A COMPARATIVE STUDY ON ELDERLY CARE PRACTICE: KYOTO AND KATHMANDU

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LIST OF ABBREVIATIONS

ADL	Activities of Daily Living
CBS	Central Bureau of Statistics
CBOs	Community Based Organizations
DDC	District development Committee
EPI	Employees Pension Insurance
EU	European Union
EHCS	Essential Health Care Services
FAO	Food and Agriculture Organization
FCHVs	Female Community Health Volunteers
IADL	Instrumental Activities of Daily Living
ICT	Information and Communication Technology
INGOs	International Non- Government Organizations
IIASA	International Institute for Applied Systems Analysis
KMC	Kathmandu Metropolitan City
LTCI	Long-Term Care Insurance
LWE	Law for the Welfare of the Elderly
LTC	Long Term Care
MoWCSW	Ministry of Women, Child and Social Welfare
MAA	Mutual Aid Association
MDHGs	Millennium Development Health Goals
MIC	Ministry of Information and Communication
MoHP	Ministry of Health and Population
NHSP-IP	Nepal Health Sector Programme-Implementation Plan
NDVS	National Development Volunteer Service
NPOs	Non-profit Organizations
NP	National Pension
NEPAN	Nepal Participatory Action Network
NGO	Non-Government Organization
NPO	Non-profit Organization
OAA	Old Age Allowance
OECD	Organization of Economic Co-operation and Development
PHCCs	Primary Health Care Centers
PHC	Primary Health Care
SEAR	South East Asia Region
SAARC	South Asian Association for Regional Cooperation
SWA	Social Welfare Act
SSNCC	Social Service National Coordination Council
SHRC	Silver Human Resource Center
UN	United Nations
UNV	United Nations Volunteers program
VDC	Village Development Committee
WHO	World Health Organization

ABSTRACT

Introduction

This research compares the elderly care practice of Kyoto and Kathmandu. The selection of these two cities for comparative analysis is based on the principle of the "Most Dissimilar Systems" approach according to Dogan & Pelassy (1990). In combination with growing internationalization a shift has taken place in comparative research from emphasizing uniformity among variety to studying the preservation of differences and uniqueness in contrast to homogeneity and uniformity (Boje, 1996). The comparative study of elderly persons serves two purposes: the first is to develop a broader understanding of the social processes in question; and the second to learn about and develop new ways of responding to the interests and needs of older people. The researcher concerned here with both aspects.

The social environment within which people grow older is rapidly changing. The size of families is decreasing, the role of extended families is diminishing, and perceptions of intergenerational support and caring for eldely are rapidly changing.

The implications of these changes in family composition and living arrangements for support and care for elderly depend on the context. In developing countries such as Nepal, where elderly have limited access to formal mechanisms of social protection, they will need to rely on the family and the local community. However, these informal protection mechanisms have been under increasing stress recently, owing to the process of population ageing itself but also, in some contexts, to a growing participation of women in the labour force and to changing perceptions about caring for parents and elderly in general. Developed countries such as Japan, may need to expand the supply of formal long-term care for elderly, including institutional living, as well as to develop alternative services to allow elderly to age in their homes if they so desire.

Family care in the world is changing, let there be no doubt. The traditional patterns of the past seem to be crumbling in the face of social, economic and demographic forces producing and resulting in changes in cultural values toward the elderly, in general, and family care to the elderly, in particular. In Japan, just a generation or two ago, adult children cared for the majority of the elderly in their own homes; as more women entered the workforce, families turned more to community home and other institutions to care for the elderly. In this context, the caring for the elderly is a challenge and can be overwhelming if not given proper consideration.

Likewise, the global phenomenon of population aging also afflicts Nepal. Historical systems of care, living arrangements, and familial responsibilities that once centered around or within the family network are changing to look more like Western, individualistic systems (Eckerman and Brauner, 2007). Though the process of aging of Nepal's population is still in its early phase, it is expected to gain momentum in the 21century and pose a major problem to the country.

Apart from other important dimensions in the field of pensions and health care systems, ageing populations will also increase pressures on social and caring systems.

Therefore care for frail elderly persons is an important component in this context (Jacobzone, 1999). The need for help can have enormous impact on the elderly and their families. Therefore, the health and social care for frail elderly persons is a serious concern for all sectors of society both in Japan and Nepal. Likewise, a comprehensible approach to including social care as a welfare dimension in the understanding of the welfare state and taking the aforementioned issues into account, it is necessary with a broadly encompassing understanding of care. The argument here is that it is the combination of formal and informal dimensions of care that constitutes the turning point for an understanding of the principles behind the social care system.

The theoretical framework of this study is based largely on the concepts of Tronto's theory of care (1993). Tronto considers 'care' to be an activity, a social practice. She insists that the activity of caring is largely defined culturally, and will vary among different cultures. Tronto distinguishes four analytically separate, but interconnected, phases in the caring process. These are caring about, taking care of, care-giving and care-receiving.

In summary, finding efficient and effective ways to care for the elderly is always an important issue and it is an issue of growing importance both in super ageing society of Japan and growing aging population of Nepal. However, the magnitude of the problem varies significantly from one country to the next.

Objectives

The main objective of this study was to examine the family, community and state based care practices for elderly of both cities in a comparative perspective.

Other objectives are as follows;

a) To investigate the physical, mental, psychological, social, economic, housing condition living arrangements, employment as well as activity and entertainment status of the elderly.

b) To analyze and find out the current situation and major issues faced by the elderly people of both cities.

c) To inquire into the patterns of social support, both formal and informal.

d) To gain a better understanding of adaptation of elderly care practices

Methodology

The mixed research design carried out for this study of both qualitative and quantitative. In other words, the research was descriptive and explorative. Mixed methods research resides in the middle of the continuum because it incorporates elements of both qualitative and quantitative approaches. Two different sources of information were consulted for this dissertation, namely primary and secondary. The former consisted of the experiences and views of governmental officials, policy makers, professionals, social workers, university teachers, medical doctor, staff nurses, and head of the elderly homes as well as elderly people by way of interview. The secondary information comprised research reports produced on the issues of aging and caring for the elderly by various types of national and international organizations as well as the published books, dissertations, journal, magazines by individual and scholars as well. A limited amount of

information was obtained from the Internet.

A carefully prepared, pre-tested and modified 95 item structured questionnaire (set A) for the elderly and 16 item mixed questionnaire (set B) for policy makers, professionals, social workers etc. was administered.

This study was based on face to face interviews with elderly people aged 65 and over and also professionals, policy makers' etc. from both cities. The study uses the data from the surveys done in Kyoto and Kathmandu, where the same sets of structured questionnaires were employed. I determined the sample size according to Cochran's formula n= (t)2 *(p) (q) / (d)2 . Hence, the sample size of the Japanese survey was 66 elderly, and the one of the survey done in Kathmandu 100 elderly. Likewise, for qualitative information the equal numbers (ten from each city) of professional respondents were selected for interview.

A purposeful sampling technique was investigated in this research. Purposeful sampling enabled the selection of subjects who best aided in achieving the research objective (Merriam, 1988). Campbell (1955) also states that both qualitative and quantitative sampling methods may be used when samples are chosen purposively. In this perspective, the researcher selected both types of samples from Kathmandu and Kyoto city. To collect quantitative data, the researcher visited to elderly people for face to face interview. The geographical coverage within which the information was collected includes all the 35 wards from Kathmandu Metropolitan and 11 wards from Kyoto municipality. At least two elderly people from every wards of KMC and six elderly from Kyoty city were consulted for interview.

Likewise, I analyzed the qualitative data manually and for quantitative by SPSS version-17. I analyzed the qualitative data manually and for quantitative analysis, I used chi-square test, t-test and used the simple statistical tools, such as frequency, distribution, average and percentages. The data were analyzed in a series of steps designed to allow sorting out, classification and description and as a final step, interpretation of the data. Information on the expressions and gestures of the respondents and also other salient points were written as field notes. The average interview length was around 42 minutes per individual.

Major Findings

The data revealed similarities as well as differences between the countries on the various dimensions that might reflect variations in family norms, patterns of behaviors and social policy traditions of the countries. Although both countries have bilateral kinship system, the typical images about Japanese and Nepalese families and elderly-care arrangements are contrasting. In Kyoto (Japan) the nuclear family is supposed to be predominant, among whom respect and care for the elderly persons is somehow lacking, because most elderly persons are cared for either in a home or in any community based homes and also institutions such as Hospitals, Nursing homes etc. The image about elderly care in Nepal is that joint family is predominant, strong family ties and respect for parents exists and elderly persons are supported within the family.

The overall health status of the Kyoto (Japanese) elderly was found to be better

than the one of the Nepalese. However, the increase in the elderly population, especially old elderly has raised many serious social and medical issues in Japan.

The Nepalese society has more positive attitude towards elderly than the Japanese one. The results show that the social status and networks of the Nepalese are better than Japanese ones. The economic status of the Japanese elderly is better than the Nepalese one. The income level in Nepal is highly scattered but among the Kyoto (Japanese) elderly it is clustered more around US $ 2000. Almost all Nepalese elders' income lies below US$ 200 per month. The income level shows that the t-test is 10.252, which is significant at df=164, and $P<0.001$.

Daughters-in law or daughters are the main care givers in both cities. In Nepal there is a tradition to keep a home servant who assists in caring for elderly as well as household's chores. In Japan there has been an increase in the number of elderly people who are themselves caring for other elderly people. The biggest part of Nepalese elderly in need of care prefers to be cared for in their own homes rather than in community. For the Japanese elderly, buying food and social expenses are the main financial problems, whereas for the Nepalese elderly, paying medical expenses followed by buying food are the main problems.

The life satisfaction and rating of life was seen betters than their Nepalese counterparts. Japanese respondents worried hardly ever about things they need in their daily life while Nepalese worried more.

Qualitative and quantitative results show that the most of Japanese respondents expressed their view that community-based care practice might be a good way for caring for the elderly in an infirm old age. In other instances, the elderly have chosen to enter an institution to avoid becoming a burden to their families. On the other hand, Nepalese professionals and respondents have showed their opinion primarily in favor of home care and secondarily in community-based care practice as well.

Even if governments major emphasis of caring for their super aged society in Japan, the public financing still remains insufficient to cover the whole costs. It may have strong repercussions on the health of elderly. This situation is more vulnerable for elderly people of Nepal. There has not been much attempt on the part of government to help and care for the elderly people in Nepal.

The great advantage of using Tronto's concepts of care is that the results become comparable and lead to insights into care needs and care provisions as universal issues. The formal, professional care is something that is available to elderly persons in Kyoto, not to elderly persons same as in Kathmandu. These differences make it difficult to compare the two cities. Most of the houses of Japanese elderly are safety and elderly friendly than the Nepalese. However, Japanese houses are narrower than Nepalese, which being difficulty to live two or more generations in a same households.

The provision of care is not a zero-sum activity and that neither is there a fixed quantum of care to be given nor is it divisible between public and private spheres. In Nepal there is complementarity rather than competition between formal and informal care.

Conclusion and Discussions

Aggravating society's care problem is the fact that the average family's ability to provide such care is decreasing, partly because of the ongoing transition from extended to nuclear family patterns. In response to these circumstances, care services need to be integrated between social and health services including reorganizing the welfare systems. They should be appropriately tailored to demand and balanced across institutions and care in the community (also at home). For that, all levels of government and all sectors of society will need to work in partnership to respond to the challenges of an aging society.

Increased life expectancy is a positive achievement, yet population aging is often perceived as a burden, especially by governments concerned about costs of care and welfare service provision for elderly. A rapidly increasing population of elderly people and also frail elderly people, public policy concern with increased costs of providing care now encompasses care in, by and for the community system. In this context, an emerging new type of care model, the community care model seems a way out for caring the elderly people. The community care model is a combination of community service and home care. Elderly people could live in their own homes while enjoying certain level of community care. This is a modern way of caring for the elderly, extending one's family to the community or taking the community as one's home.' The encouragement of true community care involves a broad approach and genuine joint strategies in social policy. A key aspect of social policy towards the care for the elderly must therefore be a positive partnership between family, the state, the market and other voluntary sectors as well.

Elders play a vital role in providing a sense of structure and cultural identity that helps keep our families and communities emotionally and mentally healthy. It is therefore essential that we develop the services to support elders so they can remain with their families and communities. Keeping our Elders near their families also supports their own mental and emotional health, resulting in longer and happier lives. And, in an interrelated way, healthy families are able to provide a safer, more supportive environment for elder care.

With the development of information resources and research, nationally and internationally, informed policies and plans for the care of the elderly can take place, ensuring successful coping by the elderly and their families of the ageing process, economically, mentally, emotionally and physically. So that elderly people are becoming a social stratum interesting to academics in the social and health care approach because they are needy, they are a group of specific size and in general, they are as yet unexploited as objects of genuine scientific investigation.

CHAPTER ONE
INTRODUCTION

1.1 Background of the Study

Aging is a broad concept that includes physical changes that occur in our bodies over adult life, psychological changes in our mental capacities and social changes in how we are viewed, what we can expect, or what is expected of us. Aging brings a distinctive set of problems which an individual must confront and master in order to achieve successful old age. People move from “middle age to young” old age and then, with increasing frailty, to “old” old age and death. Through this transition, five crises are almost universal: loss of social status; loss of significant people; internal and external body changes reflecting biological decline; confrontation with death; and modification of available roles and activities (Brieland et al., 1985: 369-371). However, aging may differ from one culture to another, not only in terms of their ethnic and racial differences but also urban and rural differences. Likewise, the health of the elderly differs from one country to another, affected by socioeconomic and environmental attributes. All old people are not alike and pre-old age characteristics such as class and gender continue to exert a strong influence across the life course. To conceptualize old age as an undifferentiated experience in both naive and unhelpful. We all bring to the experience of old age access to various resources-materials, health and social and these are strongly influenced by our experiences prior to 'old age'(Victor, 2005:5).

The definition of aging as a social problem is not an objective crisis of demography, but a crisis in the significance of biological aging, family relationships and relations between individuals and the state. Three fundamental issues lie behind the definition of elderly care as a social problem such as demographics (the “aging of society”), decreased ability to count on historically assumed family care givers to provide care and financing of services (Long, 2000). The aging population certainly will create new demands on pensions, and when coupled with low fertility, it results in a heavier economic burden for future generations. Aging is also likely to bring about demands on long-term care. Issues related to the retirement age, effective utilization of elder manpower and proper living arrangements for the elderly, etc. could all form important policy areas which need to be dealt with (Chen, 2005). The aging issue requires a long-term commitment with enough foresight; policies must be created as soon as possible with consideration for cultural and social conditions specific to each country and each city. In all countries of the world, population aging is altering dependency ratios and dramatically increasing the number of elders who will need care.

The dramatic demographic shift which is taking place in the country directly and indirectly affects every sector of society, as well as the health and well-being of the elderly. Modernization has become one of the popular theories to explain the rapid demographic, social and economic change of Japan since the Second World War (Knight & Traphagan,

2003). Modernization theorists interpret the history of modern Japan as the gradual convergence toward democratic and liberal orders of the west (Garon, 1994). The assumptions of modernization theories are evident in the demographic transition theory which claims that societies will move from traditional states of high fertility and low mortality. Modernization theorist clam that, along with demographic transition, traditional societies will economically, socially, and culturally "converge" with western or modern societies through modernization which is characterized by industrialization, urbanization, secularization and individualism (Caldwell, 1976; Crenshaw, Christenson, & Oakey, 2000; Knight & Traphagan, 2003).The general thesis of the theory is that modernization results in a relatively lower status of the elderly in any society. Modernization results in increased life expectancy and decrease in fertility because modern technology brings with it means to improve life and birth control. The consequences of modernization and urbanization will certainly contribute to the loss of a great deal of power and prestige of the elderly and also affect the care of elderly (Cowgill, 1986:54-55).

Cantor (1989) points out that the growing number of elderly is bringing about dramatic changes in family life, in the nature and extent of interventions necessary to support an aging population, and our notions about respective roles of family and community in providing for these needs. Although older people manage independently with only the ordinary assistance family members provide each other, growing numbers of the very old and persons suffering from frailty and incapacity require more extensive social care. The term "social care" is often used synonymously with "formal community services," but the concept is broader, also encompassing informal family care. Social care is directed toward needs critical to independence: socialization and self-development help in tasks of daily living and assistance with personal care. The social care should be provided within family context, turning to formal community interventions only when families are unable to provide the required assistance. Knapp (1984), also has further expounded on the concept of 'social care'; that there are advantages to adopting a broader focus of care arrangements than merely the formal ones, which should encompass informal support provided by family, neighbors and friends as well as that provided by the statutory service agencies. The argument here is that it is the combination of the formal and informal dimensions of care that constitutes the turning point for an understanding of the principles behind the social care system.

Throughout the thesis the term 'elderly person/people', 'older person' or 'elder', 'senior citizen', 'aged person' is used to describe someone who is over 65 and the term 'elderly' is broadly used to describe the generic group. There is a need to reconsider the meaning and appropriate use of the terms aging, aged, and elderly when studying the elderly. Aging, of course, invariably happens to all persons over the life course, but it is typically used to refer to persons over age 65 (Padgett, 1995). There is a trend to differentiate between the 'young' elderly those aged between 65 and 74 years, and the 'old' elderly those aged over 75 years (Victor, 2005). On the other hand, new distinctions are made between the 'young old' aged 65 to 74, the 'old-old' aged 75 to 84 and the 'oldest

old' aged 85 and over (Moody, 2006:5). Demographically, aging is defined essentially in terms of chronological age, on the assumption that for large populations the aging process, functional age, and physiological age follow chronological age closely. It must be pointed out that the older population is not a homogeneous group and that its characteristics tend to vary sharply within the band 65 years of age and over. However, for convenience and simplicity, the single broad group 65 and over is often selected for detailed consideration (Beaver, 1983:34) and even if for an international comparison of elderly people.

The definition of ageing itself is arbitrary. The ageing of the population refers most commonly to an increase in the relative proportion of the elderly in the population. The widely used cut-off point of 65 was decided as the age of benefit in the first public social security legislation in Germany in 1873 and perpetuated in the retirement regulations of other countries (Davies, 2003). Generally, in most of the developing world age 60 and above is considered as the cut off for ageing (Myers, 1990, United Nations, 2001). Demographers consider 65 years of age as the old age for international comparison of elderly people. The World Assembly on Aging adopted, as its main focus of concern, the population aged 60 or over as elderly population. In Nepal, people aged 65 and over considered as senior citizen. The age cut-off for the elderly population varies across the countries and overtime. The Government of Nepal has fixed the age of retirement as 58 years for civil servants. But at the regional court and at the university, the retirement age is fixed at 63 years. The retirement age of the chief justice of the High Court is 65 years in Nepal. However, in the agriculture sector such a distinction for the retirement age is not evident. In this case the productive age may go beyond 70 years or as long as a person is physically fit to work (Nepal Population Report, 2007:124).

Japan is moving rapidly down the road towards a society with fewer children and an aging population, with a speed unprecedented anywhere else in the world. Japan's total birth rate is declining year by year, while its average life expectancy is increasing. The aging of Japan’s population is expected to bring with it higher spending specially on social security expenses. Yet because the declining total birth rate means the number of working individuals between the ages of 20 and 64 will fall, it will be necessary not only for individuals of working age but for many other people as well to provide support for the society.[1] Care is at the heart of human existence. Without care, individuals simply cannot exist. Beyond mere existence however, care has strong implications for human growth and development. Humans need care to thrive (Larson, 1999).

Family care for the elderly in the world is changing, let there be no doubt. The traditional patterns of the past seem to be crumbling in the face of social, economic and demographic forces producing and resulting in changes in cultural values toward the elderly, in general, and family care to the elderly, in particular. Programs and services for the elderly vary greatly from country to country. These resources may be urgently need

[1]. National Institute of Population and Social Security Research, January, 2002 projections.

by many isolated, dependent and abandoned elderly and they might provide much-needed alternatives to family care (Kosberg, 1992). In this context, the caring for the elderly is a challenge and can be overwhelming if not given proper consideration. The need for elderly care in Japan is going to increase considerably over the coming decades and attempts to find a solution to this problem are rendered even more difficult by a changing family pattern.

Likewise, the global phenomenon of population aging also afflicts Nepal. Historical systems of care, living arrangements, and familial responsibilities that once centered around or within the family network are changing to look more like Western, individualistic systems (Eckerman and Brauner, 2007). Though the process of aging of Nepal's population is still in its early phase, it is expected to gain momentum in the 21century and pose a major problem to the country.

