Table 2: Health Care Systems in Japan, US, and Britain

Specifically in relation to women and health care, in Britain and Canada, specific programs are provided for women, including reproductive services, such as maternity, abortion, contraception, infertility treatment, and preventive services such as cervical cancer screening and mammography. In some areas of Britain, Well Woman Clinics run by GPs also offer free services to women. The services offered by these clinics are provided by the NHS. In Canada, again depending on area, women's clinics run by GPs and other health care related professionals also provide free services. In Japan, despite the growing public and professional awareness towards the importance of women's reproductive health and preventive care very little of that is being covered by the health care insurance. The existing medical insurance does not recognize reproductive services such as maternity (unless there is medical complications), abortion, contraception, and preventive care related to women's as legitimate items of the insurance coverage. In lieu of the insurance coverage, limited support is provided by the local governments and/or by the employers to enable older women to take examinations. However, it cannot be said that the public education on preventive care is widespread. Unlike the US, neither the Japanese, British, nor Canadian health care systems have specific bureau or section on women, although in Canada some provinces have Women's Secretariat, which deals with issues related to women including health care.

In all the four countries, the life expectancy for women is at least five years longer for women than men, but it has been shown that older women suffer higher levels of disabling conditions for longer periods during their older years. Therefore, the gender differential in disability free years is less than for expectation of life, as shown on Table 3.

Table 3: Trends in Life Expectancy without Disability at Age 65

Countries	Life expectancy At 65	Disability-free life expectancy	Life expectancy At 65	Disability-free life expectancy
	Males		Females	
	Moderate disability-free life expectancy			
Canada (1991)	15.6	8.3	19.7	9.2
US (1990)	15.1	7.4	18.9	9.8
	Severe disability-free life expectancy			
Canada (1991)	15.9	13.3	19.7	15.4
Japan (1990)	16.2	14.9	20	17.3
UK (1991)	14.5	13.6	18.1	16.9

Source: OECD (1999) *A Caring World: the new social policy agenda*, Paris: OECD

In relation to global measures of self-assessed health, there is now little gender difference, although in the past women reported poorer self-assessed health than men (Arber and Cooper, 1998). However, in all the four countries, it is found that women suffer higher levels of mental ill health, particularly depression. Attempted suicide is higher among women, but suicide rates are much higher for men.

The access health care is vital to individual and population health outcome. In Britain and Canada there appears to be national consensus that the free access to all health care services as provided by NHS or national health care is considered vital to promoting women's health. Hence the curtailing of services to older people, especially relating to domiciliary support services for frail older women living in the community and long-term care for older women is considered highly detrimental to women's health. In Britain, Canada, and the US, the welfare retrenchment since the 1980s have led to curtailment of in social services and other support services for the elderly. While few studies has shown the impact of welfare state retrenchment on the health status of women, the existing research clearly points to the importance of social support and social policy in promoting and maintaining women's health. Unlike Japan which has introduced the long-term care insurance in 2000, in Britain, long-term care (LTC) insurance schemes are only available in the private sector, which means that these tend to be taken up by people who have the money to invest. In the US and Canada, LTC has also become an important policy issue in the 1990s but no public LTC insurance exists to address the care needs of the elderly and the LTC policies continue to be dealt with on an ad hoc basis at the level of the state and provincial governments.

3. Social Care in US, UK, and Japan

Through the comparison of policies concerning care giving and care receiving in Britain, the Netherlands, and Denmark, Knijn and Kremer (1997) made it explicit the connection between the individual's right to give or receive care and the notion of social citizenship. Arguing that the concept of citizenship should go beyond the gendered character of care to include the assumption that every citizen regardless of gender should be able to claim the right to give and receive care, Knijn and Kremer evaluates the extent to which different welfare states recognize different aspects of care as part of social citizenship. Although these researchers have looked at both the right to receive and give care for children and elderly, this paper will focus specifically on those related

to the elderly. The Table 4 summarizes the caring dimensions of the Japanese, American, British and Canadian welfare states.

