people with disabilities. An evaluation in 1990 found that in several areas, the elderly or wheelchair-bound residents were constrained in some way in their efforts to move and to cope independently with everyday life.

In order to avoid such problems in Marjala, a set of design guidelines was issued that require all dwellings, shared facilities, and connecting routes to allow barrier-free access and mobility. This requirement applies even to the smallest detail in the neighbourhood so that all of the streets, pavements, squares, parks, and green spaces are accessible. The housing tenure and occupancy available in Marjala include rental, partial-ownership, right-of-occupancy, hire-purchase, and owner-occupied units to ensure that the community is accessible to all population groups.

When completed, Marjala will be a suburban area with about 3,000 inhabitants, but it will be too small to support a complete range of public services. To overcome this difficulty, a computerized multiservice channel connects residents to service providers. Through this channel, residents can get expert advice (e.g., family doctor), communicate with other residents, or discuss municipal affairs with political decision makers. The multiservice channel can be accessed from both home computers and a multiservice centre, where a services manager provides training in the use of the equipment and the channel.

Marjala has been built so that people can work, live, and enjoy their leisure time in their own neighbourhood. The city of Joensuu has developed teleworking opportunities in Marjala, allowing service providers, who are city employees, to live and provide services there. In collaboration with a private entrepreneur, residents have also set up a day care centre cooperative that serves children, seniors and people with disabilities. Cooperation between residents and city employees has created networks that provide support, increase participation, and create jobs within the area.
Source: United Nations Educational, Social and Cultural Organization, 1999

Transportation

Finland is experimenting with innovative ways to provide transportation in rural areas. The country has several years of experience with developing, testing, and implementing the Demand Responsive Transportation System (DRTS), a flexible public transport system designed to provide transportation "on demand" from passengers. The aim is to provide mobility in both rural and urban areas and to enable the elderly and disabled to participate fully in community life. The DRTS is organized through a travel dispatch centre that uses an

electronic booking and reservation system to dynamically assign passengers to vehicles and to optimize routes and schedules.

A national pilot project demonstrated the effectiveness of the DRTS, and is now in use in over 50% of Finnish municipalities. The research project showed that the DRTS can be economically profitable even in rural areas with moderate numbers of passengers and affordable ticket prices. The benefits of the DRTS include:

- mobility for all (the DRTS covers geographical gaps in existing public transport services)
- cost savings for institutions such as hospitals and other bulk users of transport services
- rationalization of regular public transport services
- door-to-door service for special user groups, such as the frail elderly and people who have a disability, and nearly door-to-door service for everyone else.

Transportation – On Demand

In Tuusula, Finland, a Demand Responsive Transportation System (DRTS) provides residents with a flexible mode of transportation that supports the mobility of the elderly and disabled and connects adults from single-car households to the local labour market. In Tuusula, peak DRTS usage is in the mid-morning and early afternoon. A pilot study found that 70% of users are female and 70% of users do not have regular access to a private vehicle. Health and social services and school boards are major users of the system.

The objective of the DRTS is to fill geographical gaps in the existing public transport services. Using specially designed computer systems, the DRTS incorporates and co-ordinates existing transportation options: taxis, invataxis (equipped for mobility- impaired people), minibuses, buses, and trains. Timetables, routes, and vehicle sizes are chosen in response to need, and vehicles only move when and where they are needed. The fleet is managed from a travel dispatch centre as follows:

1. Customers telephone in or e-mail requests for transportation to the travel dispatch centre.
2. The dispatch centre automatically keeps track of the location and status of each vehicle in the fleet.
3. The dispatch centre collects and organizes customer requests and plans a route, schedule, and vehicle accordingly.
4. The dispatch centre informs the chosen driver about the route and schedule and informs the customer about estimated pickup time when necessary.
5. The driver collects passengers and drives them to their destination.

The Finnish DRTS pilot projects ran for 1½ years and proved to be highly successful. The DRTS is now available in many Finnish communities and in other countries around the world.

Sources: Prisma Research, 2001, Local Futures Group, 2001, and Heikki Karintaus, 2001

HEALTH PROMOTION AND ILLNESS PREVENTION

Japan, Finland and Australia have all recognized the importance of health-promotion and illness-prevention programs for keeping older people out of hospitals and institutions and have established programs both for seniors and the general population. This section looks at health-promotion and illness-prevention measures aimed at older people and briefly describes some of the national health-promotion frameworks aimed at the general public.

Employers in Japan are obliged by law to implement health-promotion programs. The approach to health promotion in this country is mainly focussed on individual behaviours and lifestyles. Healthy Japan 21 (2000-2010) is a national primary prevention program aimed at all Japanese. Concrete numerical targets have been set for improving dietary habits, increasing physical activity, eliminating taxes on fees at health-promotion facilities, promoting appropriate relaxation, and reducing smoking.[32]

Early in 2001, the Japanese Ministry of Health, Labour and Welfare introduced the Care-Prevention Program, a national program to help healthy older people stay well. The program provides for the development of care-prevention plans for up to one million independent older people.