Aging is an emerging social issue for Nepal because fertility has started going down in recent years, the mortality is declining fast and the life expectancy is continuing to increase for both sexes in Nepal. It is important to understand the aging issue in the proper demographic and national context. In a country like Nepal, a marginal increase in the proportion of older people poses serious problem where people are characterized by greater spatial inequalities, poverty, stagnant economy, illiteracy and poor health status (Nepal Population Report, 2007:127). The proportion of the elderly in Nepal is not very high but the sheer size, changes therein, the direction of change over the years and the socio-economic context within which such changes have occurred makes it an eminent problem than has been realized by most social scientists and policy makers (Subedi,1999). As Nepal is taking some strides towards industrialization with the consequent urbanization and revolutionary changes in the political system and in the socio-economic structure it would be wise to assess the condition of the aged and aging to gauge the nature and proportion of the problems that attend the transformation. There is an urgent need to create awareness and change the attitude of family members towards elderly people. It is the time to use them as a resource to utilize their knowledge and skills and keep them active and lively. The study of an elderly population is in initial phase in Nepal. No single nation-wide survey has been conducted on elderly issues so far and most of the studies done in the past are based on the limited information available from census and surveys conducted for other purposes (Subedi, 1998). So that this research study is of immediate relevance because of the rapid increase in the population and absolute number of aged people concerned among the total population, which will certainly impact on socio-economic, health and welfare policies and the culture in future society of Nepal.

In summary, for overall well-being of the elderly, care and support programs are becoming a necessity and it is equally important aspect to make our elders more active and healthier in their old age in terms of active aging perspective. It is also thus crucial for policy makers of both countries to raise the public awareness and formulate and evaluate measures and social security programs to cope with the demographic challenges.

1.2 The Global Movement for Care of the Elderly

The world population increasingly become aged it's average life expectancy grows every year and reduces in mortality rate in both developed and developing countries. In the last 50 years period mortality rate in developing countries has declined. The life expectancy at birth has increased by 20 years since 1950 to 66 years and is expected to extend a further 10 years by 2050. In 2000 world population of aged 60 years and above was 600 million and is expected to be doubled in 2025 and 2 billion by 2050.Population aging is a global phenomenon: the proportion of older persons in the World's population increased from 8.2 percent in 1950 to 10 percent in 2000. It is projected to increase to 15 percent in 2025 and 21 percent by 2050. By the middle of this century one in every five persons will be "old". All countries are either experiencing population aging or can be expected to do so over the next two decades.[2]

In 2008, the population of elderly citizens (65 years and over) was 28.22 million, constituting 22.1 percent of the total population and marking record highs both in terms of number and percentage. The speed of aging of Japan's population is much faster than in advanced Western European countries or the U.S.A. Although the population of the elderly in Japan accounted for only 7.1 percent of the total population in 1970, 24 years later in 1994, it had almost doubled in scale to 14.1 percent. Average life expectancy in Japan climbed sharply after World War II, and is today at the highest level in the world. In 2008, life expectancy at birth was 86.05 years for women and 79.29 years for men (Statistical Handbook of Japan, 2009).

Over the past half-century, both the worldwide drop in fertility and concurrent rise in life expectancy have led to the gradual aging of the world's population. Since 1950, the share of persons ages 65 and older has risen from 5 percent to 7 percent worldwide. The Europe and Japan have led the way, with North America, Australia, and New Zealand close behind. However, older persons are now more than 5 percent of the inhabitants in many developing countries and by 2050 are expected to be 19 percent of Latin America's population and 18 percent of Asia's.[3] The world is undergoing a centuries-long demographic transition that, when complete, will leave the global population larger and much older, on average, than it is today. The transition was triggered mainly by improvements in nutrition, sanitation, health practices, and medical care that have dramatically reduced infant mortality and extended the life expectancy of children and adults. With more children living to adulthood and having children themselves, the world is going through an unparalleled period of rapid and sustained growth in population. As population and incomes have grown, however, people have begun to reduce the number of children they have. The resulting decline in fertility rates is gradually reducing the rate of population growth, and the world population is gradually becoming older (Congress of the United States, 2005:1).

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[2]. Report of the Second World Assembly on Aging, Madrid, 8-12 April 2002, United Nations, New York.
[3]. World Population Data Sheet-2007.

In the international perspective the elderly are cared for by both formal and informal systems in varying ratios in different countries. Design thinking at a strategic level has to consider this duality of old age concerns and find appropriate solutions. Informal systems with no governmental intervention or little market involvement are still the primary mechanism of care in most developing countries. On the other hand formal systems practiced in developed countries offer more homogeneous and reliable support for the elderly. Legislation and policies create frameworks for the formal system but design intervention requires careful thought. Formal systems evolve on urbanization, nuclear families, change in the social fabric and breakdown of traditional social norms. But such practice also alienates the elderly, offers lesser control to an individual and does not accommodate exceptions easily (Dan, 2003).

Each country's demographic transition typically involves several major phases whose duration depends on the timing and pace of changes in mortality and fertility.[4] Initially, as infant mortality declines and population growth takes off, the country's population tends to grow younger, and the youth share of the population expands. The burden of raising large numbers of children tends to restrain other types of saving and investment and thus tends to restrain economic growth. Later, as birth rates decline, the youth share of the population contracts and the working-age share expands. With fewer children to care for, the adult population can work, save, and invest more, all of which tend to enhance economic growth. When the workforce is relatively young, the country is likely to have relatively low saving and relatively high demand for investment and therefore relatively high rates of return. However, as a large portion of the labor force reaches middle age, saving may rise and the demand for investment may fall, a phenomenon that tends to reduce rates of return. Still later, however, as birth rates remain low and adults continue to live longer, the elderly share of the country's population rises. As a result, working-age adults may not have as many children to raise, but they have many more old (and increasingly older) people to support and care for. In addition, the rate of saving may decline as retirees run down their savings although that effect does not appear to be as strong as one might expect on the basis of economic reasoning alone. Other developments for example, political, economic, or environmental disruptions and post-war "baby booms" can change the age structure of a country's population in similar ways as well.

The process of reform should nevertheless respect countries' own traditions for social systems. These traditions define the political debate about long-term care within the more general debate over the future of the welfare state. OECD analysis reveals some convergence between the general orientation of the Welfare State and the socio-economic context. Japan is now half way between Mediterranean countries and the Bismarck continental countries. The US, Canada or Australia could come closer to Beveridge oriented systems. In these latter countries, care for the frail elderly is financed out of

[4]. A Congressional Budget Office (CBO) paper on Global Population Aging in the 21st Century and Its Economic Implications, December 2005, The Congress of the United States Congressional Budget Office.

general tax base revenue. The Medicaid part of long-term care has a specific role in the US. Medicaid is in theory, a social assistance benefit but may largely benefit the middle class. Along with the growing interest in ageing in the US, this may be one reason why it has a high place in the political debate. Contrary to Europe however, the main lines of the political debate in Northern America or in Australia are not about the creation of social insurance benefits or the removal of means tested systems. Instead discussions in these countries include reinforcing of means testing to focus the help towards those with greatest needs (Halton 1998). In the US, one of the primary concerns is to assess real needs and to gain improvements in the health of the older populations which reflect their cost. Nevertheless, increased efforts are being made in such countries as well to relieve the burden faced by informal carers, giving them a more prominent role, and more recognition for their caring activities[5].

While population ageing is common to all countries, the magnitude of the problem varies significantly from one country to the next. In Scandinavia, the current emphasis is on a certain degree of de-institutionalization of the elderly, whereas other countries (Japan, Korea) are seeking to do exactly the opposite. The social systems of these countries are often in a state of flux and not always equipped to deal with this type of change. In countries with insurance-based systems, the rapid rise in the cost of health care obliges decision-makers to make difficult choices given the pressures on public finance and the difficulty of reallocating funding (the United States). United States has mostly a private health care system. Benefits are often linked to the labor market or financial situation. The Netherlands has seen some changes to its model, where universal care is mainly provided in the short-term, and long-term care is increasingly dependent on networks of voluntary organizations and local programs you tap into. These networks are richer for some groups than others. This trend is a recent change, mostly due to the need to keep national health care costs down and an emphasis on self-reliance and a re-responsibility of the family in care. This change could prove problematic for the health and care needs of those who are isolated with the least social networks. Norway on the other hand still has a predominantly state-run system in both short and long-term care where the municipalities are the health and care providers. However, research has shown that families play a crucial role in providing care for the elderly (Nuland, 2008). Sweden also adopted the “Swedish model” i.e. called “a mixed system of welfare” for the elderly. There was an increasing awareness that most families and next of kin provide care and supportive services. State grants have also been distributed in order to encourage municipalities to develop and provide service and support for family carers. It is important to note that municipalities both select and finance the services offered by private caregivers. Public responsibility is becoming more narrowly defined and more

[5]. Jacobzone (1999), Ageing and Care for Frail Elderly Persons: An Overview of International Perspectives, Labour Market and Social Policy-Occasional Papers No 38, Head of Publications Service OECD 2, rue André-Pascal 75775 Paris, CEDEX 16 France.

responsibility is being place on persons in need of care, family members and the private market (Artikelnr, 2008).[6]

Asian populations and their governments are faced with increasing numbers of older adults, and this raises various social and economic issues for both the family and state. Asian societies are experiencing dramatic changes in the larger environment brought about by economic development. Urbanization, industrialization, migration and most recently, globalization, are causing changes in family structures and the intergenerational support of older persons. In a seminal work produced by the World Bank (1994), evidence was provided to show that informal support systems are breaking down in some countries, e.g., China, whereas in some other countries informal systems are adapting more positively to these changes, e.g., Thailand, Hong Kong, Singapore, Taiwan, Republic of Korea etc (Chan, 2006:270). However, caregiver issues are major concerns in Asian societies. Chronological aging brings certain life cycle changes, some of which are physically imposed, while others culturally defined or set by statutes. Among these life cycle changes are declining health status, retirement and declining roles and status in family and society. Thus, old age often brings with it dependency and disengagement and everywhere, including Asia, people and governments are concerned about the provision of care for the growing number and proportion of aged.[7] The challenge for public policy is to assess the viability of family support systems and to devise programs that will be supportive or complementary. Several governments have adopted such policies. In Singapore, children are now legally responsible for the support of their elderly parents. Many East and Southeast Asian countries are providing adult day care and other support services aimed at helping adult children care for their elderly parents. Malaysia and Singapore have revised their public housing policies to accommodate multi-generational living arrangements, and Malaysia also provides families with tax incentives for elderly care (World Bank, 1994). In many countries middle-aged people are responsible for their own children as well as aging parents. Special needs of women, who outnumber men in older age, need to be taken into account, as well as the situation of the disabled and the poor elderly. The demographics of aging need to be situated in society and the family (World Health Organization, 2004).

With the rapidly expanding numbers of older people, the inclusion of gerontologists, who are experts in the study of ageing, in political debate could be of great value and importance, as in the world as a whole there appears to be little understanding, discussion or policy development for issues related to ageing. Presently, the focus of policy-makers on ageing is fiscal in nature, and rarely addresses social issues (Torres-Gil & Puccinelli 1998). However, there are other equally critical issues, such as worker productivity; housing; health care; long-term care and demographic changes affecting family and social structure with fewer children and more elderly living alone, that need to be addressed urgently. In many countries middle-aged people are responsible for their own

[6]. Artikelnr (2008) Developments in the care for the elderly in Sweden, Artikelnr.
[7]. Journal of cross cultural Gerontology, September, 2006, p. 258.

children as well as ageing parents (Cutter and Devlin 1998). Special needs of women, who outnumber men in older age, need to be taken into account, as well as the situation of the disabled and the poor elderly. The demographics of ageing need to be situated in society and the family.

However, in the South East Asia Region (SEAR) countries there are proportions of society that earn an income sufficient only for living day to day, and some that earn even less. As these groups of people age, and as their numbers multiply with the changing demography, governments need to develop plans for their care. Moreover, those governments who provide old age pensions are becoming aware that the number of retirees is increasing steadily. These retirees are paid for by taxpayers of working age, and their numbers are not increasing (Westley, 1998).[8] Similarly, the South Asian Association for Regional Cooperation (SAARC) countries are home of approximately 20% of world's population. Most of these countries are densely populated. Average per capita in all these countries is low, except Maldives. Again except, Maldives all the SAARC countries have more than one-fifth of their population, which are below poverty line. Except Nepal and Sri Lanka, sex ratio of females is below 1000 males. Crude death rate is not very dismal. Health expenditure in all SAARC countries is very low, leading to large number of health problems and poor health facilities. However, Nepal is second in ranked in terms of health expenditure of total budget (5.3%) followed by Maldives (6.2%) (Singh, 2008). Likewise, Nepal is in third position (5.9%) of the elderly population aged 60 and above after following Sri Lanka (9.8%) and India (7.6%) (Siddhisena, 2005). In all south Asian countries the growth rate of the population aged 60 and above exceeds that of the population total. Projections indicate a pronounced increase in the elderly population in the coming decades to follow. The elderly in South Asian countries face many problems such as insolvency, loss of authority, social insecurity, insufficient recreational facilities, a lack of overall physical and mental care, problems associated with living armaments and many others (Chalise, 2006).

So that population aging raises many fundamental questions for policy-makers. How we do help people remain independent and active as they age? How can we strengthen health promotion polices, especially those directed to older people? How do we best balance the role of family and the state when it comes to caring for people who need assistance, as they grow older? How do we acknowledge and support the major role that people as they age play in caring for others? Similarly, rapid population aging and higher dependency ratios will create major challenges for states and economies. Less obvious but equally important is the profound effect that population aging will have on social institutions such as families. Who will care for the growing numbers of very old members of human societies? Will it be state governments? The aged themselves? Their families? Private care providers? These challenges are the result of four remarkable socio-demographic changes such as: extension of the life course, changes in the age

[8]. Health of the Elderly in South-East Asia, A profile, World Health Organization Regional Office for South-East Asia, New Delhi 2004SEA/GER/17,p.7~8.

structures of nations, changes in family structures and relationships, changes in governmental expectations and responsibilities. Thus it can be seen that the changing demographic situation affects all countries worldwide. It presents a clear challenge to all governments, communities and families to address and prepare for increasing numbers of elderly people.

1.3 Rationale of the Study

The growth of aging population means an increasing need for senior citizen support and a shrinking labor force. If social security systems for senior citizens are not in place, the population aging will have a great social and economic impact. In all countries of the world, population aging is altering dependency ratios and dramatically increasing the number of elders who will need care. The demographic changes that have resulted in population aging in all developed countries and rising number of less developed countries have been accompanied by changes in structure and size of kin networks (Wolf, 1994).These include the verticalisation of family structures and the increased prevalence of families with three, four and even five living generations. It is well known that population aging is likely to increase the demands for services to support and care of older people.

As people are living longer and fewer babies are being born, the factors behind the rapid aging of the population, the ability of families to take care of their elderly members has weakened. Another significant factor is the change in the role of women who have been chiefly responsible for household duties such as housework, child care, and care of the elderly. It has become economically difficult for women to live simply as a “housewife” even if they desire such a lifestyle, and a double-income family has become the social norm by necessity. Consequently, less time and energy can be directed to the care of elderly people, and, proportionately, the burden of nursing care is becoming heavier.

There are many concerns and problems of elderly population. They are concerned for their health, diminished social status and insecurities about their importance among other people, difficulty in adjusting to their retirement and change of daily routine, insecurity brought about by feelings of inadequacy in meeting daily life situations, loss of ability to socialize and be of service to others in order to get self satisfaction and joy and strong desire to be useful to others in any way. The living standard of elderly people needs enhancement.

Japan has had a long tradition of three generations (parents, eldest son and wife and grandchildren) living together in one household. In the past, informal care by the family mainly the eldest son and his wife was the main source of care for the elderly in Japan. The advancement of industrialization, however, changed this traditional household structure rapidly. Younger generations moved out of the rural areas into the city or other industrialized areas, and not only men but also some women, who had been the main caregivers for the elderly, started to work as well. As a consequence, households of only one elderly person or couple have increased. It is highly probable that these changes in

lifestyle and household structure will become permanent in Japan (Ito, 2008). On the other hand, in the Nepalese context the fact is that elderly care mainly takes place within the family (i.e. informal care), and therefore the result of restrictions by social policies or lack of effective and substantial policies and programs, which build barriers to access of formal care. There are various problems of an aging population that other countries have already been facing. There is no doubt that this problem can be very alarming and acute for a country like ours where poverty, illiteracy and destitution are so rampant. Traditional forms of care for older people in Nepal are fast disappearing like in other countries due to modernization and the nuclear family system. The older generation is isolated and left alone. Many people perceive them as useless, weak and dependent. Similarly, there is a debate on whether aging of the population is just another burden on the process of development or whether it is a positive force in that quest.

Nepal is currently in the initial phase of an aging problem and soon the amount of people dying per year will exceed the number of people being born, but Japan has already faced these problems. Japan has the highest percentage of elderly people within its aging society and it also has the highest life expectancy in the world. As of October 2005, the Japanese population of the people aged 65 and older was 21.0 percent and reached 22.1 percent in 2008 of the total population. The elderly population of Kyoto city was 20.8% of total population in 2006. But now Nepal is a young country in terms of elderly population having 4.12 percent aged 65 and over of its total population and the continued effect is felt through the decline in fertility rates and increases in life expectancies. The total population of elderly aged 65+ of Kathmandu Metropolitan City (KMC) was 3.37 percent in 2001. It is believed that due to expansion of education and health care facilities, average longevity and percent of aged persons in the Nepalese population is increasing over time. Although the nations are different, the physical process of aging is the same and there should be some commonalities and challenges. The problem of age structure changes in population in developed country results in the growing proportion and absolute number of elderly people; whereas in developing countries it results in the problem of increasing young age structure. However, the proportions, changes therein and the direction of changes are important measures of an old and aging population. The population aging is to be considered a social problem.

Why Comparison?

A comparative study can generally be done between two more similar countries. It is in fact not necessary that these countries should be equally sound in terms of economic prosperity and advanced welfare systems. According to Dogan & Pelassy (1990), for a comparative study, the most dissimilar countries can also be chosen. Comparative research refers to research design by which data from different societies and/or cultures are collected and compared. An important motivation for comparative studies seems to be the growing internationalization and diffusion of social, cultural and economic ideas across the national borders. In combination with growing

internationalization, a shift has taken place in comparative research from emphasizing uniformity among variety to studying the preservation of differences and uniqueness in contrast to homogeneity and uniformity. However, in many respects, the use of countries as units for comparisons may be seen as inappropriate. Therefore it has increasingly been necessary to combine analyzes based on quantitative statistics with more qualitatively oriented studies (Boje, 1996: 14-15).

The comparative study of old age and elderly people serves two purposes: the first is to develop a broader understanding of the social processes in question; and the second to learn about and develop new ways of responding to the interests and needs of older people. I am concerned here with both aspects. I think that the comparative method of inquiry has an applied dimension. One approach to learning is to contrast a range of possibilities and in a field where there is a considerable prejudging of knowledge and issues, a mutual exchange of ideas and practices may help in the elaboration of new responses to the situation of older people in our societies.

According to Long (2000), aging as a social problem is not an objective crisis of demography, but a crisis in the significance of biological aging, family relationships and relations between individuals and the state. Aging is thus universal and can be compared. Although Japan has developed many welfare systems for its aging society, it is still facing many problems. That's why; a comparison between two countries can be done in a descriptive and logical way.

This thesis compares the cases of Japan and Nepal. The selection of these two countries for comparative analysis is based on the principle of the "Most Dissimilar Systems" approach, according to Dogan & Pelassy (1990). They argue that in comparative welfare research, two approaches are generally used, namely choosing countries which have the most similar or the most dissimilar systems. It means Japan and Nepal can be chosen as developed and developing countries respectively. A comparative study of elderly care can be done in terms of similarities and contrasts found in two cases (Kyoto and Kathmandu in this study).

- It is well known that Japan is highly developed whereas Nepal is developing country. Japan's economic prosperity cannot be compared with Nepal. The two countries however, have distinct histories and cultural structures. Some of the cultural aspects are similar to another. For example; patriarchal system, primogeniture, son preference, gender discrimination, breakdown in traditional family and community ties etc. are similar in some extant. Nepal and Japan also share a lot of similarities in terms of culture, religion and even in terms of sentiments. Many deities worshiped in Nepal are closely linked to the Japanese culture through the deep historical parallels, which connect both countries.
- The study does not confine itself to a sole comparison of two cases. The researcher rather employs a cross-cultural perspective to examine into family/home, community and state based care practices
- People of both countries have a sense of filial piety towards the elderly for their

care. However, this piety is on the decline due to modernization and urbanization.