Table 4 somewhere around here

Table 4: The Caring Dimension of Japanese, US, and British Welfare States

In terms of the right to receive care, the US, Britain, and Canada scored rather low, while Japan scored medium to high largely on the account of the LTC insurance which has enhanced the rights of the elderly to receive care. The general lack of social care and the historical assumption of care as a private rather than social matter has clearly resulted in low policy recognition of social care as a citizenship right in the US, Britain, and Canada. In Britain, even though there has been some formal recognition of the needs of the caregivers since 1995 with the introduction of Caregivers' Act, those receiving public residential care and home care services remain low (at 6% and 9%, respectively) and studies show the vast majority of the elderly rely on their families and their friends for care (Smith, 1999).

In the US and Canada, long-term care has been debated both at the federal and provincial level throughout most of the 1990s, however very little has been developed. Like Britain, the care of the elderly is still considered as largely a private matter, and the majority of the elderly are dependent on their family, friends, private market and other social network for care. It is therefore safe to conclude that overall the right to receive elderly care in the US and Canada in is not very developed, although it has to be pointed out that there is a significant variation between states / provinces as much of the social welfare and health care delivery are state / provincial jurisdictions. The level of private expenditure on LTC also appears to be higher in the US as compared to Britain and Canada. For example, during the period of 1992-95 the estimated total spending on LTC were 1.32, 1.30, and 1.08% of the GDP for the US, Britain, and Canada, respectively; of which the estimated public spending were 0.70, 1.00, and 0.76%, respectively. In the case of the US the availability of market care provision has also meant that an increasing number of elderly who could afford the services have

turned to the market to satisfy their care needs. This has led to the increasing social polarization in terms of individual access to care along the race and class lines.

In comparison to these three countries, the rights of the elderly to receive care have improved noticeably in Japan as a result of the introduction of LTC insurance in 2000. The LTC insurance is a compulsory national insurance and all citizens over the age of 40, including the pensioners, will have to pay monthly insurance fee preset by the local governments. Under this system, all those over the age of 65 who are assessed to be in need of care will have the right to receive institutional and/or home based care, although users will have to pay 10% surcharge for all the services. Scholars have pointed out to a number of problems associated with LTC insurance schemes, including its inadequacy and the lack of equality (Peng, 2001a; 2001b), however, the fact that LTC insurance has made long-term care into a public insurance provision in itself is a significant development: it implies a formal public acknowledgement of the state's responsibilities in social care.

In relation to the rights to give care, again, none of the three countries have very high scores. In Japan, the family care leave legislation introduced in 1996 has enabled men and women to take unpaid care leave up to 4 months, however, surveys show that take up rate is very low partly because more than half of the employers have not complied to this legislation and in part because of the informal sanctions by the employers and coworkers against employees who take such leave (Ministry of Labour, 1998).[4] Until the introduction of LTC insurance, some of the local governments also made formal recognition of family's care giving role by providing small allowance for family caregivers. However, with the introduction of LTC insurance scheme the caregivers' allowance was abolished largely as a result of the pressures from women's groups on the ground that such allowance will reinforce women's care responsibilities and tie women down to their homes.

In the US, Britain, and Canada, there is no set national policies with regards to family care leave, although in the US and Canada a growing number of employers are now providing such leaves as a part of the management policy. In Britain, a limited citizenship rights have been accorded to those caring for the severely disabled. If they pass the strict entitlement rules for Invalid Care Allowance (ICA), caregivers providing

[4] From year 2000, an income replacement equivalent of 25% of the salary was added onto the care leave in order to encourage take up rate.

care to severely disabled can receive small allowance as compensation to their care giving work. However, since the amount of allowance is very low they would not able to achieve full economic autonomy through their work as caregivers alone. In Britain, the credits for care of severely disabled people could also be counted to social insurances such as pension and unemployment insurance. This increases the caregivers' opportunity to receive social insurance benefits. However, since the 1996 Britain, the US, and Canadian governments have shifted towards strengthening the work obligation of both men and women, with a result that exemptions for caregivers from work obligation has become increasingly more difficult.