As part of the program, the Ministry subsidizes half of the cost of municipal programs aimed at preventing older people from becoming bedridden. Programs may fall into one of three categories: living support services such as meal deliveries and assistance with walking, prevention programs such as classes on good nutrition or avoiding falling, and sports and leisure activities. The Ministry has also put together a manual on care prevention and has begun training people who can serve as leaders in care-prevention programs at the prefectural level.[33]

People classified as "independent" or who have not requested care services are targets of the care-prevention plans. Staff from local in-home-care support centres meet with seniors and prepare personalized plans that cover items such as meal deliveries, health consultations, participation in prevention classes, and assistance with taking a walk. Half of the cost of drawing up plans is covered by central government funds, and the remaining half is covered by prefectural and municipal funds.

In Finland, municipalities are responsible for organizing health-promotion and illness-prevention services, and over the last few years, health promotion has become a more important focus of municipal planning. Many municipalities have developed strategic action plans for health promotion and illness prevention. A national health-promotion strategy encourages municipal governments to consider health impacts in all municipal decision making, and as a result, health promotion is now more often seen as the responsibility of every administrative field, not only the health-care sector.[34]

Health 2015 is the national health-promotion strategy that outlines targets for health promotion in Finland in the next 15 years. The strategy is a broad collaborative framework for inter-sectoral action on the determinants of health for all age groups. The main targets for older adults include improving the functional capacity of older workers, improving workplace conditions, increasing the retirement age by three years, and increasing the functional capacity of people over the age of 75. To meet the latter target, the program promotes the development of housing, transportation, and local services that support independence.[35]

Workplace health promotion is a central feature of the Finnish Maintenance of Work Ability (MWA) program – another component of the National Programme for Ageing Workers. This national health-promotion initiative aims to prolong and improve the employability of the Finnish work force through a comprehensive set of measures to promote health, prevent accidents/injuries, and support rehabilitation. These operate at all levels – from the national level down to the workplace – and are targeted at both the individual and the work environment. The program has widespread support throughout Finnish society and within workplaces.

At the national level, policy and legislative changes support MWA initiatives. At the workplace level, interventions are aimed at health promotion, rehabilitation of injured workers, and improving the work environment through health and safety practices and job design. Guidelines for health promotion, illness prevention, and the evaluation of work ability in occupational health services were published with funding from the Ministry of Social Affairs and Health and distributed to every occupational health service in Finland.

A Maintenance of Work Ability Barometer was developed to measure the percentage of workplaces that have instituted MWA programs. Between 1997 and 1999 the percentage of workplaces with health-promotion programs increased from 51% to 60%.[36]

According to evaluations of the MWA program, the benefits are widespread:

- Employees benefit through improved health and well-being and increased employability.
- Employers report improvements in productivity and reductions in the costs of illness.
- Insurers benefit from reduced claims.
- The government benefits from an increase in the age of retirement.[37]

Australia has developed a range of strategies to encourage healthier lifestyles and improved population health for all Australians. Examples include Active Australia, the Food and Nutrition Policy,[38] and a Strategic Framework for the Prevention of Chronic Disease.[39]

In recognition that falling accounts for 30% of all hospital admissions among the elderly, Australians have also developed a co-ordinated strategy to reduce falls among seniors. The four-year National Falls Prevention for Older People Initiative is conducting demonstration projects in communities, developing best practices for residential and acute aged care, increasing falls-prevention competency in the work force, disseminating information about preventing falls, and conducting research.[40]

Staying on Your Feet Down Under

Stay on Your Feet (SOYF) originated as a large community-based health-promotion program aimed at reducing the number of falls among the 81,000 older residents on the North Coast of New South Wales, Australia. The program addressed the following risk factors: physical inactivity, poor balance and gait, chronic illness, poor vision, unsafe footwear, medication misuse, and unsafe home and public environments.

SOYF used multiple strategies: raising awareness, community education, community action, and policy development. The program promoted falls-safe home-improvement products, strengthened policies to reduce falls in public places, and used public health nurses to ensure that specific risk factors received necessary attention (e.g., vision testing, foot care, home maintenance, and gentle exercise).

The initiative resulted in a 20% reduction in hospitalization due to falls among seniors, and has since served as a model for several other programs across Australia that share the same name. In 1998, the state of Western Australia developed a five-year collaborative SOYF action plan to reduce falls state-wide. The action agenda includes strategies and actions delivered in five phases, each phase building on the one(s) before. The five phases are as follows: a focus on falls-prevention awareness and knowledge, a focus on medication, a focus on safe environments, a focus on physical activity, and a focus on chronic conditions.

Some of the activities that have taken place so far include:

- the establishment of community committees
- training seniors as peer educators
- training home- and community-care staff to identify and respond to risks
- talking to community groups
- new or enhanced exercise programs for seniors
- community safety audits
- seniors' safety parties promoting home-safety checklists and products
- a survey of physicians and pharmacists regarding their knowledge and beliefs about falls prevention in seniors.

Sources: A. Hahn et al., 1996, and Health Department of Western Australia, 1998

CAREGIVER SUPPORT

Support for caregivers has been a priority in all three countries examined. In addition to a full range of programs to provide care in the home, a variety of programs are aimed directly at supporting caregivers.