- Nuclear family system is gradually increasing breaking down family and community ties and aggravating the elderly's situation in both countries.
- Both countries have some similarities in terms of culture, religion and even sentiments reflecting in the caring of elderly. Cultural variations and their coping mechanisms are key common problems. The Buddhism which is practiced in both countries has affected the caring process of the elderly.
- Today Nepal is facing the aging problem (*in Japanese terms: Rogo mondai*) and in the near future it will have to face the old-people problem (*Rogin mondai*), while Japan has already faced these problems. Now Japan is entering the aging society problem (*Koreika Shakai Mondai*). It means that the physical problem of aging is the same but coping mechanisms of elderly care are different in developed and developing countries.
- Albert et al. (2006) have done a "Comparative Study of Functional Limitation and Disability in Old Age: Delhi and New York City". A comparative study between Kyoto and Kathmandu is thus reasonable.
- Household cohort size is gradually declining in both countries. The trend towards nuclearization of the family (as opposed to the extended family concept) has resulted in a greater proportion of the elderly per household. Thus a smaller household with a greater proportion of aged people can safely be predicted. This has serious implications in the quality and level of care that can be given to the elderly by their relatives.
- The construction of adequate care varies from one group to another and from culture to culture. Adequate care may vary, for example, for men and women, for children and older persons, and for Japanese and Nepalese people.
- Elderly care is nonetheless also a universal aspect of human life, because all humans have needs that others must help them meet (Tronto, 1993).

According to above description, a comparative study of elderly care practice between Kathmandu and Kyoto can be rationalized and justified showing similarities and contrasts in a descriptive manner.

1.4 Statement of the Problem

Demographic variables which interact with social, economic and cultural factors must all be considered to assess their impact on the health services (WHO 1982). Shifts in basic demographic characteristics such as age distribution, sex composition, family formation and life expectancy of the population would also have considerable effects on the economy and the social structure of a country. Some of these effects are increasingly being felt in countries whose populations are rapidly ageing and the implications are immense for social and support services-health care, housing, welfare and income security, among others. The pace of social and economic transformation could also

accentuate the problems of the aged, especially the sick and the destitute without family support. Factors such as rapid urbanization, housing development and resettlement, industrialization and labour force participation, especially of women, may also contribute to the weakening of the extended family structure and traditional support system for the elderly. A shift away from care provided in the home and community would lead to growing demands elsewhere, as well as create stresses on existing public services and the use of limited resources available. Thus, financing the care of the elderly, in particular the increasing costs of their health care, has surfaced as a critical issue in newly industrializing economies in East Asia, which are experiencing rapid demographic transition (Phua, 2001). In Japan, as in all societies, most elderly who need assistance in daily living receive help informally, i.e. family members, friends, relatives and neighbors. Yet long life expectancies, nuclear family, female employment, decreased fertility rate, changing patterns of family roles have combined to make it more difficult or less desirable to provide that care informally (Wu, 2004) and there are greatly increased demands for community and institutional care. Traditionally, in Japan care for the elderly was the responsibility of the eldest son with much of the actual physical labor falling to his wife. Extended family households of the past afforded some help but currently in Japan nuclear family households predominate, with many elderly living on their own. In numerous households both husband and wife work outside the home and housing is often small and too crowded (Lee et al., 2000) even for two generations to live together.

A profound shift has occurred over the past few decades in how society cares for the elderly. Just a generation or two ago, adult children cared for the majority of the elderly in their own homes; as more women entered the workforce, families turned more to community home and other institutions to care for the elderly. The need for elderly care in Japan is going to increase considerably over the coming decades and attempts to find a solution to this problem are rendered even more difficult by a changing family pattern.

In Nepal care for the elderly people has largely depended on the family, it remains a question whether younger generations will be able to take care of the increasing elderly population. Modernization and the increasing trend of nuclearization of the family have made co-residence more difficult; financial difficulties as well as the scarcity of social services have also made it impossible for families to rely on social support. Nepal is experiencing declining fertility and mortality with increasing longevity, resulting in both the number and proportion of the elderly people. The growing life expectancy of the Nepalese means that there will be more aged persons in coming years. Obviously the aging problem will become more pressing in the near future. If we do not do something for the elderly today, the possibility of doing something positive for them will recede further in the future. The best approach to enhance the elderly welfare is to increase their self-reliance and to provide them facilities so that they may make useful contribution to their families, communities and also to the Nation.

The proportion of the elderly in Nepal is not very high but the sheer size, changes therein, the direction of change over the years and the socio-economic context within

which such changes have occurred makes it an eminent problem than has been realized by most social scientists and policy makers (Subedi,1999). Nepalese parents are now realizing that smaller families equate to fewer children to depend on in their old age. Moreover, with the rise of modernization, urbanization, the influence of western culture, increased participation of women in outside work and growth of individualism, many young adults migrate far from their parents to bigger cities and greater opportunity. Promotion of elderly peoples association to the plight of older adults in Nepal motivates some of the younger generations to act, promote legislation, support and no longer neglect their elders that have given them so much.

It is the time to use elderly people as a resource to utilize their knowledge and skills and keep them active and lively. There is an urgent need to create awareness and change the attitude of family members towards elderly people. It is essential to assess their needs and collect information about their demographic characteristics, socio-economic, physical, mental, psychological health status.

1.5 Objectives of the Study

Aging of a population refers to an increase in the proportion of the aged and a decrease in the proportion of the young. As more people are living to old-old age, maintenance and enhance their quality of life, particularly in the final years of life, assumes increasing importance. The present research addresses the issue of elderly care of both cities i.e. Kyoto and Kathmandu. The main objective of this study was **to examine the family, community and state based care practices for elderly of both cities in a comparative perspective.**

Other objectives are as follows;

a) To investigate the physical, mental, psychological, social, economic, housing condition living arrangements, employment as well as activity and entertainment status of the elderly.

b) To analyze and find out the current situation and major issues facing by the elderly people of both cities.

c) To describe the elderly related policies and programs of two countries.

d) To inquire into the patterns of social support, both formal and informal.

e) To gain a better understanding of adaptation of elderly care practices.

1.6 Major Research Questions of the Study

On the one hand, there is growing need for care and support for the most elderly and disabled and there are difficulties in finding the people and resources to provide it, but on the other hand there is a growing need in the quite different sense of opportunity for the elderly. Success in solving this problem would benefit the family, society, even nation as well as save on the large amount of money for elderly care and support. Therefore, the study on elderly care issue of Kyoto (Japan) and Kathmandu (Nepal) is relevant for finding possible measures.

The following research questions were formulated to help define the study.

1. What are the main policies and programs for the elderly of both (cities) countries?
2. What are the demographic characteristics of the elderly people of both (cities) countries?
3. What are the physical, social, psychological, mental, emotional, economic, housing, living arrangements, employment, activity and entertainment status of the elderly of both cities?
4. How informal and formal care services are involving in caring process for the elderly?
5. To what degree does the care practice among the elderly vary between two cities?
6. How do we best balance the role of family and the state when it comes to caring for people who need assistance, as they grow older?
7. What specific interventions have been attempted to deal with the problem and how successful have they been?
8. What is the role and responsibility of the family, community and the state in providing care? How does it differ between Japan and Nepal? How does the role of "chosen families" play a role?
9. Are there lessons that Japan and Nepal can offer each other when it comes to the role of elderly in society? To the care of elderly persons in society?

1.7 Significance of the Study

Population aging, or the increase in the number and percentage of older persons resulting from reduced birth rates and increased life expectancy, raises a number of social issues. Aging has gone beyond the realm of welfare concern and needs to be viewed as a developmental challenge. It is essential that aging-related issues be mainstreamed into national development agendas and relevant policies.

The present study will contribute significantly in the following points:

a. This thesis has a societal and practical relevance for policy makers, who are expected to develop programs and social services to accommodate the problems of old age and improve the lives of older people in Kathmandu.
b. There is no effective and substantial policy, rules and wide coverage programs for elderly care in Nepal. Therefore, this study can be very useful for the policy makers and planners to the nation because they need to know the actual condition of the problem in devising appropriate policy and program to address the elderly problem.
c. This study will be crucial in getting an insight of the elderly situations of the two countries (i.e. two cities Kyoto and Kathmandu) and identify the gaps there in. It will be more valuable to Nepal to learn from the situation and lessons learned in Japan.
d. The present study will provide information about the main problem faced by the elderly people as well as their feelings and attitudes towards their family and society.
e. This study also will provide information about the quality of the care practice to the family and society.
f. This thesis has a scientific and theoretical relevance for researchers, who want to study

older people and elderly care in developing countries from a comparative perspective.

1.8 Definition of Major Terms

There are a number of important concepts which will serve as the foundation of this study. It is imperative that these concepts be operationally defined to insure maximum understanding between the reader and author. To this end, the key concepts, terms and phrases of this study are listed as follows:

Aged/Elderly/Elder

The terms ‘elderly’, 'elder' and ‘aged’ are usually taken to mean people aged over 65 years of age. However the terms can apply to younger people within specific target groups with special support needs such as the long-term homeless and indigenous people.

Aged Care: Support and services provided to the aged population by a large number of government programs as well as programs/support from the community and voluntary sectors, the private for profit sector and the private not-for-profit sector.

Ageing in Place: Aged people could remain in their home/accommodation (however defined) regardless of their increasing care needs.

Care: It is an omnibus term used to refer to:

a) Tending: Tasks which involve personal, especially intimate, contact- e.g. bathing.
b) Practical help: tasks involving less intimacy, such as housework or shopping.
c) Support: The provision of social or emotional support, e.g. acting as confidant or simply visiting. (Gordon, and Sheena, 1993, cited in Bayley et al., 1987; Parker, 1981; Willmott, 1987, Sinclair et al., 1988).

Elder Care: Elder care is “assistance to persons age 65 or older with functional impairments provided through informal and/or formal arrangements by family, friends, and service providers” (Moen & Dentinger, 2000).

Holistic Care: It focuses on the interaction among physical, psychological, social and spiritual well-being. Interconnectedness between the individual, family and community is recognized (WHO, 2004).

Integrated Care: It is characterized by integrating different care dimensions to derive the best benefit including primary, secondary, and tertiary prevention (i.e. health promotion, and disease prevention, curative care and support and rehabilitation) (WHO, 2004). According to Nies (2006) an integrated care processes of self-care, informal care and professional care.

Continuous Care: It refers to the smooth continuation of care between home/community and health facilities, including the referral system (WHO, 2004).

Successful aging

Successful aging is defined by both longevity and quality of life and that these are promoted by the interaction of three sets of factors; social engagement and participation, reduction of disease and promotion of high levels of physical and mental functioning (Victor, 2005:p,6).

Complex Needs

A person whose needs and behaviors challenge health, human services and criminal justice systems due to a combination of two or more factors including mental illness, intellectual disability, acquired brain injury, physical disability, behavioral difficulties, social isolation, family dysfunction and drug and alcohol misuse (Bartelink, 2006).

Respite Care

Respite care is care given to the dependent person with the aim of giving the carer a break. Respite care can take various forms. It can be provided in the home of the dependent person; but alternatively the dependent person may go to a residential home, a nursing home, or some other place where that person can receive the necessary care. Such care can be provided for a period of a few hours, a day or several days, or weeks. In many cases, it will be provided by the formal system, but there are also schemes where trained volunteers provide the respite care (Pijl, 2003:43). In other words, the short-term institutional care intended to provide temporary relief from care-giving responsibilities for family care givers is called respite care. In Japan, respite care is often called “short stay service.”

Informal Care

Home care or help for the elderly by family members, friends, neighbors, and more recently, voluntary organizations, usually given free of charge.

The Mixed Economy of Care

The provision of health and social care services by a combination of the four main sectors such as the state, the voluntary sector, the market, and informal grouping of families and friends is often referred to as a mixed economy of care.

The Community

Community is an elusive concept. By “community” sociologists refer to the area that an individual lives in and the people that he lives near and interacts with. Other

meanings of the term stress the condition of living with others in a particular area (district, city and so on). “Community” has also been defined as a group of people living together as a smaller social unit within a larger one, and having interests, work and so forth, in common (Beaver 1983: 116).

Productive Aging: It has been used by some synonymously with “successful” and “normative aging, as just another term to emphasize that there are positive aspects of aging. Brown discusses the views of Caro, Bass, and Chen, that the focus on productive aging implies the existence of specific roles that “older people can play in society”. As they define it, productive aging means “any activity by an older individual that produces goods or services, or develops the capacity to produce them, whether they are to be paid for or not” (Brown, 1996:12).

Political Economy: It has very different meanings. By political economy, some mean public or rational choice, theory. This is truthfully more a (often powerful) methodological than theoretical approach. Political economy can also be shorthand for what is being studied- the interplay of public and private, state and market. The mix of politics and economy often generates disciplinary colonization. To economist, political economy often means the application of economic theory to political phenomena; to political scientists, vice versa (Esping-Andersen, 1999, pp.10-11).

1.9 Limitations of the Study

There are some major limitations which must be taken into consideration when making any generalizations from the results of this study. The researcher was hindered in his study efforts by the paucity of available comparative data in terms of most developed countries and least developed countries such as Japan and Nepal. However, in reviewing the literature, the researcher found little research had been conducted in this area. Therefore, the paucity of relevant data made it harder to analyze the affects the various topics of this research.

The other limitations are as follows of this study;

a) The study is focused on two main cities; Kyoto and Kathmandu.

b) The elderly people aged 65 years and above of both sexes are selected.

c) The findings of the study will be influenced by the interpretation and analysis of the researcher.

d) The interview responses may be influenced by the presence of the other family members of the elderly.

e) The geographical area and sample size was small, and thus the results of the study cannot be statistically representational for the both countries as a whole.

1.10 Order of Presentation

This study will be presented in the following order:

Chapter one will define the statement of the problem. This initial chapter will serve as the introduction and objective of this research. Chapter two outlines the theoretical formulations upon which the study is based. Chapter three is concerned with the models of care and long-term care for the elderly. Chapter four presents an overview of aging and elderly care both in Japan and Nepal. Chapter five is directed to the literature reviews both theoretical and empirical related to elderly care to Japan and Nepal. This chapter also presents different literatures related with an international comparative study concerning to the elderly care. Chapter six is focused on the methodology of the research. Chapter seven is concerned to the qualitative data analysis and interpretation from Kyoto and Kathmandu. Chapter eight presents quantitative results of both study areas. Chapter nine is centered on the discussion and chapter ten is focused on the conclusions and recommendations of the study.

CHAPTER TWO
THEORETICAL FORMULATIONS

2.1 A Theoretical Framework of Elderly Care

The theories of ageing and elder care are relatively undeveloped is perhaps because the field of care is fragmented and splintered. It has not even been systematically questioned in scientific analyzes of modern society. The most important reason for this is that societal theories, which are the starting point for such analyzes, do not view 'caring' as a dimension of human existence that cannot be subsumed under other types of social relationships. However, this requirement is necessary to give coherence to all forms of care. Besides, the gap in theory is symptomatic. 'Care' is not a central category in culture itself, not a basic idea in the legal system, and not a fundamental quality of human existence, comparable to freedom or independence (Keasberry, 2002, cited in Manschot, 1997:102). Hence, we have to turn to theories of care that are described in studies of developed countries and see if they can be applied to a comparative study between developed and developing countries as well. Tronto attempts to develop a moral and political theory in which care is the most important relation between people themselves and between people and their environment. Tronto feels that a new theory is necessary. She criticizes the political sciences and inadequate feminist theory, rejects care as 'women's morality', and ascertains a discrepancy between the daily experience of care and theory. She suggests a new theory in which “care is a central concern of human life” (Tronto, 1993:180).

The theoretical framework of this study is based on the concepts of Tronto’s theory of care (1993) in general. The theory starts from a broad definition of care: “on the most general level, we suggest that caring be viewed as a species activity that includes everything that we do maintain, continue, and repair our ‘world’ so that we can live in it as well as possible. That world includes our bodies, ourselves, and our environment, all of which we seek to interweave in a complex, life-sustaining web” (Tronto, 1993:103).Tronto considers 'care' to be an activity, a social practice. She insists that the activity of caring is largely defined culturally, and will vary among different cultures. Tronto distinguishes four analytically separate, but interconnected, phases in the caring process. These are caring about, taking care of, care-giving and care-receiving. These concepts are all verbs, to emphasize that care is an activity, a social practice. According to Tronto the phases of caring process are as follows:

Care About: It involves the recognition in the first place that care is necessary and this need should be met. Caring about on a social and political level and describe society’s approach to elderly people in caring terms. It is a subject of public and political deliberation and of reason. Caring about requires the moral element of 'attentiveness'. Only when people pay attention to the situation of others, can they address the needs of others. If they are concerned and care about the other's needs, then they can take care of them. Caring

about others is culturally and individually shaped. Some people care about their neighbours, whom they almost consider family, while others do not even know their neighbours.

Taking Care Of: It involves assuming some responsibility for the identified need and determining how to respond it. Taking care of involves notions of agency and responsibility in the caring process and mobilization of resources. Taking care of requires the moral element of 'responsibility'. Responsibility is a term that is embedded in a set of implicit cultural practices, rather than in a set of formal rules or promises (obligations). Ultimately, the responsibility for care rests on a number of factors. For example, being a member of a family might make one feel responsible for elder relatives. One might also assume responsibility because one recognizes a need for caring, and there is no other way that the need will be met except by meeting it. In this way, one might feel responsible for taking care of a childless, elder neighbour, because he/she has no one else who could provide for him/her.

Care-giving: It involves the direct meeting of needs for care. It also involves physical work and almost always requires that care-givers come in contact with the object of care. In the other sense care-giving is an intention to care. Care giving requires the moral element of 'competence'. Failing to provide good care, means that in the end the need for care is not met and hence, care has not been given adequately. Giving money is not a form of care giving, because money does not solve human needs, though it provides the resources by which human needs can be satisfied.

Care-receiving: It implies that the object of care responds to the care received. In other words, care receiving provides the only way to know that caring needs have actually been met. It also implies neediness, dependence, functional inadequacy and so on. Care receiving requires the moral element of 'responsiveness' of the care-receiver to the care. Throughout our lives, all of us go through varying degrees of dependence and independence, of autonomy and vulnerability. However, to respond in a way that shows the given care is adequate, the care-receiver needs to be aware of his/her vulnerability and accept his/her dependency of the care-provider.

These four phases of caring process we can conclude in sum, while caring about and taking care of represents the public, the universal and rational aspects of caring and care-giving and care-receiving represents the private, the menial and the emotional aspects of caring. Likewise, good care requires that the four phases of the care process must fit together into whole. Similarly, to act properly in accordance with an ethics of care requires that four moral elements of care; attentiveness, responsibility, competence and responsiveness, be integrated into an appropriate whole. Good care also requires a variety of adequate resources such as material goods, time and skills. Given the likelihood of conflict, of limited resources and of divisions within the caring process, the ideal of an

integrated process of care will rarely be met. Nevertheless, this ideal can serve us analytically to determine whether care is being well provided. Conceptually care is both particular and universal. The construction of adequate care varies from one group to another and from culture to culture. Adequate care may vary, for example, for men and women, for children and older persons, and for Japanese and Nepalese people. Care is nonetheless also a universal aspect of human life, because all humans have needs that others must help them meet (Tronto, 1993).

Ageing and caring patterns may be differs from one culture to another, not only are their ethnic and racial differences but urban and rural differences of both countries. Similarly, the health of the elderly differs from country to country, affected by socioeconomic and environmental attributes. The care of the elderly therefore involves a holistic combination of health care, socioeconomic care, and the provision of a suitable environment. Considering of the above background, a theoretical framework of the study was mainly focused attention on the demographic characteristics, physical, mental, psychological, social, economic, employment, housing condition, living arrangements as well as activity and entertainment status of the elderly of both cities. The research was set up with a comparative perspective towards Kyoto and Kathmandu city. The different study areas share common problem of the societal consequences of the ageing process. However it was assumed that given the different demographic and socio-economic contexts, patterns of household and family care (informal) and formal care for the elderly as well as the socio-economic position of the elderly people would differ.