4. Conclusion: Social Care and Women's Citizenship

This paper discussed the concept of social care and citizenship, and examined their relationships to gender and welfare states. The comparison of Japanese, American, British, and Canadian social security and health care systems show that while these Liberal welfare states all share common root characterized by the Beveridgean model of social security, there are noticeable differences amongst them with respect to the extent of income security and social welfare support. Yet, in all cases, it is clear that the assumption of the male breadwinner household underlying the Beveridgean social security system has led to qualitatively different kind of citizenship rights for men and women. In health care, such gendered nature of work pattern and access to social and economic resources is reflected in the differential health outcomes for men and women. In all these countries, women's life expectancy is higher than men, but older women suffer higher levels of disability for longer periods, which undercuts the gender differential in disability free years.

As welfare states face a growing crisis of care as a result of population ageing and changes in women's employment patterns, care has become an important domain of state policy activity. In Japan, US, Britain, and Canada social care has also been a central policy issue throughout the last couple of decades. Comparison of the social care dimensions in these welfare states suggest that despite the public acknowledgement of the importance of social care, very little progress have been made with respect to social care and the individual rights to give and receive care continue to be low. The only exception is Japan, where the introduction of the LTC insurance in 2000 has significantly enhanced the elderly people's right to receive care.

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Country	Type of Heath Care System	Health Care Organization	Levels of Coverage	Criteria for coverage	Extent of Coverage
Japan	· Mandatory social insurance schemes organized along different occupational groups. · Half of the national health insurance is funded by tax. · Almost all services require users pay 30% of the cost of the services. · A proportion of the population carries private health and other related medical insurance.	· Central government is responsible for regulating medical and health services. · Except for basic preventive health such as immunization and other mother and child health (which is part of social welfare, and delivered by the local government), most medical and health care services provided through market system. · Doctors paid based on fee for services.	· Theoretically the whole population is covered. · According to the 2000 survey only about 85% of the population are actually covered (i.e. have been paying into the national health insurance).	· Based on health insurance payment	· Covers medical treatment and hospital care only, such as physician consultation, drugs, and dental care. Preventive care, immunization (other than the most basic ones like Polio, BCG, etc.), organ transplant, pre- and post-natal care, and healthy child delivery not covered.
US	· No national health care insurance; all private insurance; free market model of medical provision · Medicare and Medicaid available to low income elderly and low income people, respectively.	· Most Medical and Health care services provided through market system. · Doctors paid based on fee for services.	· Approximately 46% of the population had health care coverage in 1995. With private insurance coverage the proportion covered is about 86%.	· Based on health insurance payment	· Coverage dependent on the insurance.

Table 2: Health Care Systems in Japan, US, Britain and Canada-1

Britain	· Funded largely from central taxation (via the National Health Service). · Mainly free services, although an element of user-fees exists and a proportion of the population carries private health insurance (which does not disqualify them from NHS care)	· Central government is responsible for the organization of most health care delivery in the UK – typically devolving to 8 Regional Health Authorities. Central government also regulates private health care. · Local authorities are responsible for the running and delivery of some aspects of healthcare – e.g. elements of personal social services. · Doctors paid according to salary	· The whole population is covered by the NHS. · According to the 7th wave of the British Household Panel Survey, approximately 13% of the population has also some form of private health insurance in their own name.	· Based on citizenship	· The NHS covers: basic physician consultation, hospital treatments, primary and preventive care, pre- and post-natal care, organ transplant, dental care, etc.– although user fees may be required in some cases. · The private health sector typically places more stringent cover restrictions.
Canada	· Funded by insurance premium and central taxation. · Mainly free services, although some provinces have introduced limited user-fees for specialized treatments, and a proportion of the population carries private health insurance as well (which does not disqualify them from the national health care)	· Health care responsibilities are shared by the federal and provincial governments, although the federal government is mainly responsible for ensuring the equity of health care and affect delivery through funding, while the provinces manages the actual organization of service delivery. · Provincial governments are responsible for the delivery of health care, including hospitals. · Doctors paid based on fee for services	· The whole population is covered by the national health care. · A segment of population carries private health insurance to cover services that are not covered by the health care, such as dental care, semi-private rooms in hospitals, and drugs.	· Based on citizenship	· Although some variations among provinces, most of the services are covered. These include: basic physician consultation, hospital treatments, primary and preventive care, pre- and post-natal care, organ transplant, dental care within hospital, etc.. · The private health sector typically places more stringent cover restrictions.