In both Finland and Australia, caregivers are paid for their services. Since the mid-1980s, every municipality in Finland has provided some form of caregiver allowance. This allowance is granted to the person receiving care but is paid directly to the caregiver, providing a degree of financial independence. More recent legislation sets a minimum rate that is both taxable and considered for pension purposes. Caregivers also have a legal right to an annual vacation and at least one free day each month. In recent years, Finland has experimented with service vouchers that caregivers can use to purchase the support services of their choice from private-sector providers. Caregiver allowances and other services are funded by municipalities, which have a great deal of autonomy in deciding levels of payments and eligibility criteria, and there is much variation across the country.

Supports for Caregivers

Salaries and payments

Reimbursement of costs

Respite services

Resource centres

Toll-free help lines

More recently, Australia has introduced a similar payment to provide income support (similar to a pension) for caregivers who have no other pension income. In addition, a "carer" allowance is available to help cover the additional costs of caregiving, and this is neither taxed nor income-tested. Caregivers who receive either or both supplements are legally entitled to 20 hours per week and up to 63 days per year of respite without losing entitlement to the payment. Respite is provided through nursing homes and community day centres, and in-home respite is available both day and overnight.[41]

The 1997, the National Respite for Carers Program established a Carer Resource Centre in every state capital and 82 regionally based Carer Respite Centres around Australia. Carer Respite Centres improve access to respite by acting as a single contact point to help caregivers plan for and obtain respite through services available in their area. The centres purchase, organize, or manage the delivery of respite care packages tailored to each caregiver's needs and also deal with emergency respite needs. The Carer Resource Centres across the country provide a range of information and advice to caregivers and can be accessed both in person and through toll-free numbers.[42]

A National Dementia Behaviour Advisory Service toll-free number provides 24-hour assistance to caregivers of people with dementia. The telephone line is funded by the Commonwealth government and managed by the Alzheimer's Association. Professionally qualified staff respond to calls.[43]

In Japan a Law Concerning Child Care and Family Care Leave[44] entitles all workers to take up to three months of unpaid leave for caregiving. It also requires employers to implement shorter working days and to limit late night shifts for workers who have caregiving or parenting responsibilities.

The strong tradition of family responsibility to provide care has made payment of caregivers a highly controversial issue in Japan. While caregivers do not receive a pension or salary,

families are entitled to a grant to help cover the costs associated with caring for a family member. Caregivers in Japan are also entitled to one week of respite per month, which is provided through short-stay beds in nursing homes. Regular respite is also widely available through day-service centres. Neighbourhood In-home Care Support Centres provide advice and guidance for family caregivers.

HEALTH AND SOCIAL SERVICES

Creating an integrated network of health and social services to support a large and growing population of very old people has been the major focal point for reforms in all three countries. Well over a decade of effort at the national, state, and local level has been invested in creating the required infrastructure. The following section provides only a glimpse of the experiences, programs, and learning in each of the countries examined.

The Commonwealth government in Australia funds residential aged-care services and, in conjunction with state governments, also funds community-care services. The country has a long history of investment in institutional care for the elderly. During the 1960s and 1970s, the number of nursing homes in Australia expanded rapidly, and by the early 1980s, Australia had one of the highest rates of seniors in nursing homes in the world.

Over the past decade, the priority has shifted to community care, and more recently an Aged Care Reform Strategy has been aimed at correcting the imbalance between community and residential care and the lack of integration of policies and services. The country has since developed a wide variety of national programs that provide older people across the country with a choice of care options. Some of these are described below:

Home and Community Care (HACC)[45] is a national program that funds a wide variety of service agencies to provide a variety of support services for frail older people and people with disabilities who live at home, as well as for their caregivers. The services include:
- home help: cooking, cleaning, washing, ironing, or banking
- transport: for medical, social, or other reasons
- food services: meals-on-wheels, congregate meals, or help with grocery shopping
- personal care: bathing and dressing
- health services: home nursing, physiotherapy, or podiatry
- home maintenance: help around the house with small tasks and gardening.

HACC is funded jointly by the national and state governments and is provided by community agencies. Fees are charged for these services; however, special arrangements are made for those who cannot afford to pay. In December 2000, 460,000 people were receiving HACC.[46]

Alternatives to Institutionalization

All three countries have adopted a policy of keeping the elderly out of institutions. They offer the following services as alternatives:

Home-help services

Home nursing services

Home-care co-ordination

Day-service centres

Supportive seniors' housing

Group homes for people with dementia

Short-stay respite facilities

Caregiver-support centres

Geriatric medical facilities

Community Aged Care Packages (CACPs)[47] are integrated packages of services for frail older people who would otherwise be in an institution. CACPs enable people to deal with only one contact person, who arranges all of their necessary care, instead of having to deal with a range of service providers. The provider receives a uniform payment based on the level of care needed and is responsible for either providing or arranging for all of the care and services a client might need – ranging from housekeeping and lawn maintenance to nursing and respite care. In 2001, 26,898 CACPs were available (one for every 65 people aged 70 or older).[48] The program is funded by the national government. Although fees may be charged, no one is denied service because of an inability to pay.