2.2 Conceptualizing Care

How is the concept of care to be understood? The word “Care” is highly ambiguous, remarkably flexible and variable in nature. Its interpretation may vary between speaker and hearer, the care giver and recipient and different for professionals, scholars and others. It is also common word deeply embedded in our everyday language. The care cannot be understood apart from the understandings of the world which are shared to varying degrees among policy makers, professionals, volunteers, families and the elderly themselves within a family, a community or a nation (Long, 2000:3). It is a shared task between family, community and the state as well as elderly themselves.

In the feminist literature, care has frequently been taken to be synonymous with unpaid work provided mainly by women in the household (Lewis, 1992, 1995). The emotional relationship between the carer and the cared-for has been the central focus, often characterized as being a ‘labour of love’ (Finch & Groves, 1983). Thus caring has been considered a rather unorganized and spontaneous occupation based on ‘feeling’ and ‘affiliation’ (Bulmer, 1987). Other scholars, however, have pointed out the dualism of the concept of care, in that there may also be a formal side to caring, namely ‘social’ care. In addition to being unpaid and private, care can also be paid for and public (Leira, 1992).

Care is a multi-faceted term that can combine feelings of concern and anxiety for others alongside the provision of practical labor and tasks that attend to a person’s needs

(Cancian and Oliker, 1999). While it is difficult to specify the complex emotional and material concerns that caring entails, there are a variety of caring processes that are crucial to the organization of everyday life and future thoughts and plans for family, children, friends and relatives (Bowden, 1997). Caring as a combination of feelings of tasks has been conceptualized in two ways: as 'caring about'- the feeling part of caring; and 'caring for'- the practical work of tending for others (Parker. 1981). Caring frequently combines an emotional relationship (a tender touch, verbalized concern, affection) with physical care (bathing feeding and provision of meals, taking a child or relative to the doctor). As Williams (2001) asserts, 'care as a practice invokes different experiences, different meanings, different contexts and multiple relation of power'. At some point in all our lives we will require or give care. Thus 'caring expresses ethically significant ways in which we matter to each other' (Bowden, 1997).

The care giving and receiving is imperative to human existence but is experienced differently at various points in the life course and on the basis of gender. The context of the family is often the first and the last location in which care is given and experienced. In other words, caring, dependency and need are inextricably bound. Caring is fundamental to every society. The meanings that are attributed to caring work are never 'given' but are variable, mutable and context bound. According to Wilmot (1997) care denotes a relation, an exchange of energy, of giving and receiving. The giving of energy may involve a burden, a discomfort, a labor. The receipt of that energy may involve a maintenance, a nurturance, an enfolding and preserving. The predisposition to provide is often taken as morally laudable, whether we value the motive, the desire, the attitude or the action and what is received is often taken as a moral good, as happiness is for the utilitarian or freedom for the existentialist. We may take a predisposition to care as in some sense definitive of the moral profile of a person or a group.

A comprehensible approach to including social care as a welfare dimension in the understanding of the welfare state and taking the aforementioned issues into account, it is necessary with a broadly encompassing understanding of care. The concept of 'social care', as used by Knapp (1984), for example, has the advantage of adopting a broader focus of care arrangements than merely the formal ones, and is able to encompass informal support provided by family, neighbours and friends, as well as that provided by the statutory services agencies. In this sense it would include, as Daly and Lewis (2000: 285) suggest, '… the activities and relations involved in meeting the physical and emotional requirements of dependent adults and children, and the normative, economic and social frameworks within which these are assigned and carried out.' The argument here is that it is the combination of formal and informal dimensions of care that constitutes the turning point for an understanding of the principles behind the social care system.

2.3 Understanding Elder Care

Elder care is "assistance to persons age 65 or older with functional impairments provided through informal and/or formal arrangements by family, friends, and service providers" (Moen & Dentinger, 2000). Elder care covers a wide range of care-giving tasks, and the intensity of emotional and physical care tasks is diverse as well. Highly intensive physical care includes assisted daily living tasks (e.g., bathing, dressing, toileting). Other types of less intensive care include assistance with transportation, finances, and housekeeping. The amount of care and who provides it are highly variable. However, elder care typically refers to unpaid, informal care performed by family members (Varner & Robert, 2000). Care for the elderly includes a broad area of comprehensive social welfare measures. These relate to pension, social insurance, employment, subsidy schemes, housing, food, clothing, social respect and other provisions and aspects where the state and the society as a whole should play a substantial role. The care of the elderly therefore involves a holistic combination of health care, socio-economic care and the provision of suitable environment.

Despite their complexity, there are only three core processes in both health and social care; such as: assessment, treatment and care (Foote and Stanners, 2002). *Assessment* is the process of inquiry that provides information from which decisions are made and action may be taken. Assessment is often perceived as a 'one-off' exercise that involves an individual person and an individual practitioner. Though assessment is often thought of as a social term, in its broadest meaning it includes clinical diagnosis. *Treatment* is the process whereby some transaction takes place to alter the condition of the older person, usually following some form of assessment. The term has a strong medical implication but again in a wider sense, it involves giving attention to people's needs and this would certainly fit with a social context. *Care* is the process whereby concern is expressed and shared, people are looked after and considerations about safety are made. It is more than just the physical act of looking after someone. Elder care is concerned with every aspect of the aging process, including the importance of family support and role reversal when the adult child takes on the responsibility of making the choices for an aging parent. Likewise, it is not just a familial responsibility but also a supportive role of the state as a whole.

2.4 The Domains of Care

As Foote and Stanners (2002) argue that the domains of care describe the component areas within the assessment that together make for a holistic process. The domains are not only programme-specific (that is, related to preventive measures or improvement of mental or physical health or other conditions) but may also be discipline-specific. The domains and sub-domains of care are as follows:

1.User's perspective (problems and issues in the user's own words, user's expectations and motivation around improving the quality of life and end-of-life issues) 2.Clinical background (history of medical problems, history of falls, medication use and ability to

self-medicate) 3. Disease prevention (history of blood pressure monitoring, nutrition, immunization history, drinking and smoking history, exercise habits, history of cervical and breast screening) 4. Personal care and well-being (personal hygiene, dressing ability, pain symptoms, oral and dental status, foot care, tissue viability, especially of skin, mobility, continence and difficulties with bowel and bladder function, sleeping patterns) 5. Senses (sight, hearing, communication) 6. Mental health (cognition dysfunction including memory status, depression, reactions to loss and other emotional difficulties) 7. Relationships (social contact and networks including relationships and interests, care arrangements from family, organizations and voluntary and neighbor support) 8.Safety (abuse and neglect, personal safety particularly in relation to the immediate environment, public safety and the risks posed by the older person to others) 9. Environment(care of the home and managing domestic tasks such as cooking, shopping and cleaning, accommodation and heating, financial competencies and financial provision, access to local facilities and services).

2.5 The Conceptual Framework of Factors Affecting Well-Being of the Elderly

A conceptual framework of factors affecting well-being of the elderly is provided in Figure 2. It highlights and attempts to reflect both the major societal-level interrelationships and policy concerns usually addressed via aggregate level on the circumstance of the elderly and determinants of their well-being. Within both countries long-standing societal and cultural arrangements guide the familial support and exchange institutions, which in turn largely determine the well-being of the elderly in terms of health, economics and work. These traditional arrangements are under pressure from the rapidly changing demographics and socio-economic conditions, which also affect the resources and range of policies and programs that policymakers can undertake in response. The well-being of the elderly is viewed as consisting of three broad dimensions: economic well-being; physical, mental and emotional health and activity levels which incorporates work, retirement and leisure activities. Broad societal factors that set the boundaries within which the more proximate policies, programs and influences operate (Intermediate Institutions and Influences). These exogenous social, economic, demographic and cultural factors influence personal characteristics of the elderly (e.g. level of education), their living arrangements and support/exchange systems and the formal arrangements through government programs that are available to them.

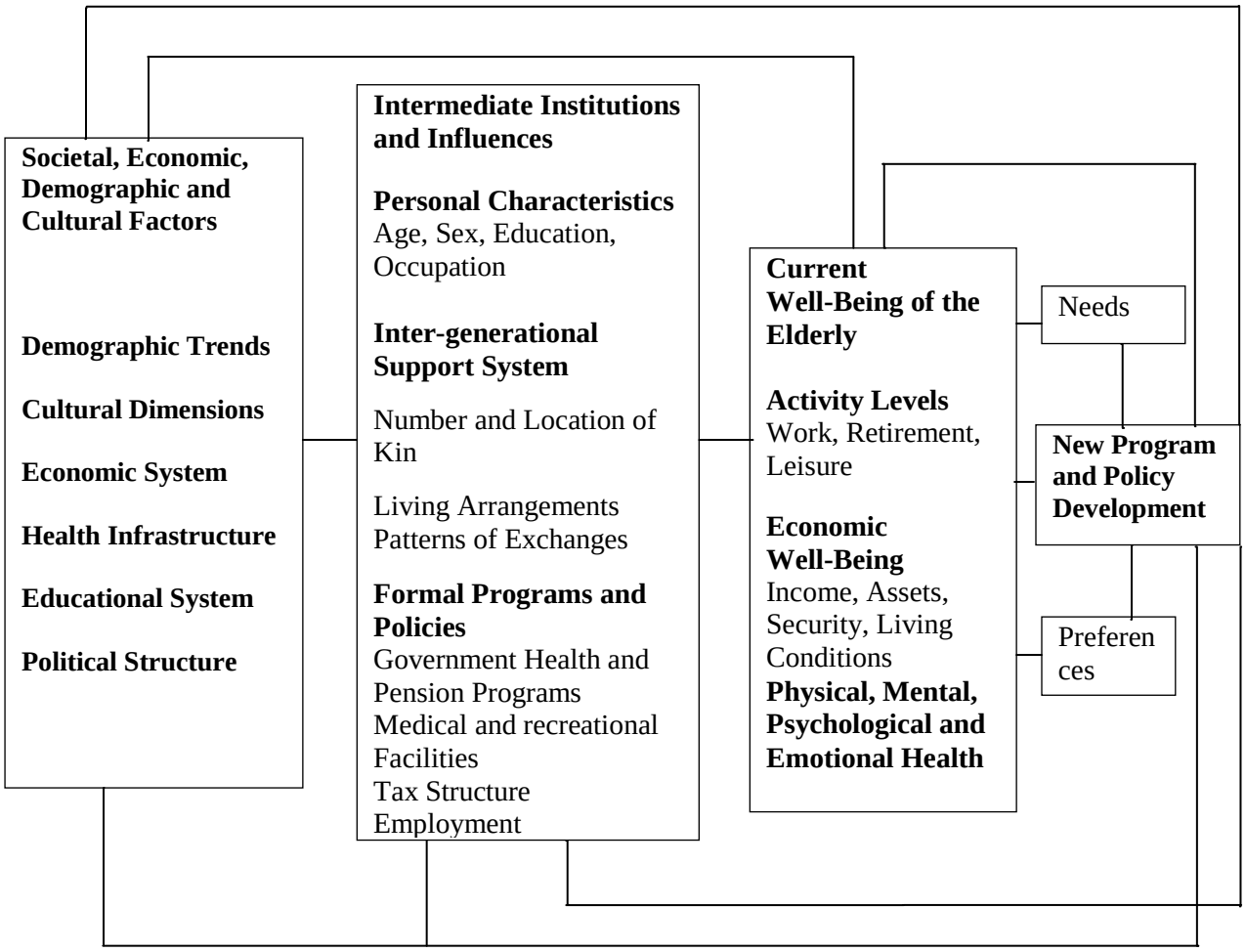


Figure 1 Conceptual Framework of Factors Affecting Well-Being of the Elderly and Policy Formation

Source: Reproduced from Hermalin (2002, p. 108)

Figure 1 also attempts to represent several other important processes. The development of new programs and policies that affect the elderly is viewed as guided by perceived needs and preferences. The process is clearly dynamic, as new policies and programs, along with ongoing social change, affect the well-being of the elderly and the structure of the influential institutions. This feedback process is suggested by the dotted lines in the diagram. As policies and programs affect levels of well-being, the adequacy of the response, along with the political influence of the elderly and other forces, guide future program development.

CHAPTER THREE
MODELS OF CARE

3.1 A Global Model of Care

According to Anderson and Newman (1973), to construct a model of care utilization, there are three main aspects; needs, resources and predisposing circumstances (Figure 2).The needs are the most important precondition and determinant of care utilization and are related to health problems; such as: physical disabilities, depressive symptoms and cognitive impairments. In other words, needs are typically measured by indicators of health status including presence of chronic diseases, functional limitation and self-perceived health. There are two kinds of means of responding to needs: the availability of care resources (informal care and formal care services) and social circumstances. These social circumstances also can be subdivided into predisposed characteristics (age, sex) and achieved characteristics (education, income).

Health is an aspect that is strongly related to age. Obviously, in all countries elderly persons will need more care than young person's will. For the elderly, the 'social rights' dimension of social exclusion possibly will be strongly influenced by access to adequate care. Broadly speaking, a person with a health problem can choose between three options: no care, informal care or formal care. Pommer et al., (2007) note that there are several views on the relationship between formal and informal care, which can be expressed in different typologies such as primary responsibility for meeting care needs, may lie with the individual, the nuclear family or in the extended family. In other words, the main criterion they use to distinguish countries is "primary responsibility", which may lie with the individual (Scandinavian model), the nuclear family (Continental model) or the extended family (Mediterranean model).The more responsibility lies with the individual and not with their family, the bigger the role played by the government. In Mediterranean countries, the family often has a legal duty to support relatives up to the third degree. If care responsibilities are not primarily a family matter, the government may step in, as in the Scandinavian model.

Formal and informal cares are usually complementary activities. In no care regime does formal care, whether public or private, completely crowd out family care (Bonsang 2008), while in the Scandinavian countries informal, family care complements public care, in other care regimes the family must search for ways to combine public and private sources to complement its own caring (Simonazzi, 2009).

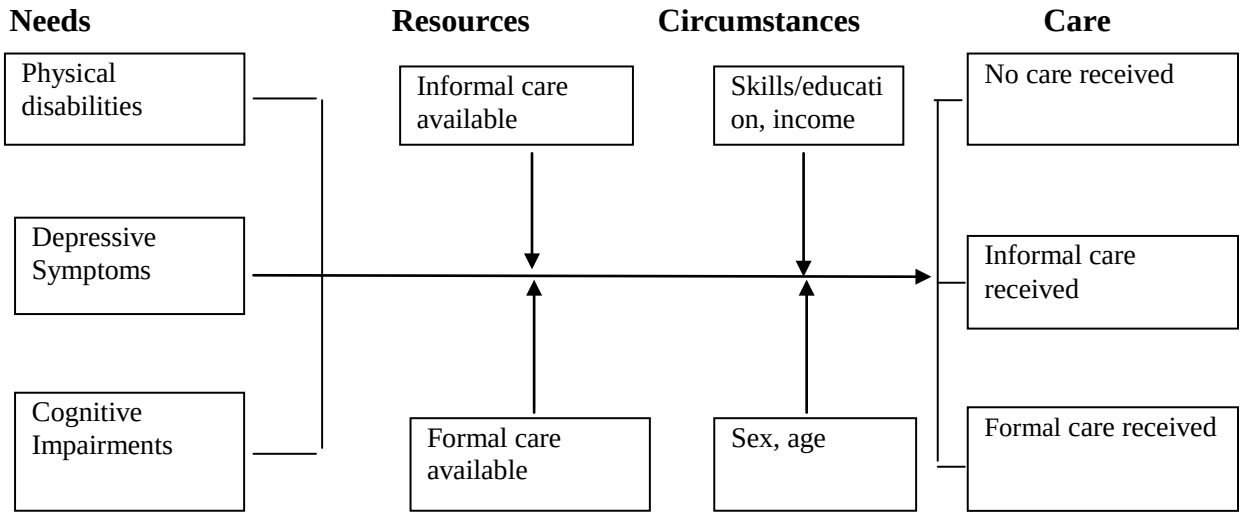


Figure 2: A Global Model of Care

Source: Pommer et al., (2007)

In Mediterranean countries the family has a legal duty to support relatives up to three times removed. In continental countries the family is the primary caring unit, but persons with more health problems have a legal entitlement to public services. In Scandinavian countries the public sector has primary responsibility for persons in need for care. In general, therefore, three types of care regime are distinguished: a family type, a mixed type and a public type. We can choose among these welfare regimes according to countries need.

3.2 A Health Promotion and Aging Model

The Ottawa Charter for Health Promotion, sponsored by the World Health Organization, defined health promotion as "the process of enabling people to increase control over and to improve their health". The Charter defined health as "a resource for everyday life.....a positive concept emphasizing social and personal resources as well as physical capabilities". Health is therefore considered an instrumentality for successful living (Harris and Fries, 2002). In other words, a broad definition of health includes three components such as; disease prevention, health prevention and health promotion. Health promotion is an invaluable tool to promote good health, and to prevent the onset of disease and accident, including the expenses involved. According to O'Donnell (2002) "Health promotion is the science and art of helping people change their lifestyle to move forward a state of optimal health. Optimal health is defined as a balance of physical, emotional, social, spiritual and intellectual health. Lifestyle change can be facilitated through a combination of efforts to enhance awareness, change behavior and create environments that support good health practices". Likewise, health promotion has been defined as the process of enabling people to increase control over their health and to improve it. This process places emphasis on personal participation, supportive

environments, and the shared responsibility of all sectors in improving individual and collective health (Macrina, 1999).

Health is intrinsically connected to aging. Health care is provided for their people to a greater or lesser extent, by most countries of the world. With an increase in numbers of the elderly, the cost of public health care is expected to increase. The definition of good health in late life can be re-framed substantially by viewing it from the unique perspective of extraordinary accomplishment. Health promotion can increase the level of well-being and promote self-actualization, thus decreasing the probability of specific illness or dysfunction. This is primary prevention. Secondary prevention is the early diagnosis and prompt intervention to prevent the deleterious effects of illness. Tertiary prevention sees the rehabilitation of the individual to restore an optimal level of functioning within the constraints of disability (World Health Organization, 2004).

Health promotion is a more proactive term than primary prevention, which tends to imply a reaction to the prospect of disease. Health expectancy is more important to older adults than life expectancy. Two fundamental assertions within this health promotion and aging model are that it is better for older adults to collaborate with health professionals than to take a passive, compliant or equally like non compliant role and it is also better to collaborate than to engage in health-promoting activities on one's own. These assertions are based on two facts: a) that most older adults have medical conditions that require professional supervision and health-promoting activities can affect these medical conditions, and b) that health professionals who keep up with the health promotion field can make vital contributions to the health promoting efforts of older adults (Haber, 2006). He further discusses the effective communication between client and health professionals is an essential component of collaboration and can lead to better results and more satisfied clients and health professionals. Likewise, health education has advanced considerably beyond the idea that mere knowledge inspires change. First, given the plethora of information that pours out of the media, bookstores, libraries and mouths of experts, it is difficult for individuals to sort out accurate, up-to-date information that is pertinent to their particular health needs. Second, older adults learn best in andragogical (adult-oriented learning) situations in which new ideas are presented though collaborative relationships and in small participative groups, where they have control over the learning and maintenance processes. Third, education by itself is typically insufficient to inspire behavior change. It is far more effective to add behavior and psychological management techniques to the transmission of knowledge as well as to infuse the educational process with the social support.

Social cognitive theory underlies health behavior assessments and interventions and suggests social, behavioral and psychological management techniques for health behavior change. Regarding social support, the most likely sources come from family members, friends, neighbors and peers. The medical profession is also a potential source of social support, but because it tends to slight behavioral, psychological and social interventions, it is underutilized. It is important for health professionals to learn multiple

social, behavioral and psychological techniques in order to address the unique and multifaceted needs of older adults (Haber, 2006:33).

In summary, by promoting health and preventing the loss of health at the level of nation, community and family, countries can assist their people to take an active role in their own health, thereby enhancing the quality of life in old age. Moreover, active aging will lead to healthy older people with less demand on public health care services. Thus it can be seen that the changing demographic situation affects all countries worldwide. It presents a clear challenge to all governments, communities and families to address and prepare for increasing numbers of elderly people.