Table 2: Health Care Systems in Japan, US, Britain and Canada-2

Country	The Right to Receive Care	The Right to Time for Care
Japan	Before 2000, Low; after 2000 Mid to High · Before the introduction of Long-term Care (LTC) insurance scheme, family and not the state was considered responsible for care. · With the introduction of the LTC insurance, all the elderly assessed to need care are able to receive care; but all citizens over the age of 40 including pensioners will have to pay monthly insurance premium, and all the service recipients will have to pay 10% of the care services. · Despite the LTC insurance, family is still considered primary caregiver for the elderly. · In 1995, approx. 6% of people over the age of 65 were receiving institutional care (including those in hospitals), while 5% were receiving formal help at home · Estimated public spending on LTC (1992-1995) was 0.15-0.62% of GDP	1) family care leave: Low-Medium · Since 1996 unpaid care leave up to 4 months have been granted as part of the new employment policy reform, but the take up rate is very low because more than half of the employers have not complied to this legislation yet. 2) exemption from obligation to work and other payments for care: Low · Some small payments for family carer have been provided by local governments before the introduction of LTC insurance scheme. But LTC insurance provides no provisions for caregivers. All social welfare recipients have obligation to work regardless of care responsibilities. 3) possibilities for part-time work: Medium · Huge expansion in part-time work during the 1990s. · Unemployed on benefit have to be available for full-time or part-time work. People working part-time have few social security rights
US	Low · Family and not the state is responsible for care · Family is the primary caregiver for elderly, not the home help · Outside of the family, market is the main care provider · Approx. 5.7% of people over the age of 65 are receiving institutional care, while another 16% are receiving formal help at home · Estimated public spending on LTC (1992-1995) was 0.7 % of GDP	1) family care leave: Low · No national policy on care leave; employer policy available 2) exemption from obligation to work and other payments for care: Low · A strictly defined small category of caregivers is exempted from the obligation to work. 3) possibilities for part-time work: Low · Unemployed on benefit have to be available for full-time employment. People working part-time have few social security rights

Table 4: The Caring Dimension of Japanese, US, and British Welfare States-1

Britain	Low · Family and not the state is responsible for care. · Family is the primary caregiver for elderly, not the home help. · Growing importance of market. · 2.4% of male and 5.1% of female over the age of 60 were in communal establishment (1991). · Approx. 5.1% of people over the age of 65 are receiving institutional care, while another 5.5% are receiving formal help at home · Estimated public spending on LTC (1992-1995) was 1.0 % of GDP	1) family care leave: Low · No care leave 2) exemption from obligation to work and other payments for care: Medium · Payments for care/ICA; a strictly defined small category of caregivers is exempted from the obligation to work; care credits in social security. 3) possibilities for part-time work: Low · Unemployed on benefit have to be available for full-time employment. People working part-time have few social security rights
Canada	Low · Family and not the state is responsible for care. · Family is the primary caregiver for elderly, not the home help. · Growing importance of market. · Approx. 6.2-7.5% of people over the age of 65 are receiving institutional care, while another 14% are receiving formal help at home · Estimated public spending on LTC (1992-1995) was 0.76 % of GDP	1) family care leave: Low · No care leave 2) exemption from obligation to work and other payments for care: Medium · Payments for care in some cases; a strictly defined small category of caregivers is exempted from the obligation to work 3) possibilities for part-time work: Low Unemployed on benefit have to be available for full-time employment. People working part-time have few social security rights

Table 4: The Caring Dimension of Japanese, US, and British Welfare States-2