Extended Aged Care at Home (EACH) packages were launched as a pilot project in 1998 to test the feasibility of providing high-level nursing-home care to people at home. An evaluation completed in 2001 found that EACH packages are economically viable, target recipients' needs effectively, and can deliver high-level care to people in their own homes provided that clients are selected appropriately. The government has since announced funding to establish EACH as an ongoing program.[49]

Residential care is provided through both nursing homes, which provide high-level care, and hostels, which provide low-level care or assisted living. Generally, nursing homes provide 24-hour nursing care, while hostels provide accommodation services and assistance with the tasks of daily living, with nursing care available occasionally. Approximately 7% of Australians aged 65 and over live in either a nursing home or a hostel.[50] Since 1997, nursing homes (which developed out of the medical system) and hostels (which developed out of government housing programs) have been administered under one residential-care system. Part of Australia's efforts to prepare for the aging boom is an emphasis on aging in-place, and the distinction between nursing homes and hostels is disappearing. For example, the new reimbursement system allows hostels and retirement villages to provide nursing-home care if they choose to do so and if the required standards are met. This means that services have the flexibility to meet a broader range of care needs, with more opportunities for older people to move from low- to high-level care without having to move to another establishment. The government is developing new brochures and information sheets that describe aging in-place, as well as a booklet for those

who provide residential care, to describe various options for establishing aging-in-place homes.[51]

Aged Care Assessment Teams (ACATs) are multidisciplinary teams that assess older people for access to both residential-care and community-care packages. There are 140 ACATs across Australia.[52] The primary role of ACATs is to ensure that only those who really need this level of care receive it and to inform those who do not about other programs and services available to support them.

The Commonwealth has in place a comprehensive framework to ensure that access to both CACPs and residential-care places is related to the distribution of the population. The services are planned and provided on the basis of national benchmarks applied on a regional-population basis. The benchmarks stipulate that there should be 90 residential-care places and 10 residential-care packages (provided in-home) per 1,000 people over the age of 70.[53]

The Community Visitors Scheme is a nation-wide Australian-government initiative designed to help establish links between people living in an aged-care facility and their local community. It provides one-to-one volunteer visitors for socially isolated seniors whose quality of life would be improved by friendship and companionship. The Commonwealth Department of Health and Family Services provides financial support to 170 community-based organizations to operate the scheme.[54]

Multi-purpose centres provide aged care in rural and remote areas. The centres are focal points for the delivery of family and health services. In addition to nursing-home and hostel care, the centres may provide home care, podiatry, radiology, mental health, women's health, palliative care, community nursing, meals-on-wheels, and services for young children and their parents. As of June 2001, there were a total of 56 multi-purpose centres with 1,223 flexible aged-care places.[55]

Dementia services provides a range of programs to address the needs of people with dementia, as well as their families. A National Behaviour Helpline and a Dementia Education and Support Program provide information, education, and support. A psychogeriatric unit in each state provides expert diagnosis, assessment, advice, and support to ACATs, service providers, and families. Peer support groups have been established to provide early intervention for people with dementia and their caregivers, and caregivers of people with dementia have access to enhanced respite-care services. In recognition of the high cost of psychogeriatric care, the government has amended funding formulas for residential facilities and ACATs.[56]

Coordinated Care at Home – Australian Style

The following case study illustrates how coordinated care planning has improved one Australian's care and reduced hospitalization.

Mr. Daly is 75 years of age and lives alone. He is on seven different prescribed medications, including those for heart disease, diabetes, and high blood pressure. Due to mild dementia, he forgets to take his medications, to attend appointments, and to eat his home-delivered meals. He has frequent hospital admissions due to falls associated with his heart condition, his medications, and inappropriate footwear. Hospital stays are prolonged due to his nutrition problems. He has unsuccessfully tried residential care.

The aim of Mr. Daly's care plan is for him to continue to live independently at home. His medication is now delivered in weekly blister packs by the community pharmacy, and his doctor is supervising a gradual reduction in psychotropic medication use. A volunteer sits with him while he eats his home-delivered meals, and taxis transport him to doctor's appointments, weekend meals at a football club, and Tai Chi classes to improve his physical fitness and balance. Appropriate footwear has been purchased. He is being trained, under supervision by a nurse, to monitor his weight daily. His care coordinator and general practitioner provide ongoing monitoring.

The costs associated with transport and other services for Mr. Daly have been more than offset by the reduction in hospital admissions and medication usage. Coordinated care has improved Mr. Daly's health and well-being and has enabled him to remain in his own home, where he wishes to be.