3.3 Care in, by and for the Community Model

Community care is a term which is widely used in English speaking countries, but must be recognized as a broad concept susceptible to vague definitions. Community care means providing the right level of intervention and support to enable people to achieve maximum independence and control over their own lives (Means and Smith 1998). In broader sense, it includes housing, domiciliary health and welfare services, health services outside the home, day care services and the social, leisure and educational facilities that help to maintain the older person's quality of life. In other words it means simply care for the older people who live in their own homes, irrespective of whether those homes are in ordinary housing, carer's homes, specialized or small scale residential settings. Community care used to contrasted with institutional care, but some institutions are now included as community care (Tester, 1996). There are three main ways to defining the community care: 1) Care in the community 2) Care by the community 3) Care for the community. Care *in* the community means care which is geographical placed within a locality with close proximity to the people living there and is a part of their local culture and everyday life. The most common form of care *in* the community is care within the home. But sometimes social services are delivered in a fixed sites such as a clinic, a drop-in center or a community centers. Whether this care is formal or informal, the home is the predominant site of its provision. Care *by* the community also has two distinct meanings. One is care by state professionals, trained personnel who take a formalized system of care into people's homes or to the loosely connective sites. The workers may be a mixture of paid and voluntary workers from the private or public sectors, but they are part of an organized network. The other form of care in this sector is provided by individual family members, neighbors and friends and by voluntary helpers both with and without formal management. Care *for* the community is a wider provision. It requires a distinct definition of who constitutes “the community”. It can take the form of a universal system of public health, welfare benefits, social security, which covers all the population, or it can take the form of distinguishing distinct groups within the population as either needing or requiring care.

Peng, (2002) highlight the family care crisis and also political economy (in a mixed economy perspective) of care in Japan. He further discusses Daly and Lewis's (2000) concept of social care as lying at the intersection of public and private, formal and

informal, paid and unpaid and involving cash and service provisions required to meet the needs of the individual. The social care is considered to embody three sets of analytical questions such as; care as labor, an obligation and responsibility and also as activities with financial costs and benefits, which are inter-related between family, community, state and market in Japan. Peng summarizes, the welfare state restructuring of the 1990s has resulted in important changes in the mixed economy of social care. It seems that the policy reforms have been largely focused on relieving women of undue care burdens by putting most of the effort on expanding social care.

Although until fairly recently of the literature on care for elderly in industrialized countries has focused on care provided by agencies, it is now recognized that by far the largest proportion of care is provided by the informal sector, that is family friends and neighbors, mainly women. Similarly, although much attention has been devoted to state-provided services, most countries have pluralist systems of care provided by governmental and non-governmental agencies, formal organizations and informal carers (Tester, 1996). Walker (1995) examines the changing relationships between families and health and personal social services in a mixed economy of care perspective. He argues the term 'mixed economy of care' suffers from limitations such as lack of clarity. Rather than, as is sometimes suggested, occupying a monopoly position or near monopoly position in the provision of care to elderly people, the public health and personnel social services are, in fact, junior partners. They may still dominate the delivery of formal services, at least as far as home care is concerned, but with regard to the totality of care, the vast bulk of which is informal-from friends, neighbors and especially kin- their roles is comparatively small. He argues that policy is important in determining the context in which family care takes place and assesses the assumption made, implicitly or explicitly, about the availability and supply of such care. The funding or demand dimension of the mixed economy describes the source of revenue: who pays for a service, either as consumer, tax payer or donor.

The term 'welfare mix' also used in the caring process, probably similar as the term 'mixed economy of care'. The mix of welfare provision consists formal, quasi-formal and informal; public and private sectors. Although, this concept is primarily analytic, in that it does not describe a discrete approach, it does provide the basis for understanding that in all developed countries there a number of 'social actors' involved in responding to the situation and needs of older people (Huston, 1991).These social actors are: the state, the market, private households including families and elderly themselves, NGOs, NPOs (Hugman, 1994).

3.4 Long-term Care for the Elderly

The health needs of older persons, either unmet or expressed in actual utilization of health services, are much greater than that of the rest of the population. This expected rise in demand for health care is intensified by both the increasing proportion of the elderly and by the ageing of the older population itself, that is, the growing number of older persons who are living longer. The elderly are particularly vulnerable to chronic

debilitating diseases and severe disability, and are more likely to need long-term care (Phua, 2001). Long-term care intends to restore, support and balance these factors in order to achieve optimum quality of life. When most people think of long-term care for the elderly, they think of nursing homes. But it can involve much more than that. It also means home health care and personal care, and help with chores, all of which can be necessary for older people living at home.The term long-term care is defined by WHO (2000) as "the system of activities undertaken by informal care givers (family, friend and/or neighbors) and/or professionals (health and social services) to ensure that a person who is not fully capable of self-care can maintain the highest possible quality of life, according to his or her individual preferences, with the greatest possible degree of independence, autonomy, participation, personal fulfillment and human dignity". This definition implies that long term care is not merely a task and responsibility of paid care workers. Older people themselves (self care), their primary social network (informal care) and volunteers have a significant role as well. Moreover, the definition implies that older people need self-direction or control over their own lives for as much as possible to achieve the highest and fullest levels of quality of life and human dignity. Long-term care includes both informal and formal support systems. The latter may include a broad range of community services (e.g., public health, primary care, home care) as well institutional care in nursing homes and hospices. It also refers to treatments that halt or reverse the course of disease and disability.

In developed countries, long-term care needs mainly results from population aging, although the level and mix of services differ among them. On the whole, they are attempting to include home-based care service as part of a *continuum* of different types and levels of care, as called for by the Madrid International Plan of Action on Aging (United Nations, 2002). Many of these countries are thinking of ways to put greater emphasis on bringing home-care services to the appropriate level and to support and build the skills of family caregivers. Home-based health care is being encouraged through the provision of several financial incentives and various health care and welfare services. In developing countries, however, population aging is but one of the factors underlying the need for long-term care. Infectious diseases and injuries caused by armed conflicts and traffic accidents, which affect all age cohorts, also require such care. Demand for long-term care resulting from aging is strongly increasing with the speed of the demographic transition in these countries. The focus of the remainder of the present section will be on the provision of long-term care to older persons. It is difficult, however, to draw an aggregate sketch of the coverage of long-term care because of widely differing country situations. Moreover, because the long-term care services are often provided not only to older persons, but also to the poor and the disabled within a single institutional or informal support system, separating the two components is not possible in many cases. Many countries envisage taking measures to develop formal community health care. This approach seems compatible with the development of home-based long-term care. Generally, long-term factors are making traditional care arrangements more difficult, including the increase in

female labor-force participation, often associated with migration, and the greater importance of the nuclear household in urban areas. On the other hand in case of developing countries also Nepal, where the primary health care (PHC) is pressing concern rather than long-term care. In other words, the long-term care literature and need for long-term care (LTC) have been generally associated with industrialized countries. Whereas family support is a predominant pattern of care in many developing countries, development of other mechanisms for LTC is a growing need (Wu et al., 2008:219). Therefore, it is necessary to develop long-term care system for the well-being of their citizen including most vulnerable groups such as elderly and so on.

Likewise, Jacobzone (1999) advocate an "active aging" approach to long-term care policies. An active aging approach requires the provision of long-term care services to be better integrated with other social policies. This is needed both to foster efficiency and to enable equitable access to care for all, and particularly those with the greatest needs.

3.5 Japanese Long-Term Care Insurance Model for the Elderly

Japan has moved decisively toward "socialization of care" for the frail elderly by initiating public, mandatory long-term care insurance (LTCI) on 1st April 2000.[9] In other words, the Japanese government inaugurated the public LTCI system under the slogan, ''From Care by Family to Care by Society,'' promoting ''socialization of care'' for the frail elderly. Long term care an explicit and universal entitlement for every Japanese person aged 65 and older plus anyone ages forty to sixty-four with an aging-related disability (such as Alzheimer's disease or stroke), is eligible for LTCI. Eligibility for the younger group is designed to provide a tangible payoff so that all who must pay premiums have access to benefits. The LTCI program covers both institutional and community-based care giving. Everyone age forty and older pays premiums. Everyone age sixty-five and older is eligible for benefits based strictly on physical and mental disability, in six categories of need. Benefits are all services, with no cash allowance for family care, and are generous, covering 90 percent of need. Long-term costs seemed not to be a major consideration in program design. Consumers can choose the services and providers they want, including use of for-profit companies.

LTCI aims to (1) shift a major responsibility for care giving from the family to the state; (2) integrate medical care and social services via unified financing; (3) enhance consumer choice and competition by allowing free choice of providers, including even for-profit companies; (4) require older persons themselves to share the costs via insurance premiums as well as co-payments; and (5) expand local government autonomy and management capacity in social policy. LTCI program operates mainly on social insurance principles; half of the money is to come from general revenues 50 percent national, 25 percent each from prefectures and municipalities.

The LTCI system has developed in the Japanese health care context

[9]. Japan's Long-Term Care Insurance Programs (2000)

characterized by a pluralistic universal social insurance and egalitarianism. All Japanese persons are required to enroll in a medical insurance plan; employees of large companies and public service agencies join their employer's plan, small business employees join a plan insured by the national government, and the self-employed and pensioners join their municipal government plan. People are free to choose any doctor or hospital. The national fee schedule (the price list of all the services covered by any plans) governs the fee-for-service system. The price is the same throughout Japan regardless of the provider or the health plan. Long-term care (LTC), alternatively, used to be provided in the tax-based social security system targeting low-income seniors with limited family support. Nursing home (NH) and home care were not widely available. Seniors with LTC needs often stayed in hospitals for years, which partly explained high average lengths of hospital stays in Japan. By the late 1980s, in light of the rapidly aging population, such use of hospitals and lack of LTC resources became a social problem. In 1989, the government came up with the ''Gold Plan'' to expand LTC services within the tax-based social security system, followed by the 1994 New Gold Plan to further enhance the LTC infrastructure. In this process, municipalities were given a new role of planning services for older people. LTCI was introduced as part of Japan's social security policy reform to address a prolonged economic slump and soaring medical and LTC expenditures for older people. The social insurance model is less constrained by the national budget than tax-based models of expanding LTC provision such as in Scandinavia and England, as well as in Japan's own Gold Plan strategies. Although tax revenues fluctuate with the economy, insurance premiums allow the government to secure a stable source of revenues. Furthermore, the taxed-based social security system with means tests stigmatized LTC and produced little competition between providers. Elderly beneficiaries contribute a 10% co-payment for services received. Of the remaining LTCI revenues, half comes from premiums, which every person starts paying at the age of 40, and the other half is derived from national and local taxes. Although largely based on the model of Germany, which pioneered LTCI in 1994, the Japanese LTCI system incorporates Scandinavian-style community-based management, in which municipalities act as insurers. They manage their LTCI finances, set premium rates for people aged 65 and older, and plan and oversee services (Tsutsui, and Muramatsu, 2005).

The services covered by the LTCI program are divided into institutional and community-based care (which may be either delivered to the home or provided in institutions to persons who live in the community). Both categories have hitherto been covered under both social services and health insurance, an exceedingly complicated situation that should be simplified in the long run by unified financing under the new LTCI program. Transitional problems will be difficult, particularly in dealing with current recipients who might be disadvantaged by the new system (Campbell and Ikegami 2000). Japan's long-term term insurance plan, municipalities as the insurers of the long-term care insurance have the responsibility of promoting the health and welfare of the elderly at home. However, municipalities contract with a wide variety of

organizations including private- sector companies for home care. This reflects not least the fact that care users access services based on individual long-term care service usage plan and can make use of public and private medical care and welfare services comprehensively. They can choose the type of service and facilities they desire from services provided by various organizations such as private companies, agricultural cooperatives, livelihood cooperatives, volunteer organizations and so forth (Burau et al., 2006:8).

Thus the Japanese approach to LTC has emphasized the provision of at-home (non medical) services, as well as room and board for those requiring institutionalization. The Japanese LTC system is a rather complex tax-and-transfer scheme, supported by mandatory but means-tested premiums levied on workers and retirees by local governments, as well as general tax revenue from central and local governments. Benefit eligibility is determined by local boards appointed by municipalities, but fees for benefits are set at the national level. For-profit competition is permitted in the at-home care arena, but in the medical and institutional care arenas only non-profits and government providers are allowed.

3.6 The Long -Term Care Triad/ Bureaucratic Model

The long-term care triad also called a bureaucratic model of care. The model includes the older person, family and bureaucracy. Sussman (1977) discussed the difference between the family and bureaucracy and the need for coordination these two groups. The long-term care triad refers to the relationship among the dependent older person, family and bureaucracy. Each of these components influences the delivery of long-term care services to older people. Brubaker (1987) discusses the structural and social psychological aspects of the long-term care triad. The older person, family and bureaucracy interactions are influenced by these factors and consequently, the meshing of needs and services is affected.

Long-term care seeks to provide assistance to meet the physical, socio-emotional and economic needs of dependent older people and their families. It includes the provision of services within the older person's home as well as within the community or institutional setting. Individual involved in the provision of long-term care services include older person's family members and variety of professionals.

The interface among the dependent older person and bureaucracy requires different skills from each part. The older person needs to the family and bureaucratic representatives. The family as mediator between the older person and bureaucracies has two primary tasks. One is to help the older person negotiate the bureaucracy so that the older person's needs can be met. The other tasks relate to advocating for the older person to the bureaucracy. On an individual level, the family has family-specific knowledge that might be helpful in the long term care of an old person and the family may need to ascertain that this information is conveyed to the bureaucratic personnel. The "family as mediator" requires negotiation and advocacy skills to enhance the interface between the older person

and bureaucratic organization.

The bureaucracy needs to be responsive to the idiosyncratic features of the older person. Families as mediators can provide bureaucracies with the information necessary to modify the delivery systems. However, the bureaucracies need to be responsive to the family-specific information (Litwak, 1985). According to Brubaker (1987) the triadic relationships among the dependent older person, family and bureaucracy is illustrated in Figure3.

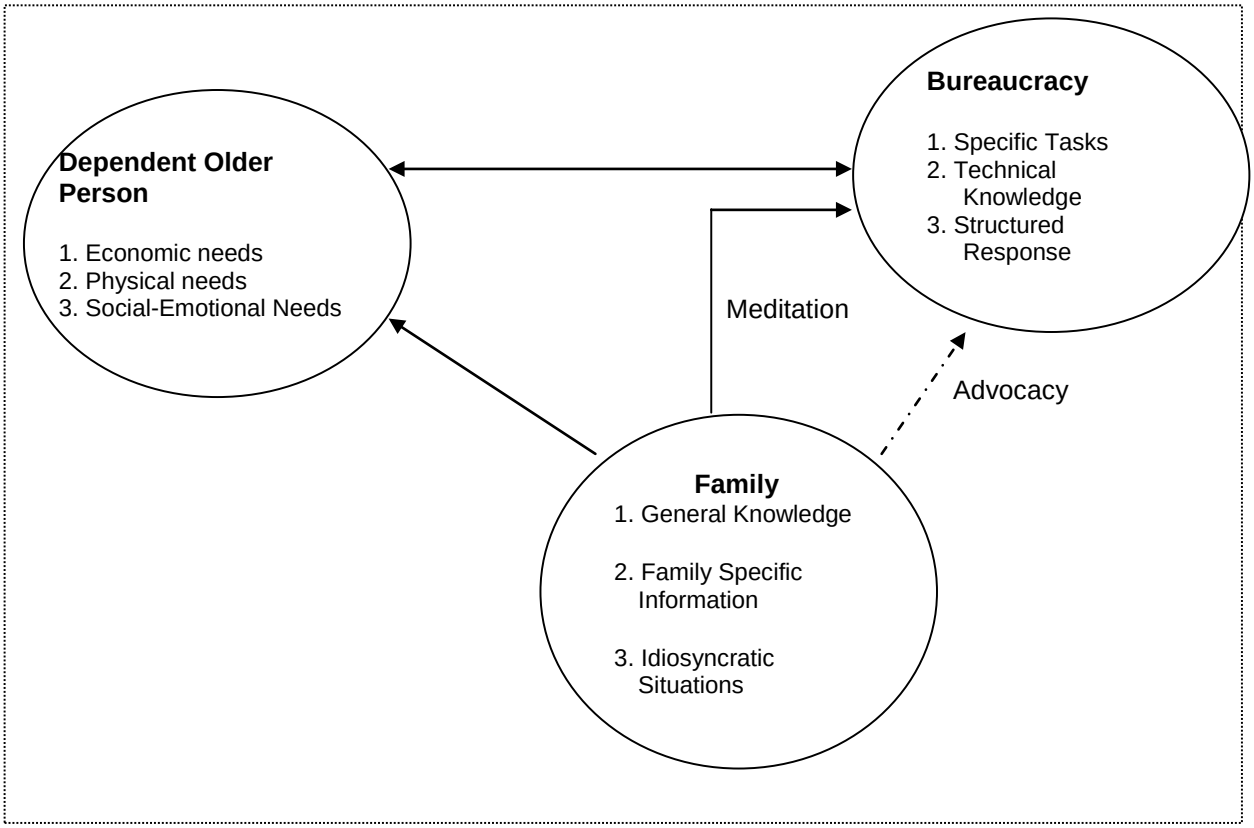


Figure 3 Triadic Relationships among Dependent Older Person, Family and Bureaucracy

Source: Brubaker (1987)

The dependent older person has several types of needs and these needs can be met by the family and/or bureaucracy. The family can influence the bureaucratic care giving relationship directly thorough medication or indirectly through advocacy. It is important to emphasize that the older person, even though dependent, may have resources that may be activated to address a need. To mediate or advocate for the older person, the family cannot be passive in its relationship with bureaucracies.

Social Psychological Aspects of the Triad

The social psychological factors influence the definitions held by the individuals who represent the three component parts of the interaction. For all three members of the care giving triad, several factors are influential in creating definitions of another and tend to interpret the interaction on the basis of their own attitudes toward, or knowledge about, older people. In the same way technical or bureaucratic knowledge influences the older person's and /or family member's definition of the bureaucratic organization. Knowing what can be done and what should be done to solve a problem enables the older person and/or family member to evaluate the information given by the bureaucratic representative. The third factor relates to the participants' assessment of legitimacy to provide assistance. The bureaucratic structure sets the environment in which the three participants in the long-term care process interact. The social psychological factors define the way in which the participants interact in the environment.

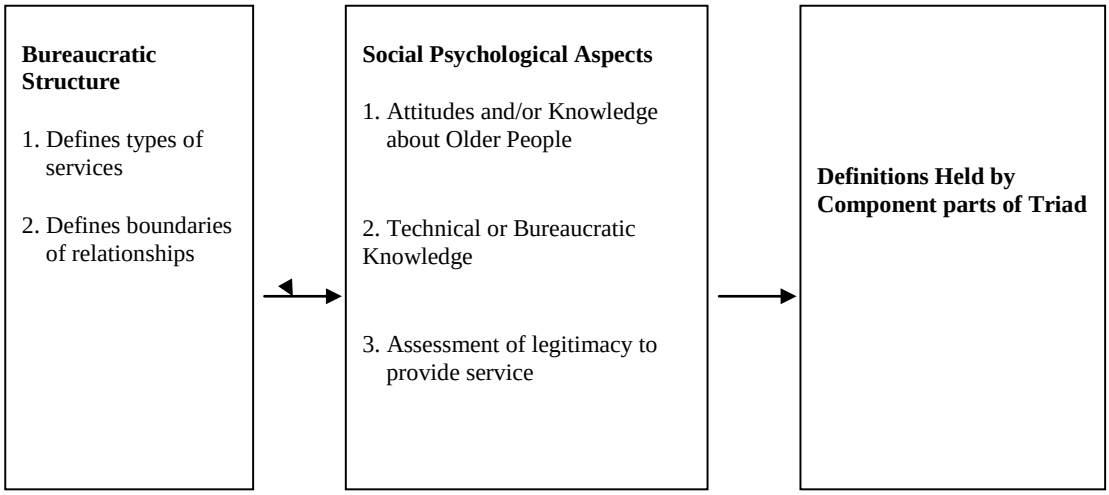


Figure 4 Bureaucratic and Social Psychological Factors Influencing Definition within Triad

Source: Brubaker (1987)

The care giving triad cannot be understood solely from the structural perspective. Nor it can be adequately comprehended from the social psychological approach. Both perspectives are necessary (Brubaker, pp. 19-22). The long-term triad can be helpful to address the elderly person's need as well as dependent older person who need care.

CHAPTER FOUR
THE OVERVIEW OF AGING AND ELDERLY CARE

4.1 JAPAN

4.1.1 The Aging of the Japanese Population

As of 2008, the population of elderly citizens (65 years and over) was 28.22 million, constituting 22.1 percent of the total population and marking record highs both in terms of number and percentage. The speed of aging of Japan's population is much faster than in advanced Western European countries or the U.S.A. Although the population of the elderly in Japan accounted for only 7.1 percent of the total population in 1970, 24 years later in 1994, it had almost doubled in scale to 14.1 percent. Average life expectancy in Japan climbed sharply after World War II, and is today at the highest level in the world. In 2008, life expectancy at birth was 86.05 years for women and 79.29 years for men (Statistical Handbook of Japan, 2009). In other words, Japan is the most aged society in the world. By 2020, one in four Japanese is expected to be over 65.The ratio of age 65 and over, which was 10.3% in 1985, 14.6% in 1995, 17.4% in 2000, and 21.0% in 2005, 22.1% in 2008 and is projected 28.7% by the year 2025(Table 1).

According to the Internal Affairs and Communications Ministry the population of octogenarian and older has topped 7 million for the first time, accounting for 5.6% of the total population. The number of men totaled 11.69 million; accounting for 18.8% and female came to 15.75 million, making up 24.1 % of the entire population.[10] The rate of population aging in Japan is much greater than that in other developed countries. Therefore, the various systems which are affected by these changes, such as pensions, medical care and long term care, need to be rebuilt. The issue of long term care for the elderly is one of the most important issues faced by Japanese citizens, along with the issues of medical care and pensions.[11]

Ogura (1997) argue that the almost all newborn babies are now expected to reach age 65 and more than half of them are expected to reach age 80. This is the best mortality record in the world, and probably in the history of humankind. The improvements in mortality, which began largely in the 1970s, combined with the reductions in fertility, have led to tremendous changes in the age structure (Martin, 1991). As shown in Table 1, the age structure of the Japanese population has shifted to a substantial degree. The child dependency ratio (age 0-14) and working age people (15-64) are also decreasing The total number of children aged 0-14 were 14.6 percent in 2000 and projected 11.6 percent in 2025.The productive population aged 15-64 were also decreasing gradually 68.1 in 2000 and projected 59.7 in 2025.

[10]. The Japan Times, Sept., 17, 2007.
[11]. Japans Long-Term Care Insurance Program (2000).

Table: 1 The Age Structure of the Japanese Population

Year	Percentage Distribution (%)		
	0~14 years old	15~64 years old	65 years and over
2000	14.6	68.1	17.4
2005	13.9	66.2	21.0*****
2010	13.4	64.1	22.5
2015	12.8	61.2	26.0
2020	12.2	60.0	27.8
2025	11.6	59.7	28.7

Source: Statistical Abstracts on Health and Welfare in Japan (2005), Statistics and Information Department, Minister's Secretariat, Ministry of Health, Labor and Welfare, Health and Welfare Statistics Association.
*****As of October, 2005

These data suggests that Japan's population will continue to be the oldest in the world. More importantly, Japan will reach the world's highest level of aging at an unprecedented rate (Ogawa and Retherford, 1997; Ogawa, et al., 2003). On the other hand, the children and old age dependency ratio and also elderly-children ratio is increasing for the time being (Table 2).

Table 2: Trends in Age-Structure Index of Future Population (2000~2025) of Japan

Year	Defining Productive Age as 15~64 Years old			
	Age Dependency Ratio (%)			Elderly-Children Ratio (%)
	Total	Children	Old-age	
2000	46.9	21.4	25.5	119.1
2005	51.0	21.0	30.0	143.2
2010	56.1	20.9	35.2	168.3
2015	63.4	21.0	42.4	202.3
2020	66.7	20.3	46.4	228.9
2025	67.5	19.5	48.0	246.5

Source; Statistical Abstracts On Health and Welfare in Japan (2005), Statistics and Information Department, Minister's Secretariat, Ministry of Health, Labor and Welfare, Health and Welfare Statistics Association.

As shown in Table 2 the total dependency ratio was 46.9 percent and will be reached 67.5 percent in 2025. Likewise, the children and old age dependency ratio was 21.4 and 25.5 in 2000 respectively. Likewise, elderly-children ratio was 119.1 in 2000 and will be reached 246.5 in 2025. The rapid decline in the child dependency ratio and the rise in old age dependency have created significant new policy challenges. This pronounced upward shift in the age distribution of Japan is prone to generate a substantial increase in the demand for medical and long-term care services, both formal and informal.

According to Campbell (1992) evolution of "problem consciousness" through the 1980s as going through three stages in Japan; (a) Ageing Problem (*Rogo Mondai*): In this

stage people worrying about what will happen to them when they get old. The response was expansion of public pensions in the 1950s and early 1960s. (b) Old-People Problem (*Rojin Mondai*): It concerns about poverty, lack of medical care and other plights of current old people. These were addressed with a series new programs or big expansions in the early 1970s. (c) Aging –Society Problem (*Koreica Shakai Mondai*): It implies that impact of so many old people on Japan's overall economy and society. These concerns led to rationalizations of the pension, old age medical care and social welfare systems associated with "administrative reform" in the 1980s (Long, 2000).

The aging process of Japan not only increased the ratio of the elderly in the population but also accompanied a fundamental change in family and community that provided support to the elderly. The household size has become smaller from approximately 5 persons in 1950 to 2.7 persons by 2000 and 2.58 persons in 2005. The proportion of households consisting of a single elderly person or an elderly couple has risen from 28% to 47%; the proportion of elderly person living together with their child or children has fallen from 69% to 46%. Since the size of the labor force will decline after 2000 and the ranks of the retired will grow, government payments for pensions, health care and welfare will raise. The strain on the social fabric this will cause is being exacerbated by a breakdown in the pattern of the extended family, which in the past could be relied on to provide much of the care of the aged. A shift of population from rural to urban areas resulted in the overcrowding of cities and depopulation of the country side, causing a breakdown in traditional community ties. Neighborly relationships and mutual assistance prerequisites for living in the traditional society have become weaker and weaker with the advanced industrialization and urbanization. The trend of the elderly are often left alone at home during the day time both urban and rural areas (Aratame, 2007).

These changes all suggest a decline in number of caregivers and more fundamentally, a departure from the traditional pattern of elderly care through family members living together. Similarly, local communities that have supported daily life of elderly have also undergone a significant change. The rapid decline in the child dependency ratio and the rise in old age dependency have created significant new policy challenges. This pronounced upward shift in the age distribution of Japan is prone to generate a substantial increase in the demand for medical and long-term care services, both formal and informal.

Population Trends of Kyoto City

Demographic changes mean that the number of elderly people has increased dramatically and is set to carry on rising. The total population of Kyoto city was 14.72million as of October 2006. The elderly population of Kyoto city was 20.8% of total population in 2006, which was 14.7% in 1995. The productive population aged 15-64 years was71.6% in 1995 and it is decreased 2006 into 67.1%. Similarly, the younger population of aged less than 15 years also decreased from13.8% in 1995 and 12.1% in 2006 (See Table 3).The elderly female are always greater than male population. As of October 2006 the female and male population of 65 years and over was 23.3 % and 18.0% respectively (See Table 4).These demographic changes will certainly impact upon health and social services, placing greater strain on the current system to consider new program and policy to maintain and enhance the well-being of the elderly.

Table 3 Population of Different Age Groups (%)

Year	0-14	15-64	65+
1995	13.8	71.6	14.7
1999	12.9	70.6	16.8
2003	12.4	68.5	19.1
2006	12.1	67.1	20.8

Source; Senior Citizen Welfare Division, Kyoto City

Table 4 Aged Population 65 and over by Sex (%)

Year	Male	Female	Total
1995	11.8	17.3	14.7
1999	14.0	19.4	16.8
2003	16.4	21.6	19.1
2006	18.0	23.3	20.8

Source: Senior Citizen Welfare Division, Kyoto City

4.1.2 Brief history of Elderly care in Japan

Before the Meiji restoration (-1868) the welfare of the elderly in Japan can be traced back to charitable work by Buddhist temples. That time the Buddhism was in effect the national religion in Japan and the state was providing relief to poor elderly people. Similarly, older people were the main recipients, as the Tokugawa regime placed a special emphasis on the virtue of respect for the elderly. After restored the new Meiji government the famous administrative order called Relief Order 877 was stipulated for support to frail elderly of 70 years and above. The new public relief law stipulated that the national government should take responsibility of relief for the poor which was very limited from the standpoint of modern welfare philosophy. Japan entrance into the Second World War in 1941 caused a devastating effect on the lives of Japanese people, especially on the lives of older people without children on whom to depend, of orphans and of the disabled. Just one year after the end of the war the old public relief law was abolished and a completely new

public assistance law i.e. “Livelihood Protection Law” was enacted in 1946. In 1950 the Livelihood Protection Law was abolished and new Livelihood Protection Law enacted. This is the present Japanese public assistance law, which organizes the legal right of people to ask for the provision of assistance. Due to this law the living condition of the Japanese poor older people were significantly improved.

The traditional living arrangement of the Japanese elderly is the patri-lineal, patri-local stem family. Typically, co-residence family provided all kinds of support. Even if the elderly were completely dependent, their lives seemed secure because the co-resident family members were “protective” (Hashimoto, 1996). The traditional Japanese value system, which emphasizes filial piety and respect for older people, has placed primary responsibility for the support of older people on families. The norm of filial piety was propagated by the Imperial Japanese Government in combination with loyalty to the Emperor. Filial piety was repeatedly taught in moral education; for example, children were instructed to obey parents absolutely and never resist them. They were not even to stretch their feet in the direction of their parents while sleeping. Filial piety was an extremely important moral virtue corresponding to the infinite grace of parents, including the grace of bearing, nurturing and allowing marriage. The traditional Japanese system the “practice of primogeniture gave status to sons over daughter and first borns over others. The eldest son would inherit the family residence and assets and in turn would be responsible for his parents in their old age (Rindfuss et al., 1992). The status of the eldest son and the presence of other siblings who might compete over parental resources can lead to distinct attitudes toward familial responsibility and transfer to elderly parents in Japan.

The provision of public support dates back to the famous Relief Order in 1874, which provided assistance for older, sick persons aged 70 years and above who had no relatives to support them. In 1932 a new public relief law was implemented. This gave responsibility for relief of the poor to the National Government. In the late 1940s social welfare became a more important national goal, and by 1950 new public assistance laws had significantly improved the living conditions of older people. Since 1961 the National Government has enacted laws and issued policy statements designed to further promote the welfare of older people.

In Japan, the universal public pension and health insurance schemes were established in 1961 and a system of free medical care services for older people was introduced in 1973. Cost sharing arrangements, along with co-payments by older patients, were adopted in 1983 to cope with the increasing health care needs of older people. They were designed to spread the burden of medical expenditures for older people more equitably across the generations and the various insurance programs. The public pension system was restructured in 1985 to cater for the projected aging of the population, and retirement benefits were rationalized. Prior to 1988 long-term care was provided in welfare institutions, called Special Nursing Homes for the Aged, and in special types of geriatric hospitals and wards. In 1988 Health Care Facilities for the Aged, funded through the health insurance scheme, were established to meet the rapidly expanding needs for

long-term care of older people. These institutions are best described as halfway houses, between hospitals and the community, providing long-term care for older people with chronic illnesses who need intensive care and rehabilitation but not hospitalization. Subsidies have been widened with the establishment of community welfare centers and other facilities for older people. Tax deduction programs have been used to reduce the financial burden on families of supporting and caring for aged parents, especially those who were frail and impaired, in their own homes. Initiatives contained in the 'Gold Plan' of 1989 and the 'New Gold Plan' of 1995 effectively transferred responsibility for public health and welfare services for older people to local or municipal governments. The plans also established service development targets for a range of in-home services, facilities and staff development. The basic principles underlying the plans were autonomy, user-orientation, universality, supply of comprehensive services and regionaliation. The introduction of the Long-Term Care Insurance to Japan in April 2000 based health and welfare services for older people on the principle of universal insurance. Complementary changes in the structure and delivery of aged care services are integral to the introduction of the long-term care arrangements (Commonwealth of Australia, 2001).

4.1.3 Elderly Related Policy and Programs of Japan

To address the elderly issues, the Japanese government has introduced and implemented the following major policies and programs:

(a) Public Long-Term Care Insurance Plan

Japan introduced the Public Long-Term Care Insurance Plan in 1997. This plan is designed to provide care for the elderly via a new type of social insurance. The plan provides the legal basis for the shift from a government-based welfare system to a more plural one which would include both private and nonprofit service providers. From 2000 Japan implemented a new social insurance scheme, the Long Term Care Insurance for the frail and elderly. In fact, it is an epoch- making event for the history of the Japanese public health policy, in which Japan has moved toward socialization of care in modifying its tradition of family care for the elderly. In April 2004, the revised long-term care insurance system was implemented and "long-term care prevention-oriented" system was established. Municipalities should provide "community support services" to the elderly people who are likely to be in need of support or long-term care in near future. "Community support services" include support for training muscles, improving nutrition, and dental care. It is expected that 5% of the elderly population use the community support services. The long-term care insurance system is the mechanism for giving those in need of long-term care due to a disease caused by old age or for other reasons necessary services in a comprehensive and uniform way so that they can lead an independent life as much as possible. It is a user oriented system where they can use the service by their own choice.

Four goals of the long term care insurance program are: (1) to enable a chronically impaired old adult to chose long-term care services; (2) to deliver a

comprehensive long term care service package; (3) to provide a variety of arrangements for receiving long-term care services; and (4) to reduce unnecessary hospitalization.

Basic Principles of Long-Term Care Insurance (LTCI) System

The basic principles of long-term insurance system are as follows:

(a) Elderly people should be entitled to utilize home care services and facility services in accordance with their own needs and desires without feeling a sense of reluctance, regardless of their income level and family situation.

(b) The second principle is to integrate the two existing systems for the elderly, the welfare system and the Health Service System for the Elderly.

(c) The third principle is to encourage diverse private sector. Under the conventional welfare system, there has been a mechanism in which municipal governments choose service providers and contract with them to deliver service.

The long-term care insurance system, however, will abolish the system of contracting by the municipalities in order to have the same conditions for public and private sector service providers for competition.

(d) The fourth principle is to introduce the concept of "care management" in order to provide a variety of services in conjunction.

This mandatory long-term insurance program requires everyone age 40 years and older to contribute premium payments to the national insurance pool. For workers aged 40-64 the program will provide services in the event of disability. In addition, general tax revenues will fund 50% of the program with this burden shared by the national and local governments (25% national, 12.5% prefectures and 12.5% municipalities). The beneficiaries, mostly frail elderly, will pay a 10% co-payment at the point of service for nursing care.

Under Japan's long-term care insurance system, the central government, prefectures and municipalities are mandated to work together to implement long-term care for the elderly. While the outline of the Gold Plan is set at the national level, localities retain significant flexibility in adapting it to local norms. Interestingly, this policy introduced a new concept to Japanese society, that long-term care is no longer expected from the family or allocated by the state on the basis of need, but rather a social contact based on a system of mandatory contributions, uniform entitlements and consumer choice (Izuhara, 2003). On the one hand, it redefines care of the elderly from a filial to a social function but on the other by including financial benefits for informal family cares as well as formal ones, it reinforces traditional Japanese values.

Japan's long-term term insurance plan, municipalities as the insurers of the long-term care insurance have the responsibility of promoting the health and welfare of the elderly at home. However, municipalities contract with a wide variety of organizations including private- sector companies for home care. This reflects not least the fact that care users access services based on individual long-term care service usage plan and can make use of public and private medical care and welfare services comprehensively. They can choose the type of service and facilities they desire from

services provided by various organizations such as private companies, agricultural cooperatives, livelihood cooperatives, volunteer organizations and so forth (Burau et.al., 2006).

Enomoto (2006) stated the following services are provided under the long-term care insurance system:

(A) In-home services 1) Home-visit services (Home-visit long-term care, Home-visit bathing, Home-visit nursing care, Home-visit rehabilitation, In-home medical care management counseling 2) Commuting services (Commuting for care, commuting rehabilitation 3) Short-term stay (Short-term stay at a care facility, Medical care service through a short-term stay 4) Other services (Care service provided in for-profit private homes for the elderly, Welfare devices leasing, Allowance for purchase of welfare devices (B) Support for in-home long-term care (C) Services at facilities (Long-term care welfare facilities for the elderly, Long-term care health facilities for the elderly, Long-term care medical facilities for the elderly (D) Community-based services (Small-sized multi-functional in-home care, Home-visit long-term care during nighttime, Day service for the elderly with dementia, Community houses for the elderly with dementia, Community-based care service provided in for-profit private homes for the elderly, Community-based long-term care for the elderly in long-term care welfare facilities for the elderly (E) Other: Allowance for home renovation (handrails, removal of level differences, etc.).

Framework and Responsibilities of Public and Private Sectors in Providing Long-term Care Services in Japan

As of July 27, 2007, there are 47 prefectures and 1,804 municipalities in Japan. There are central government and local governments in Japan. Local governments consist of municipalities and prefectures. Municipalities are basic local governments responsible for supplying basic public services to residents. Prefectures are wide-area local governments responsible for supplying public services which require special knowledge in supplying them and the coordination between municipalities. Municipalities are mainly responsible for providing long-term care for the elderly people. They are insurers of the long-term care insurance system and the elderly people consult with the municipalities about long-term care services. Prefectures are responsible for supervising long-term care service providers and bear a part of costs necessary for providing services. Central government establishes the legal framework of the system and bears about 1/4 of the costs. There are mainly two types of specialists/professionals who provide health and welfare services to the elderly people currently in Japan; such as: (a) Medical Doctor and Nurses are as specialists of health services and home helper, certified care worker, and certified social worker are involved in providing welfare services to the elderly.

Likewise, long-term care services are mainly provided by service suppliers in private sector. They provide services to the elderly people and claims costs to municipalities. Facility services are provided only by social welfare corporations, which are specially established for providing welfare services. Other services can be provided

by any forms of private entities. Recently, the number of for-profit corporations and NPOs (non-profit organizations) which provide long-term care services is increasing. However, it is getting difficult to maintain the level of the quality of care.

(b) The Gold Plan

The Japanese government developed and implemented the Gold Plan in 1989 which defined specific goals to be achieved over a ten year period ending in 1999. The purpose was to increase and restructure community based health care and social services while restricting the use of long term institutional care facilities. It stressed the need to keep disabled elderly in the community and out of institutional care. In recognition of a rapidly aging population and inadequate or overburdened home care, efforts were made to coordinate health and welfare services as well as community and short term institutional care by municipal governments. The unique feature of the plan was the development of systematic community facilities and services to provide care for the elderly and their family care givers. The major part of the Gold Plan was directed at improving home-based services for the elderly by improving three types of services: (1) home helpers, (2) short-term stay facilities, and (3) elder day care centers. In short these goals included numerical targets for facilities and workers in the field of long term care for the elderly.

In implementing the gold plan, each of the municipal governments conducted fact-finding survey on the elderly people living within its jurisdiction, and formulated a specific action plan for the development of a service infrastructure based on the results of the survey. Prefectural governments also drew their action plans of the municipalities within their prefectures. Making these plans at these prefectural and municipal levels increased public interest for the issue of long-term care for the elderly. However, while in the process of creating action plans at local levels, it became apparent that the target levels specified in the Gold Plan were not sufficient to meet the needs of the elderly people. So in 1994, Japanese government revised the Gold Plan and formulated the New Gold Plan by raising the numerical targets and the “Direction for Health Care and Welfare Measures for the Elderly". Families are expected to pay little or nothing for these Gold Plan services. They are to be paid for by national and local governments. If the Gold Plan 21 is completed, the quality of life of frail elderly and their families will be improved significantly compared to the present level. (See Appendix-A)

(c) Old-Age Pension and Medical Care Plans

To address the issue of care for the elderly, Japan managed to establish its universal pension and medical care schemes in 1961. Since then, Japan’s social security system has grown remarkably. Currently, Japanese public pension has "pay as you go" system, in which the premiums paid by the working-age population (normally ages 20-59) are used to pay for the pension benefits of the elderly. A part of the pension benefits comes from the public tax. The public pension system has two tiers. The "national pension" is for all the citizens, and it provides the basic benefits. The additional benefits are provided depending on the income level through either "employees' pension" or "mutual aid

pension. People usually become eligible to receive the pension benefit at age 65, but they can start receiving it before reaching 65. Yet, this system is gradually fading out. As the population ages, the amount of pension premium and benefit are revised every 5 years.