Source: Commonwealth Department of Health and Aged Care, *National Strategy for an Ageing Australia: World Class Care Discussion Paper,* 2000

The National Continence Management Strategy is a four-year plan to reduce incontinence, one of the major reasons that Australians enter nursing homes. The strategy includes a National Continence Helpline, managed by the Continence Foundation of Australia to offer free professional and confidential advice, as well as both community and research projects.[57]

Sub-acute Medical Care provides rehabilitation and specialized geriatric medical services for older people following acute illness or injury. These age-appropriate services focus on complex, low-intensity, and post-acute care. The specialized setting and multidisciplinary team approach result in cost savings and more appropriate care than is available in an acute-care hospital.[58]

Commonwealth Carelink Centres across the country help older Australians access the wide range of support options available to them. Over 60 regional Carelink Centres were launched in storefronts in 2001. The centres, which also have a toll-free telephone line, act as a single contact point to provide reliable information and guidance about aged-care services available

locally. They also assist older Australians who choose to live in their own homes. Each centre maintains an extensive database of up-to-date and local information, including local services such as household help, personal care, home nursing, meal services, home repairs and modification, respite care, day-service centres, and continence assistance, as well as ACAT services and eligibility for residential-care placements.[59]

The government also maintains an Aged Care Internet Web site and toll-free line. Many publications aimed at seniors are available in over a dozen different languages. An Age Page in all municipal telephone directories provides easy access to information about services for seniors.

The Australian government continues to develop and test innovative ways to provide better care at a lower cost. A new Enhanced Primary Care Package supports older Australians who have complex care needs through the following measures:[60]

- Medicare coverage of the time doctors spend in care planning and case conferencing
- professional education programs for doctors about care planning and case conferencing
- continuing trials of alternative approaches to coordinating care and integrating services across sectors.

In contrast to the strong role of the national government in Australia, health and social services in both Finland and Japan are largely the responsibility of municipal governments. Until recently, Japan's national policies reflected the traditional belief that children should take care of their aging parents. As a result, Japan had few facilities and services for older people as well as few people trained to work with them. As families became less able to care for their aging parents, general hospitals were used to provide long-term care, contributing to sharply rising health-care costs.

In the late 1980s, Japan launched a series of strategy documents aimed at developing services to cut down on extended hospital stays and to meet the needs of the rapidly growing population of elderly. As in both Australia and Finland, the aim of much of the reform has been to keep older people in the community as long as possible. The first of these plans, the Ten Year Strategy to Promote Care and Welfare for the Elderly (known as the Gold Plan), was established in 1989. The Gold Plan had seven major goals: to develop in-home services for the elderly at the municipal level, to reduce bedridden older people to zero, to establish a Longevity Social Welfare Fund, to rapidly develop institutional facilities, to enhance productive aging, to promote gerontological research, and to develop social institutions for the elderly.[61]

An important feature of the Gold Plan was the decentralization of services. Municipalities were assigned responsibility for developing and implementing programs for the elderly and were required to produce a Local Health and Welfare Plan for the Elderly. Another significant feature of the Gold Plan was a shift to in-home services for the elderly. The plan included targets for the development of a comprehensive range of care services. These targets were to be attained by 1999, but in 1994 it was recognized that the targets were too low to meet the rapidly growing need. The New Gold Plan (1995) revised the targets to accelerate

the development of services and included a strategy to rapidly increase the skilled workers required to provide the services. The new plan also began reimbursing families for the costs of home-care aides, nursing visits, home remodelling, and special nursing-home care.

By 1999, the end of the 10-year plan, approximately 3% of Japanese over the age of 65 were living in institutions. Most of the 1995 targets had been met or exceeded nationally; however, there were gaps in certain municipalities and service types. In April 2000, the government launched Gold Plan 21 to continue to develop programs and services for older people.[62] The national targets for service development in each of the Gold Plans are shown in Table 2.

	Baseline 1989	**Gold Plan** Targets for 1999	**New Gold Plan** Targets for 1999	**Gold Plan 21** Targets for 2004
Home helpers (# of helpers)	31,405	100,000	170,000	350,000
Short-stay service (# of beds)	4,274	50,000	60,000	96,000
Day-service centres (# of facilities)	1,080	10,000	17,000	26,000
In-home-care support centres (# of centres)	-	10,000	10,000	10,000
Home-visit nursing stations (# of stations)	-	-	5,000	9,900
Special nursing homes for the aged (# of beds)	162,019	240,000	290,000	360,000
Health-service facilities for the aged (# of beds)	27,811	240,000	280,000	297,000
Group homes for the elderly with dementia (# of facilities)	-	-	-	3,200
Care houses (# of people)	200	100,000	100,000	105,000
Multi-purpose seniors' centres (# of centres)	-	-	600	1,800

Table 2: National targets for developing services for older people in Japan
Sources: Kazuhito Ihara (2000), Masoto Kosaka (1996), National Institute of Population and Social Security Research (2000), Ministry of Health, Labour and Welfare (2000)

The services created as a result of the Gold Plans are described below:

Home-helper services provide housework and assistance with activities of daily living for the frail elderly at home. Services are often provided by private non-profit self-help organizations that have their roots in small-scale citizens' self-help movements; however, many of these are now becoming citizens' enterprises. Most of the service providers are women in the 40- to 60-year-old age group, and many are volunteers.[63]

Short-stay service facilities are beds exclusively reserved for short-term and respite care and are usually located in special nursing homes.

Day-service centres provide baths, meals, physical activity, recreational activities, health checkups, and rehabilitation. Transportation is provided by shuttle bus.

In-home-care support centres provide nursing-care consultations and guidance by specialists to support the long-term care of family members at home.

The Home-Visit Nursing Care Service for the Aged provides the following home nursing services under the supervision of family physicians: health-status screening, physical or occupational therapy, health education, bathing, personal care, and regular position changes for those who are bedridden. Staff include nurses, nursing assistants, and physical and occupational therapists.[64]

Special nursing homes for the aged are long-term-care facilities that provide support with the activities of daily living and personal care. Staff coordinate health and social services for residents but do not provide nursing care.

Health-service facilities for the aged fulfill a role midway between that of a hospital and a nursing home. These facilities are designed for bedridden elderly people who require medically supervised nursing care, physical therapy, and personal care. The facilities are intended for stays of up to three months, and the aim is to return patients to their own homes. In practice, people stay much longer. Health-service facilities for the aged are required to employ physicians, nurses, physiotherapists, occupational therapists, and nutritionists.

Group homes for the elderly with dementia are small-scale facilities in which a few people live together and share household tasks in a home-like atmosphere. These group homes were first introduced as a pilot project that demonstrated their effectiveness in both slowing the progress of dementia and stabilizing its symptoms.[65]

Care houses provide elders who are relatively well-off with the support they need to continue to lead independent lives. Meals, social activity, and other services are provided on site. These have been compared to the assisted-living facilities in North America.

Multi-purpose seniors' centres are small facilities that provide support for care at home, day services for about 10 users, and residential facilities. While these were initially developed for isolated and rural areas, multi-purpose centres are now also appearing in cities.

All of the above services are provided by a variety of business entities, including private-sector companies; social-welfare foundations; and agricultural, consumer, and worker cooperatives. In Japan's major cities, high real estate prices and land scarcity have made it difficult for local governments to build new facilities. To alleviate land shortage and encourage intergenerational contact, local governments are increasingly building multi-purpose public facilities. There is a growing trend to converting abandoned schools into public facilities that house special homes for the elderly, classrooms for adult education, and civic centres. New services for the elderly are often located in the unused classrooms of active public schools or are combined in a single building with a child-care centre. To promote this approach, the Ministry of Health and Welfare has distributed a booklet on classroom conversion throughout the country.[66]

Rapport Fujisawa: A Japanese Co-operative Approach to Eldercare

Rapport Fujisawa is a special nursing home for the elderly and an in-home-care support centre. It was established in 1994 by a Japanese consumer co-operative called the *Seikatsu Club Seikyo Kanagawa* (life consumer co-operative) that was initially created to purchase safe foods and environmentally friendly products. The group became concerned about the aging society in the early 1980s and decided to work together to develop a system that would be there to support them in their old age. Their first step was to develop *Tasukeai* (group mutual help), a workers' collective in which members both directed the program and delivered the home-help services.

Over the next decade, the services provided by the co-op expanded to include *Rapport Fujisawa,* four day-service centres, and many other community-based service enterprises. By 1996, the *Seikatsu Club* co-operative included 47,150 member households, employed more than 700 full-time workers, and had formed 70 workers' collectives. Providing a flexible transition for women from unpaid to paid work is one of the central aims of the *Kanagawa Seikatsu* movement. The work is seen as the means to a new way of life. Co-operative caregiving in particular is seen as an intermediate work form that lies somewhere between regular employment and the work of women at home.

Rapport Fujisawa, the special nursing home for the elderly, has 30 resident rooms with 70 beds: 50 beds are for long-term residents and 20 reserved for short stays. One floor of the home, with 30 beds, is for residents with advanced senile dementia.

The adjoining in-home-care support centre serves a population of 60,000 elderly people. The centre provides the following services under contract with the municipal government:

- two professionals on staff
- a day-service centre open five days a week
- a bathing service
- home-visit nursing services
- a 24-hour emergency telephone service
- meals-on-wheels (the food is prepared by a workers' collective)
- home-help services.

As of 1996, *Rapport Fujisawa* had 43 paid staff. In addition, cooking, laundry and care-assistant services were provided by two workers' collectives (made up of previously unemployed homemakers) with a total of 61 members. Volunteers, called "citizen partners," and one companion dog worked closely with paid staff.

Sources: Masoto Oka, 2000, and Anita Lord and Mary Mellor, 1996

Even with this wide variety of services, the cost of aged care became a burden on Japan's health-insurance systems. In 2000, the Japanese government implemented a new mandatory Long-Term Care Insurance Program designed to share the burden of caring for Japan's elderly among all members of society. This program replaced the previous piecemeal system of government support for individuals whose families could no longer care for them.

Every Japanese person over the age of 40 is required to contribute to the insurance program. Premiums of about $30 per month are deducted from the pensions of those aged 65 and over, and deductions are taken from the salary of people in the work force. These premiums cover half of the financing for the system; the balance is shared by national, prefectural, and municipal governments as well as co-payments by users.