Between 1961 and 2005, the share of social security benefits increased from 4.9 to 23.9 percent of the national income (National Institute of Population and Social Security Research, 2007). Moreover, the proportion of the social security expenditure allotted to the pension schemes increased from 22.7 percent in 1964 to 52.7 percent in 2005, while the corresponding value for the medical schemes declined from 54.4 to 32.0 percent over the period in question. Owing to population aging, as well as the maturity of the old-age pension schemes, the relative share of pension benefits paid out in national income has been on an upward trend in recent years. Japan undertook major reforms of its public pension schemes in 2004. One of the primary objectives of the 2004 pension reform was to fix the level of future contributions in order to make the program more transparent for younger workers, but this reduced the benefits considerably. The government introduced a mechanism to automatically balance benefit levels according to future changes in the population age structure. The goal was to avoid repeated reforms and to restore the younger generations' trust in government pension schemes. This may be regarded as a paradigm shift in Japan's social security provisions (Sakamoto, 2005).

The second major component of social security benefits is medical aspect. Subject to Japan's economic growth performance, the coverage in medical insurance plans has been revised on a periodic basis. Despite these changes that have taken place in the past few decades, the absolute amount of financial resources allotted to medical care services has been continuously rising. One of the factors that have been causing the rapid growth of medical costs and set Japan apart from other industrialized nations is an extremely long period of hospitalization in Japan (Ogawa et al., 2007). In 2005 it was 35.7 days, which is the longest among the 19 OECD countries, followed by 13.4 days in France (OECD, 2007). In response to the upward spiral in medical care costs, the government of Japan implemented the Long-term Care Insurance Scheme (LCIS) in 2000 with a view to reducing the average duration of hospitalization for inpatient care by facilitating in-home care. The LCIS is expected to alleviate the care-giving burden to be placed upon family members, many of whom are middle-aged women (Ogawa and Retherford, 1997). Because the expenditure for the LCIS had grown at an alarming rate since its inception, the scope of its services was critically reviewed and downgraded in 2006 with a view to curbing future costs.

In April 2008, the government of Japan implemented a new medical insurance scheme specifically for senior citizens aged 75 and older as another step toward curbing the nation's mushrooming medical costs. Under this new medical scheme, premiums are automatically deducted from pension payouts. However, because premiums have actually become higher under the new scheme for a certain segment of the targeted elderly age group, a possible revision of the new scheme has already become one of the most urgent political issues at the national level.

(d) The Welfare Law for the Elderly

Homes for the elderly, home care aid services, respite care which is called "short stay program" and other similar services have been covered by the funds from the taxes of the central and local governments under the Welfare Law of the Elderly which was enacted in 1963. This law has two characteristics: (a) it is a fundamental law that stipulates several basic principles with which all the other laws, as well as governmental and voluntary actions related to the life of the elderly, should conform and (b) it regulates public social services for the elderly, including institutional services, community services, health related services, educational services and recreational services.

The Law for the Welfare of the Elderly (LWE) regulates three types of institutional care for the elderly as follows:

a) Nursing home for the aged (for seriously impaired older persons). Anyone can apply for admission to this home, regardless of their income. When the income of an applicant and family is under a certain level, a fee is waived. b) Home for the aged (for slightly or moderately impaired older persons with income under a certain amount set by the national government). c) Home for the aged with moderate fees (for those older persons who are independent in daily life and with a limited income). It is to be noted that Japan was one of the leading countries in the world to enact a special law for the welfare of the elderly.

(e) Development of Community Services

There were no public community services for the elderly before 1962. Since then, a variety of community services has been started. The national government focuses on three major community services for the frail elderly: (a) home help service, (b) short term stay service and (c) day service. In addition, the national government subsidizes several other community services for supporting family care to the elderly. The special loan is also available for those family care givers who plan to build or remodel their houses so as to have a room for their aging parents. The income tax-deduction program is applied to those taxpayers, regardless of the amount of income, who are supporting a person aged 70 or older. When an older person is seriously impaired, the deductible amount is increased (Maeda and Nakatani 1992:204-5).

(f) Enactment of the Law for the Health and Medical Services for the Elderly

This law which was enacted in 1982 is based on chapters on health and medical services from the Law for the Welfare of the Elderly. New provisions that every local government is required to give health check up services regularly to all citizens age 40 and older are provided for a moderate fee and free of charge were added. The law again introduced a new facility for the impaired elderly which is called Health Care Facilities for the Aged. Such facilities provide long-term care for older persons who are suffering from chronic diseases but do not need hospitalization.

(g) The Health Service System for the Elderly

This introduced facility services in special nursing homes and home care aid services among other services which are provided under the Welfare Law for the Elderly. In Japan, all of the citizens are covered by an insurance plan for medical services. Elderly

people in particular can receive medical services with a lower co payment than the working generation under a special system for the elderly which is called the "Health Service System for the Elderly". This system covers all of the medical services necessary for the elderly, including admission to hospitals.

The Ministry of Health and Welfare along with the Ministry of Finance drafted the Health Care for The Aged Law of 1982 which effectively terminated the free medical care for the aged by imposing a small deductible charge for outpatient and hospital care. This law also discouraged the use of acute care hospitals for long term care. It should be noted that in Japan hospitals and clinics are often owned and operated directly by the resident physicians where they also dispense the medicines which they prescribe. The introduction of this law also effectively curtailed any unjustified use of these hospitals for extended care and private profit. With the percentage of the very old rapidly growing, family size shrinking and the cost of health care and pensions increasing the Japanese government was forced to devise a new and inventive program geared to meet social needs and containing costs (Lee et al., 2000:139). Although the Japanese health care system is well organized and has ample hospitals, many hospitals offered only basic facilities and fairly low staffing levels. As a result, low income people faced the prospect of a poor standard of care.

(h) Promoting Social Participation

In Japan, it is the custom to respect people to retire at the age of 60 and to search for alternative employment between the ages of sixty and sixty five. Most people aged 65 or over are supported by the social security system, although recently the number of such people who wish to work as long as possible has increased. As a consequence, the ratio of elderly people in the work force is quite high compared to other developed countries.

There are many activities offered by voluntary organizations and senior citizen's clubs in Japan. As many as 40 percent of the population sixty years of age and over attend a total of roughly 130,000 senior citizen's clubs. Their purpose is to promote health, provide a social service and enrich the mind to cope with the processes of change. As an indication of their perceived importance, the national government provides subsidies for upgrading club activities, in order to promote the social participation. All over Japan, there are also many "recreation homes" in places such as hot-spring areas, where elderly people can stay for a short period.

(i) Adult Guardianship Program

The elderly are most concerned about the health of themselves and their families. Their next biggest concern is daily care and guardianship in old age. For those who have physical disabilities and/or cognitive dysfunctions, the local welfare and human rights protection program provides assistance in management of their financial and administrative matters as well as utilization of welfare services. The adult guardianship program takes a further step. When people suffer from dementia, they can have someone they trust manage their finance and apply for long-term care services under this program.

This program started in April 2000, the same as the long-term care insurance. The program consists of optional system and statutory system. Under the optional system,

people can assign their guardian (e.g., family member, relative, lawyer, and judicial scrivener) when their cognitive status is intact. They will sign the notarized deed. The statutory system provides support for those who suffer from dementia. Their spouse, relative, or mayor can submit an application at a family court, and the court chooses the appropriate guardian (there are 3 levels of guardians depending on people's cognitive level) to support them. This program is essential in order for us to live with dignity even if we suffer from dementia. However, this program is not widely used yet probably because of the slow progress to train the guardians.

Old age ideally represents a time of relaxation of social obligations, assisting with the family farm or business without carrying the main responsibility, socializing, and receiving respectful care from family and esteem from the community. In the late 1980s, high (although declining) rates of suicide among older people and the continued existence of temples where one could pray for quick death indicated that this ideal was not always fulfilled. Japan has a national holiday called Respect for the Aged Day, but for most people it is merely another day for picnics or an occasion when the commuter trains run on holiday schedules. True respect for the elderly may be questioned when buses and trains carry signs above especially reserved seats to remind people to give up their seats for elderly riders. Although the elderly might not have been accorded generalized respect based on age, many older Japanese continued to live full lives that included gainful employment and close relationships with adult children.

4.2 NEPAL

4.2.1 The Aging of the Nepalese Population

Aging is the ultimate manifestation of biological and demographical activities in individual human being and population at large. Until recently very little attention was paid particularly in developing countries about the dynamics of aging in human beings. However, continued increase in percentage of aged persons in the population is creating humanitarian, social and economic problems in many developing as well as developed countries. It has been observed that since last one decade, social scientists and demographers all over the world are trying to explore the dynamics of aging. In Nepal's case, though attention on social aspect of aging has been paid since ancient time, no attention has been paid yet on its demographic aspect (Singh, 2003).

In Nepal care for the elderly is fast emerging as a critical element of public and private concern. The interface between the State and social institutions in the care of the elderly forms an important area of inquiry. There is complementarity rather than competition between formal and informal care. The elderly people being member of joint family, they contribute in household chores and rarely supported by their families. However as the nuclear family system is gradually replacing joint family, their situation further aggravates. There are two contradictory practices prevailing in the Nepalese society, on the one hand elder people are highly respected while on the other, they viewed

as a burden. There is no bond and affection between the older and young generation. Traditional forms of care older people in Nepal are fast disappearing like in other countries due to modernization and nuclear family system. The older generation is isolated and left alone. Many people perceive them as useless, weak and dependent. Similarly, there is a debate on whether aging of the population is just another burden on the process of development or it is a positive force in that quest. There are various problems of older population that other countries have already been facing. There is no doubt that this problem can be very alarming and acute for a country like ours where is poverty; illiteracy and destitution are so rampant. Likewise there is no effective and substantial policy, rules and wide coverage programs for elderly care in Nepal. In essence, the fact is that elderly care mainly takes place within the family (i.e. informal care), and therefore the result of restrictions by social policies or lack of effective and substantial policies and programs, which build barriers to access of formal care.

Despite various efforts to help senior citizens and use their knowledge and experience for the development of society, there is still much to do in these areas. Although there have been increases in the population of senior citizens, there have not been proportionate increases in the resources and budget for their welfare. Inadequate resources; sub-standard and inadequate old-age home facilities; lack of relevant institutions, human resources, and community arrangements to look after the need and health of senior citizens; and a lack of long-term plans, regulations, and coordination mechanisms among the related agencies are the present challenges. In particular, poverty and the rise in nuclear families taking the place of joint families present special challenges to this sector.

The rapid increase in the proportion and absolute number of aged people among the total population will impact on socio-economic and health policies and the culture in future society of Nepal. The elderly population growth rate per year is always more than total population growth rate of the population in Nepal (Table 5).

Table 5: Growth rate of total and the elderly population, 1952/54-2001

Census Year	Inter-census Growth Rate (%)	Elderly Population Growth Rate (%)
1961	1.65	1.79
1971	2.07	2.42
1981	2.66	3.26
1991	2.1	2.26
2001	2.25	3.5

Source: CBS, 1952/54, 1961, 1971, 1981, 1991 and 2001.

From the above table, the growth rate of the elderly is always higher than that of the total population. If this elderly population growth rate continues at the current rate, the population of the elderly will double in 20 years. Moreover, due to the possibility of a further decline in fertility rate, the elderly population in the future would appear to increase at an even quicker pace and the proportion of elderly will actually double in less than 20 years.

The percents of aged persons of various groups in Nepalese population during different time periods are shown in the table below.

Table 6: Percents of Aged Persons in Nepalese Population

Aged	Time period			
	1911	**1941**	**1971**	**2001**
60+	4.28	5.33	5.88	6.5
65+	2.43	3.17	3.17	4.21
75+	0.45	0.65	0.87	1.3

Source: Singh, M.L. (2003) "Aging population in Nepal: Population Monograph of Nepal", Vol. II. CBS pp 251-294.

Due to urbanization and changes in demographic composition, family and household structures have been changed with an average family size of 4.1 in 2004 which was 5.4 in 2001. In 1911 the elderly population aged 65 over was 2.43%, and reached 4.21 percent in 2001. As shown in Table 6, the elderly growth rate was 3.5 % where as national population growth rate was 2.25% in 2001. A comparison of the size and growth rate of the elderly population with the national population suggests that both have been rising for the past 5 decades. It is believed that due to expansion of education and health care facilities, average longevity and percent of aged persons in Nepalese population is increasing over time.

Table 7: Population of Kathmandu Metropolitan City (KMC)

Year	Total Population of KMC			Elderly Population aged 65+		
	Male	Female	Total	Male	Female	Total
1981	227934	194303	422237	8990(58.3%)	6424 (41.7%)	15414 (100.0%)
2001	360103	311743	671846	10102(44.5%)	12601 (55.5%)	22703 (100.0%)

Source: CBS (1981, 2001) Government of Nepal

The total population of KMC was 422,237 in 1981 and reached 671,846 in 2001. Likewise, the population aged 65+ of KMC was 15,414 in 1981 and has increased to 22,703 in 2001(Table 8). The elderly male and female population was 58.3% and 41.7 in 1981. Surprisingly, the elderly female population was increased into 55.5 % in 2001 where as males was 44.5% in the same year. The total population of elderly aged 65+ of KMC was 3.37 percent in 2001.

Table 8: Households of KMC

Households of KMC in Percentage								
One person	Two persons	Three persons	Four persons	Five persons	Six persons	Seven persons	Eight persons	Nine and more persons
6.95	12.25	17.71	23.26	16.71	9.31	5.59	2.55	5.63

Source: CBS (2001) Government of Nepal

The KMC alone had 23 per cent of the total urban households of the country and massive influx of population every year from all parts of the country has further increased its population. According to 2001 census, there are 235,387 households in the Kathmandu Metropolitan City (KMC). Among them four persons household (i.e. 23.26%) are the greatest bulk of total households of KMC in 2001, followed by three persons (17.71%) and five persons (16.71%) households (Table 8).

4.2.2 Elderly Related Policy and Programs of Nepal

1. Legislation on Elderly Person

Little legislation exists that focuses on older people. The Constitution mentions older people by stating people who have to be specifically taken into account. Also, Nepal participated in the Second World Assembly on Aging. Last the following articles about Legislation on Older People reveal that the government has taken some action, if limited, to protect older people.

The Interim Constitution (2006) of Nepal aims at protecting children, women, disabled and older people in various fields such as Education, Health and Social Security.

2. The Social Welfare Act 1992

The Social Welfare Act (SWA) 1992 sets up a framework for Government of Nepal to undertake social welfare activities through social organizations or associations. It vests authority on social welfare council to coordinate between government and social organizations and monitor social welfare activities of organizations and associations.

The act also enables government to undertake social welfare programs through concerned ministries and social organizations for the purpose of supporting the all round development of the nation. It empowers government to undertake special programs aimed to serve the interest and ensure the welfare of children, the old, disabled; protect and promote the rights of women, ensure a respectable life for unemployed, poor and illiterate people.

The Tenth Plan aims to establish 'geriatric wards' in national, regional and zonal hospitals and implement mobile health check camps. The policy now is to encourage non-governmental organizations and local institutions to implement religious, recreational, income generating centers for the benefit of senior citizens. At present the government is aiming to establish a model old age home in each of the five development regions, a senior citizen's club, and mobilize NGOs, local institutions and civil society to establish an insurance system for the elderly.

3. Existing Laws and policies towards the senior citizens:

1. Applied Senior Citizen Act 2006
2. Introduction of the Plan of Action 2005 with following components
    - Economic aspects

- Health, nutrition and care
- Participation/ inclusion
- Educational and recreational aspects
- Legislation and so on.

3. Highlighted the senior citizens issues in the 3 years Periodic Plan of Nepal Government.
4. Applied Senior Citizen Health Service Program Implementation Guideline 2004
5. Preparation is going on for bringing out senior citizen rules (Draft is completed).
6. Under preparation of the Senior Citizen welfare Fund mobilization Policy

7. Nepal is committed the following international acts and policies:
   - Madrid International Plan of Action on Aging
   - Macao Plan of Action on Aging

8. Existing Institutional Arrangements towards the Senior Citizens:

   - Establishment of Ministry of Women, Children and Social Welfare (MWCSW)
   - Women Development Office (in all 75 districts) as focal point
   - Formation of National Coordination Committee chaired by Minister of Women, Children and Social Welfare
   - Formation of a section in National Planning Commission
   - Formation of committees at the national and district level for providing health services.

4. Major programs to Senior Citizen of Nepal Government:

- Senior citizen Health Service Program (SCHSP) in 75 districts.
- Senior Citizen Allowance Program (distribution of universal senior citizen pension (allowance) of NRs. 500 to aged 75 plus.
- Destitute (helpless) Widow Allowance Program (distribution of destitute (helpless) widow pension (allowance) of NRs. 500 to aged 60 plus.
- Awareness Raising and Sensitization Program
- Program to Support Rehabilitation and Institutionalization. The program includes financial support to the elderly home, day club/care centers, Senior citizen NGOs.
- Program to support capacity of organizations working in senior citizen's concerns
- Establishment of senior citizen trust fund
- Establishment of 5 model elderly homes

5. Initiation of National Senior Citizen Organization Network- Nepal (NSCONN):

Established in the year 2003 AD, National Senior Citizen Organization Network Nepal (NSCONN) is a not-for –profit non-governmental member based network organization with 21 member organizations. Since its establishment NSCONN is actively involved to the rights and security of senior citizens as well as networking on ageing issues. Some key

program focuses of the network to mention are:

- Based on human rights, sensitization/advocacy on ageing issues has been highlighted through different Medias.
- Providing technical and consultative assistance to the Ministry of Women Children and Social Welfare to prepare act, policies and programs.
- Mobilize network member and other likeminded organizations to celebrate senior citizen day (October 1) each year by organizing various program activities
- Provide forum to its members to share their experiences
- Organize conference

6. Major stakeholders on ageing issues in Nepal:

1. District Development Committees
2. Village Development Committees
3. Organizations working on issues of senior citizens
4. Day care centers
5. Elderly homes
6. NGOs/CBOs
7. National Senior Citizen Organization Network Nepal (NSCONN)
8. Nepal Participatory Action Network (NEPAN)
9. Regional networks
10. Help Age International (HAI)
11. UNFPA (UN agency)

4.2.3 Overview of Health Services in Nepal

It will be rational to consider the development of the health services in the context of the various multi-year plans, which have been made and implemented since 1951. Nepal, having signed the HFA 2000 document at Alma Ata in 1978, had accepted primary health care as being an effective method by which essential health services were to be provided to the community in an acceptable and affordable way, and with their full participation. The Ninth Plan (1997-2002) which focused on the task of poverty alleviation had the health sector play a major role in its implementation. The ninth five-year plan (1997) had set a target to improve public health status by strengthening of the existing infrastructure for preventive, promotive, curative and rehabilitation services. Having made specific and annual plans in the context of national needs, on the basis of priorities and by bringing about co-ordination between government, NGO's and donor agencies. The Tenth Plan too has been focused for the task of poverty alleviation and covered the period from 2002 to 2007. The National health policy was adopted in 1991 to bring about improvements in the health of the nation. The primary objective of the National Health Policy was to extend the primary health care (PHC) system to the rural population on an equitable basis. Decentralization and regionalization was one of the key areas identified to

be address through the National Health Policy among different other important subjects. Based on the National Health Policy, the government of Nepal has developed its 20 year Long Term Health Plan (1997-2017) to guide health sector development for the improvement of health of the population. The last decade of the 20th century also bore witness to the creation of many medical colleges across the length and breadth of the country.

The Ministry of Health has developed a 20-year Long Term Health Plan with the vision of an integrated health system including public, NGO and private sectors in which there is equitable access to health care, self-reliance, full-community participation, decentralization, gender sensitivity and efficient management, resulting in improved health status of the population. It aims at improving health status of the people, particularly those whose health needs are often not met; the most vulnerable groups, women and children, the rural population, the poor, the under-privileged and the marginalized. It also emphasizes on assuring equitable access by extending quality essential health care services with full community participation and gender sensitivity by technically competent and socially responsible health personnel throughout the country. In Nepal, hospitals are categorized into three main groups:

1. Governmental (civil, for service personnel and educational)
2. Non-Governmental, including mission and not for profit health institutions such as private medical schools
3. Private, for profit nursing homes/hospitals

National Health Care System (NHCS) comprises district-level health care, referral health care and central and specialized health care system. The district health care system includes three tiers: community first institutional and district-level health care. Only primary health care services are available at the community level, which is supported by Female Community Health Volunteers (FCHV), Trained Traditional Birth Attendants (TBA) and two types of outreach clinics. The institutional set up at the grassroots starts with the sub-health posts (SHP) at the VDC level. The SHPs, along with the Health Posts (HP) and Primary Health Care Centers (PHC) or Health Centers (HC) in the electoral constituencies, are grouped into one category and commonly identified as 'first institutional health care". These institutions are responsible for the delivery of disease-control services, reproductive health care services, child health care and nutritional services importance is given to alternative medicine as is evident from the presence of District Ayurvedic Health Centers.