The program introduces "care management" to provide appropriate and coordinated services to meet specific individual needs, whether at home or in an institution. Users are free to choose a care manager and service suppliers from a variety of private-sector suppliers, and the costs are covered by the program. The kinds of services covered by the program include:

- home help
- at-home bathing, nursing, and rehabilitation
- outpatient rehabilitation
- at-home medical-care-management counselling
- day services
- short-stay services
- group homes, special nursing homes, and health facilities for the elderly
- subsidies for care equipment and home alteration to meet care needs.

For most services, individuals are required to pay a user fee of 10% of the cost. To receive Long-Term Care Insurance benefits, a person must be assessed by the municipality to determine the level of care required. The assessment is based solely on the individual's health and mental condition – neither the income nor the family situation are reviewed for this purpose. A six-level dependency scale is used to determine access to long-term care and the maximum benefit that an individual can obtain. The highest level provides 24-hour institutional or live-in care for the most dependent, and lower levels provide for various combinations of home care, day services, and short-stay facilities.

The plan is scheduled for full evaluation and review in 2005. There is already an active debate about the possible shortcomings of the system, including concerns about whether enough services are available to meet the demand it will generate, about the cost of premiums and user fees, and about ensuring quality care.[67]

In Finland, social and health-care services are financed mainly (90%) through public funds raised by municipal and state taxation. Client and user fees account for about one-tenth of the costs. These fees are either fixed or determined in accordance with the client's income. By law, some services are free of charge.

Here, too, the policy has been to provide community services to enable older people to remain in their homes. These include the caregiver's allowance, home help, home nursing, day hospital care, and short-term care in institutions. As a result, people do not resort to institutional care until they are severely incapacitated, and nursing homes as such do not exist. Historically, long-term care of the elderly has been provided in hospitals; more recently, separate wards in primary-care hospitals have been developed for this purpose. The share of the elderly in long-term care has dropped steadily since the 1980s. In 1995, 2% of people aged 65+ were receiving long-term care in an institution, while 9% were receiving home nursing care.[68]

During a serious recession in the early 1990s, major changes in health and social-service provision occurred in Finland. At that time, municipalities were given more freedom and decision-making power in health and social-service delivery as well as the right to charge for these services. At the same time, the amount of funding they received from the federal government to provide the services was greatly reduced. As a result, unlike Australia and Japan, each municipality decides which services it will provide, how much it will charge for the services, and whether they will be provided by municipal employees or by the small but growing private sector. The resulting diversity of services in the 460 municipalities makes it nearly impossible to describe the services available for older people in Finland. While the larger and wealthier municipalities provide a wide range of services, often at no cost, smaller and more remote municipalities provide few services and may charge significant user fees.[69]

Instead of nursing homes, most municipalities have developed service housing to provide basic services and security for older people. While these homes are not staffed around the clock, residents have access to home nursing services. Many municipalities have drawn up strategic action plans to meet the challenges of population aging. However, in many other municipalities, services to support the elderly who live in ordinary housing have not been increased or developed to any great extent.[70] Instead, the approach has been to provide payment to a friend or family member to care for older people in the community. Finland is recognized as a world leader in providing salaries for caregivers.

In addition to service housing and caregiver allowances, the main services for the elderly are home helpers, home support services, and day programs. Finnish home helpers are a quasi-professional group and require a 2½-year full-time training program. Aside from assistance with everyday chores and personal care, home helpers monitor health status and provide guidance to available services. Some of the support services available include meals-on-wheels, day centres, transport and escorting services, various emergency telephone lines, laundry services, and cleaning services.

The 1993, legislation allowing municipalities to charge fees for home-support services resulted in a rapid decrease in the demand for these services. In 1998 there were about 40% fewer elderly households receiving home help than in 1990.[71] Even so, staff numbers in municipal home help have increased. In many municipalities, home-help services for the

elderly are concentrated on those in the poorest health. The number of clients has gone down, but the level of help needed by individual clients has gone up.[72]

In response to recent widespread dissatisfaction with the patchwork of municipal services that have developed over the past decade,[73] the federal government has developed a National Framework for High-quality Care and Services for Older People[74] as part of a broader national-standards project. The framework promotes standards for elderly care that are not binding on local governments but that encourage municipalities to draw uplocal policy strategies and action plans. Implementation of the framework will be monitored nationally.

CONCLUSIONS AND POLICY IMPLICATIONS

Together, Finland, Japan, and Australia provide a powerful illustration for policy makers of the diverse range and mix of policies and programs that can emerge in countries that share a common goal for the support and care of older people but that have different cultural and political traditions. While the approaches and measures are unique to each country, several common elements can serve as models for both Canada and the Atlantic region.

Common Areas of Policy Reform

Whole-of-government policy frameworks

Employment of older workers

Pension reform

Alternatives to institutionalization and support for care in the community

Comprehensive support systems for family caregivers

Supportive housing

Private-sector service providers (both commercial and not-for-profit)

National standards for care

The first of these is the development of whole-of-government strategic frameworks at the national level for coordinating and gaining support for age-related reforms. All three countries felt the need to develop comprehensive age-related policy frameworks with principles, goals, and objectives that consider all of the determinants of active aging as well as economic prosperity. These frameworks involve all government departments, social partners, non-governmental organizations and the general public. While the frameworks vary in scope and structure, a main purpose has been to build the public understanding and consensus required to support the reforms – some of which would otherwise be unpopular. These frameworks have provided national leadership for action and a coherence in activities in different sectors and levels. They are believed to have helped sustain reform over a longer period of time than is typical in public policy. In Finland and Japan, strategic plans for population aging are also required at the state or municipal level. The Australian approach has involved the general public in a national debate to develop the framework.

Another common theme is the concern with labour issues such as mature-age unemployment, early retirement, and worker shortage. All three countries have begun experiencing the impact of population aging on the labour force. They have recognized the folly of incentives for early retirement and have made 180-degree policy shifts in this area. They have also instituted policies to promote rehabilitation, retraining, and lifelong learning to enable older people to remain in the work force at least until the age of 65. Both Japan and Finland have developed comprehensive policy frameworks to address work-force aging. In Atlantic Canada, as in Finland, we are more familiar with unemployment than worker shortage, and

this issue may be hard to grasp. However, we have recently begun to see signs of worker shortages in professions such as nursing, teaching, and medicine in Atlantic Canada. Unemployment among older resource workers is at an all-time high in our region, and future employment prospects for those with limited literacy and training are discouraging.

Another strong theme is the priority that Finland, Japan, and Australia have placed on keeping older people out of institutions. Each has adopted a comprehensive range of measures to keep older people in the community. In Australia and Japan, the expression "long-term care" no longer refers to institutionalization because long-term care is now available both at home and in a range of facilities. A wide variety of supportive services have been rapidly created to encourage care at home. This profusion of in-home support and care services has led to the need for care coordination. In all three countries, a care coordinator is assigned to people who require several support services.

Also to facilitate care at home, the countries examined have all developed strong support systems for caregivers. These all include some form of payment, legal entitlement to respite services, and easy access to both advice and emotional support.

For older people who cannot remain at home, all three countries have emphasized the construction of a range of supportive housing such as hostels, cluster homes, service homes, and special nursing homes. These facilities all provide security and assistance but do not provide nursing care. In most cases, they are not staffed around the clock.

Another common element of these reforms is the reliance on the private sector for providing many of the supportive services for seniors. While services are purchased by the government, they are increasingly delivered by private-sector providers, including both for-profit and not-for-profit organizations.

Both the growing private-sector involvement and the decentralization of services to municipalities (in Japan and Finland) have led to concerns about inconsistencies and quality in all three countries, which are all now developing mechanisms such as national standards and accreditation programs to enhance quality and consistency.

Canada can also learn from the significant differences in the approaches used by each country. A strong theme across all Australian programs is public participation and access to information. The Australian government's consultative approach to developing the National Strategy for an Ageing Australia, with five discussion papers available in 13 languages, is in sharp contrast to the top-down Japanese approach. The Australian government has made access to information a priority, with many free publications available in several languages, a number of toll-free information lines, and a variety of storefront information centres available across the country to keep seniors and their caregivers abreast of all available services and programs.

Japan's very systematic approach to planning can also provide a model for policy makers in Atlantic Canada. With demographic projections of the number of older seniors who will be

requiring care in our region in the next two decades, municipalities, health regions, and provinces can begin to set targets now for building the required infrastructure – the same way in which Japan did in its series of Gold Plans.

Policy makers in Atlantic Canada might well ask who will pay for these extensive reforms. Experiences in Finland, Japan, and Australia suggest that there is no one source of funding. Each country uses a combination of measures to pay for new programs and services. In Finland's cradle-to-grave welfare system, most programs are still funded through general taxation, with employers bearing some responsibility to provide services to employees and their families. User fees have been introduced for many programs. The Australian system requires means testing for most services. For the first time in its history, Australia's older population is relatively well-off financially, and users who can are expected to pay for services. The Japanese, who are highly averse to taxation, have a strong belief that people should be self-reliant. Even so, when the first Gold Plan was introduced in 1989, the Japanese government introduced a goods and services tax for the first time. While the two measures were not officially linked, there is a general belief that they are related. More recently, Japan's new Long-Term Care Insurance Program requires employers, workers, and seniors to pay regular premiums to support the reforms. In addition, users are required to pay from 10% to 30% of the costs for most services. All three countries have taken measures to reduce the burden on national pension and unemployment-insurance programs. Clearly, none of these measures have been popular with the general public, but over time they have been accepted. Informed public discussion about alternatives for both reforms and their financing will provide an opportunity for all of us in Atlantic Canada to design the right mix of services and payment schemes to meet our own unique situation.

Population aging is a demographic phenomenon that is not going to disappear. It will only increase in our lifetime. Experiences in Finland, Japan, and Australia demonstrate that it takes more than a decade to develop a comprehensive and integrated infrastructure that will maintain prosperity and support an aging population. The unique blend of policies and programs in each of these countries has emerged from the complex interactions of their culture, traditions, and economic priorities. The emerging similarities between Finland, Japan, and Australia in their responses to the aging of their communities offer strong role models to policy makers in Atlantic Canada and to the country as a whole.

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