The age 65 years and above are categorized as senior citizens. According to the administrative set up of Nepal, Village Development Committee (VDC) and municipal ward office are the fund-distributor of the old age allowance for the elderly above 70 years in the rural and urban areas respectively. Recently the Government has increased the old age allowance Nepalese Rupees (Rs.) 200 into NRs.500 of monthly basis. However, it is not sufficient for normal daily living.

There are not any geriatric hospitals in the country. However, the geriatric ward in

government and some private hospitals is to be set up at the national level to provide treatment for the elderly. From 2001, a senior citizen can get NRs. 2000/ at a time for medical treatment and a total of NRs. 4000/ in a year. Poverty affected elderly people are provided free medicine and treatment up to NRs. 4000 at a time in a limited areas in all 75 districts (max budget is NRs. 100,000 a district) through a bureaucratic scrutiny.

To achieve equity in health, the concept of access assumes a central role. The purpose of increased access is to assure that all people but particularly those whose health needs often are not being met, are able to use services at rates proportional and appropriate to their need for care (the most vulnerable groups; women and children; the rural population; the poor; the disadvantaged and marginalized). Thus the individual dimensions of access which affect a person's ability to make use of the health system will be addressed in health sector development - geographic/physical access, economic access, social/cultural access and organizational access.

The constitutional right to health care is being translated into a policy of universal free essential health care. In December 2006, emergency and inpatient services were declared free for the disadvantaged, destitute, underserved, the elderly, the people living with physical and psychological disability, and Female Community Health Volunteers (FCHVs), at district hospitals and primary health care centers (PHCCs). Moreover, outpatient care was declared free in 35 low human development indicator districts. In October 2007, Government of Nepal further decided to offer essential health care services free of charge to all citizens at all health and sub-health posts from mid-January 2008. Commitment to health sector as part of development oriented social justice, Ministry of Health and Population (MoHP) developed Health Sector Strategy (HSS) with an aim to provide an equitable, high quality health care system for the Nepalese people residing in the poor to reach un-reached, ultra poor, marginalized and provide Essential Health Care Services. The goal of HSS is to achieve Millennium Development Health Goals (MDHGs) with improved health outcomes for the poor and those living in remote areas and consequent reduction in poverty. It aims to improve the health status of Nepalese population through increased utilization of health services by the rural poor, marginalized and vulnerable population.

The Nepal Health Sector Programme -Implementation Plan (NHSP-IP) of MoHP is the road map of the Nepal Health Sector Strategy. It envisages increasing the coverage and raising the quality of Essential Health Care Services (EHCS), with a special emphasis on improved access for poor and vulnerable groups using efficient sector wide health management system and provision of adequate financial resources. Therefore, the post PHC effect has assured social justice in health sector by MoHP through implementation of NHSP-IP which will guide for undertaking all health related activities in Nepal.

Likewise, the Government of Nepal has been prepared a three year interim health plan to enhance the well-being and quality of life of their citizens. The future course of action will be guided by the objectives and activities formulated in this plan. In order to achieve the objectives, some of the key activities for the initial period of

planning cycle are:

• To strengthen on-going high priority EHCS and achieve MDGs in accordance with the principles of Primary Health Care, equity and social justice

• To redesign health system to make people oriented, efficient and effective through reform in institutional management and health professional education

• To ensure availability of good quality services and essential medicines to all at affordable prices

• To strengthen public private partnership

• To develop performance based planning and budgeting system

• To strengthen financial information system including monitoring and feedback

• To encourage the implementation of decentralization approaches in health service delivery system.

• To develop capacity of the health workers and stakeholders involved in health facility operation and management

4.2.4 Social Status of Elderly in Nepal

In Nepal, though only recently, aging is considered as an economic problem; socially it is considered, since ancient time, the continued upgrading in social status. Higher the age of a person, more is his/her social status. Eldest male member of the family or the community automatically takes the role of head- ship in the family/community. Almost all social and religious activities are guided as well as performed by him. His views and words are taken as the rules and regulations to be followed by the community / family members. Also individuals who manage to survive more than 75 years of age are considered as those who have attained the god hood. In Newar society of Nepal, elderly persons are facilitated as gods in attaining certain ages through three different ceremonies called Janku. First ceremony is conducted when a person attains the age of *77th year, 7th month, 7th day, 7th hours, 7th minute 7th Pala (Lowest unit of Nepalese chronological time)* and second ceremony is conducted at age of 84 and third at the age of 90 years. This shows the high respects shown by Nepalese towards their elderly persons.

Considering the physiological aspects of aging, Nepalese law have made provisions for protecting elderly persons from possible misuse of their physical and mental disabilities. Nepalese law prohibits making any property and financial transactions with elderly persons aged 75 years and above in absence of his /her near and dear ones. Also, there is a system of providing free foods and lodging to old persons who were discarded by their relatives (examples: Pasupati Bridhasram, Tripurshowr temple and other religious places). Besides at present, government of Nepal is giving pension of Rs. 500 per month to all those who are aged 75 years and above. It is very good gesture shown by the government to its senior citizens. Similarly, the expressions *Hajurba (Baje) hunu* or *Hajuraama (bajai) hunu* (local terms for grand parental generations) and also the term *Kura sunnu bhudha ko* (listen to elderly) bear the meaning of attainment of elderly status.

4.2.5 Nepalese Tradition in Caring For Aged

The Pluralistic, multi-religious and mosaic culture of Nepalese society has adopted and adjusted with the culminating onslaught of western life styles and culture. The villages are no longer be set with old aged cultural and social tradition. There are signs of transformations in every sphere of social life, be it of social values, life patterns, customs and usages. The modern amenities and materialistic development has suppressed outwardly the foundation of spirituality, the basis of Nepalese society.

The care and honor given to the elderly in traditional Nepal is structured through socialization. Children are brought up to treat the grandparents as if they are deities. During auspicious occasions such as during alphabets learning (Saraswati puja) and for the atonement of misdeeds children are made to pray to the elderly for blessing and forgiveness. Children and visiting relatives fall at the feet of the elderly and pray for blessing. During Dasain festivals (Hindus greatest festival) especially elderly aged persons are revered and are to be respected first.

The elderly in Nepal play the most active part in the socialization of children. A good part of the socialization is done through storytelling, of which their life stories and those of ancestors become dominant. As a result the children are integrated into the family and society by developing associated cognitive structure in them. Children grow with awe for the knowledge of their grandparents and are deeply attached to them because of the love and care they give to the grand children, It is expected in Nepali tradition when people are old they will be respected, obeyed and taken care of. Even today the old people retort to the young ones that "they may know much that is in books, but we know the real things that come only with experience"(Regmi, 1993, pp. 29-33).

4.3 Active and Healthy Aging

4.3.1 Introduction of Active Aging

The current paradigm of aging as a “dependent” stage of life and our attendant social welfare policies, do not match up either with current realities or with likely scenarios for the 21st century. It is an opportune time to consider new definition of “aging,” work, retirement, education and leisure, including rethinking today’s chronological benchmarks for engaging in life’s major activities. Aging reflects the desire and ability to many seniors to remain engaged in economically and socially productive activities. Stereotypes of seniors as unproductive and dependent are unfair and detrimental to the vitality of society as well as the dignity of individuals (U.S. Department of Health and Human Services, 1997).

The word “active” refers to continuing participation in social, economic, cultural, spiritual and civic affairs, not just the ability to be physically active or to participate in the labor force. The term “active aging” was adopted by the World Health Organization in the late 1990s. It is meant to convey a more inclusive message than “healthy aging” and to recognize the factors in addition to health care that effect how individuals and populations

age (Kalache and Kickbusch, 1997). The active aging approach is based on the recognition of human rights of older people and the United Nations Principles of independence, participation, dignity, care and self-fulfillment. Active aging is the process of optimizing opportunities for health, participation and security in order to enhance quality of life as people age. Active aging applies to both individuals and population groups. It allows people to realize their potential for physical, social and mental well being throughout the life course and to them with adequate protection, security and care when they require assistance (WHO, 2002).

4.3.2 Determinants of Active Aging

Active aging depends on a variety of influence or "determinants" that surround individuals, families and nations. Understanding the evidence we have about these determinants helps us design policies and programs that work. These determinants are; behavioral and personal determinants, determinants related to physical and social environment, economic determinants and health and social services.

1. Behavioral determinants: Lifestyles: use of alcohol, tobacco, eating habits and medications and so on). 2. Personal determinants: Biology and genetics and also psychological factors such as lack of motivation, low expectations and lack of confidence and social factors (loneliness and isolation). 3. Determinants related to physical environment: Such as Safe housing, falls, clean water, clean air and safe foods. 4. Determinants related to the social environment: Social support, violence and abuse, education and literacy. 5. Economic determinants: Income, work. 6. Health and social services.

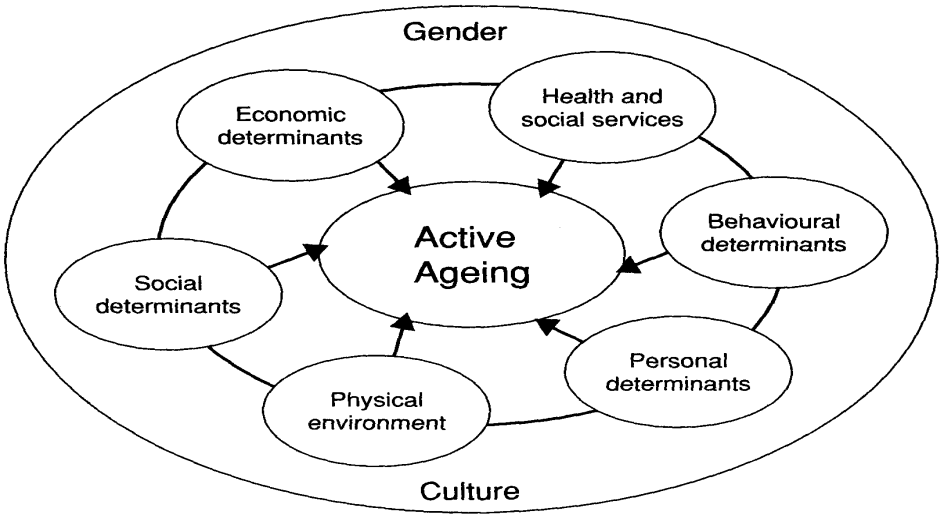


Figure 5 Determinants of Active Aging

Source: Kalache et al. (2005)

These determinants apply to the health of all age groups and become particularly important as individual age. All these determinants need to be approached while paying close attention to two critical dimensions: the *cultural* context where one lives and *gender*, also paramount importance to the aging process (Kalache et al.; pp. 41-43).

As Usui (2003) noted the Japanese people will tend toward "active aging" not just because they enjoy good health, but because they do not view leisure-based retirement as an entitlement. That is, they do not expect to completely take it easy at the end of a long career, partly because Japan's public pension programs are relatively new (introduced in the 1960s) and partly because continuing as a productive member of society is seen as virtuous. Thus, leaders in Japan can more feasibly implement policies for encouraging active aging compared to other countries where generations of people have looked to retirement as "prepaid leisure." Likewise, Jacobzone (1999) also argues that an active ageing approach requires the provision of long-term care services to be better integrated with other social policies. This is needed both to foster efficiency and to enable equitable access to care for all, and particularly those with the greatest needs. The OECD is promoting a general strategy of active ageing to respond to the challenges of ageing. This implies major reforms in the field of pensions and health care to adapt them to a changing environment. More effective health and long-term care spending should be promoted. As people are living longer and healthier lives, health and long-term care services should remain cost-effective and meet the most pressing requirements: reducing time spent in dependence and time in chronic care. This means that medical research and technology should be focused on the reduction of dependence arising from conditions

which particularly afflict older people, such as senile dementia or arthritis. As demographic trends point to a particularly large growth in the numbers of people in the oldest age groups, explicit policies and financial arrangements for care-giving are needed that deliver efficient and high quality services.

4.4 Healthy Aging

4.4.1 Introduction of Healthy Aging

"Health" refers to physical, mental and social well-being; therefore, policies and programs that promote mental health and social connections are as important as those improve physical health status. Health is seen as a positive resource for everyday living, not the objective of living or the absence of disease (WHO; Canadian Public Health Association; Department of Health and Welfare, 1986). Promoting good mental health is increasingly recognized as a priority in policy and program development for seniors. By working to increase self-efficacy, self-esteem, coping skills and social support, mental health promotion empowers people and communities to interact with their environments in ways that enhance emotional and spiritual strength. It fosters individual resilience and mutual aid. Mental health promotion also challenges discrimination against those with mental health problems and fosters respect for culture, equity, social justice and personal dignity. In light of this holistic understanding of health, healthy aging is defined as follows:

Healthy aging is "a lifelong process of optimizing opportunities for improving and preserving health and physical, social and mental wellness, interdependence, quality of life and enhancing successful life-course transitions" (Health Canada, 2002). This definition takes a comprehensive view of health that includes physical, mental, social and spiritual well-being. From a World Health Organization perspective, a healthy aging approach is one that considers people of all ages' ability to be able to live a healthy, safe and socially inclusive lifestyle within the physical, social and economic fabric of society (WHO, 2002).

4.4.2 Conceptual Framework of Elderly/Seniors' Determinants of Health

The conceptual framework of elderly/seniors determinant of health is shown in Figure 6. The different determinants of healthy aging are concerned to address the needs of seniors. The basic model is applicable to the general population: this adaptation by Rosenberg may be more appropriate to seniors (Anderson, 2005). At this point, it is not possible to attribute direct causation to any one determinant; however, the substantial body of evidence on what determines health suggests that all of these factors (and interplay between them) are the good predictors of how well both individuals and aged persons.

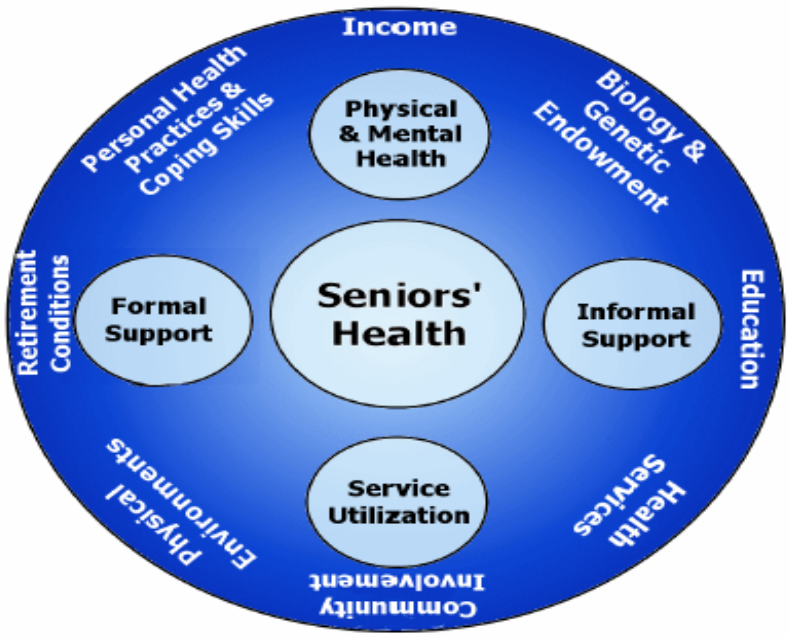


Figure 6: Conceptual Framework of Elderly/Seniors' Determinants of Health

Source; Anderson (2005)

Healthy aging is linked to a combination of interrelated factors of different health determinants. Identified determinants of healthy aging are health and social services, income and social status, social support networks, education, employment and working conditions, social environment, physical environment, biology and genetic endowment, personal health practices and coping skills, healthy development, formal and informal support, service utilization, retirement conditions, community involvement, and two cross-cutting determinants of gender and culture.

In summary, government policies and programs should promote to achieve healthy aging, including full social and economic integration into society of older people with due regard to individual choices and circumstances. The health authorities and other stakeholders should be encouraged to develop active and healthy aging strategies and interventions that take full account of the determinants of health lens. This will ensure that underlying factors for lifestyle behaviors can be defined and addressed.

4.5 Welfare State Regimes and Care for the Elderly (Old Age)

It is difficult to define what a welfare state is, and it is therefore equally difficult to define a topology which can cover the many historic traditions and economic circumstances. It is even more difficult when analyzing and describing the transition from welfare state to welfare society. Many have tried to define the welfare state. The confusion

among writers concerning the delineation of topologies might be the reason why some raise question of whether topologies are just empty spaces in which every country can specify its own characteristics in comparison with others. It could also be argued that typologies are a kind of Pandora's Box. Each new layer taken off reveals a new box with new typological problems, new knowledge concerning how different types of welfare state work and function, and new insights into how welfare state models can be compared. Even without any solid methodological background for theorizing about making topologies and acknowledging the problems of doing so in a comparative perspective, it is, however, worthwhile and a way towards a better and more elaborate insight into the balance between state, market and civil society (Greve, 1996).

As Jespersen (1996) noted that the welfare is created partly by the market system and partly by political decisions. Welfare is not only about redistribution through cash flows from the government; the creation and transformation of institutions are equally important together with understanding of how the entire economic system interacts. Adam Smith observed that 'a man is poor when he cannot appear in public without feeling ashamed'. A welfare society should prevent the creation of circumstances which make people feel poor or where basic human rights are disregarded. In the political sphere the concept of welfare has of course many more dimensions among which to secure the basic human (and political) rights of weak and minority groups within society. This is a crucial part of welfare state as well. In other words, the term "welfare state" is closely linked to Marshall's (1950) concept of social citizenship based on the recognition of materials and social needs to give rise to economic and social rights. An influential way of specifying social citizen rights is linked to Esping-Andersen's concept of de-commodification: the weakening of the connection between income and market participation (Esping-Andersen 1990). As Martin (2005) discusses that the degree to which policies and social security systems are designed in recognition of social and economic rights is reflected in legal entitlements, eligibility, coverage, the linkage of benefits to individual contributions and the existence and level of minimum standards, e.g., minimum benefits or the quality standards of services.

Although, this section will focus on Esping-Andersen's welfare state regimes model but it should be also rational to discuss the Bismarckian and Beveridge systems. The first refers to a social insurance based care system with a strong purchaser-provider split and a wide variety of autonomous not-for profit organizations that provide the services; the second to public provision of services and 'single payer' financing from taxes, where the payer is largely responsible for managing the services. This distinction explains the stakeholders within a welfare regime and their respective responsibilities, as well as how complex it is to match all parties involved. The Bismarckian context requires cohesion and integration between government, providers of care and services, insurance companies, administrative bodies, clients' organizations, and the various governments and their agencies at all relevant layers. In countries with Beveridge systems health care is usually organized at regional level, whereas social and long term care is often a

responsibility of local authorities.

A comparative approach to the study of health care policy is a useful way to see how challenges play out in different systems in different stages of development with their care and health systems. All welfare states have some way of dividing the responsibility for caring for the elderly between the family and formal service systems, but the actual form of this state-family mix varies considerably (Herlofson & Daatland 2001). However idiosyncratic the national models are, all countries seem to share a common concern about the future. They are all trying to adapt to greater longevity, more heterogeneous demand and older populations. There are several differences between different welfare states. There are differences in the mechanisms used to achieve policy goals, the institutional frameworks for formulating and delivering social policy, and the functional relationship between the state, the private sector, the individual and the social groups (Nuland, 2008). Thus, researchers in welfare policy usually refers to welfare models or welfare state regimes, based on ideal-typical classifications of actually existing welfare states (Esping-Andersen 1990, Leibfried 1993). Most welfare state classification however is based on aspects of the role of market vs. state, labor market policy and income distribution. Although health care is an important policy aspect of the welfare state, health care policy and services are less often used as a way to divide welfare states into different regimes.

In order to qualify the relatively stable institutional arrangements between the three providers of welfare; family, state, market- Esping-Andersen (1990) uses the concept of welfare state regimes or models. He identifies three distinct regimes, the liberal regime, the conservative-corporatist regime and the social-democratic regimes. Esping-Andersen employs basically two criteria, de-commodification and universalism, to develop his theoretical structure. De-commodaification means to remove the dependence of people on market by political force and universalism indicates the scope of service provisions, being universal or selective. The first group includes America, Canada and Australia. The second group refers mainly to the Nordic countries. And the third contains countries of the European Continent, such as Austria, France, German and Italy. The Japanese model, according to G. Esping-Andersen, is a hybrid of the liberal and conservative regimes. According to G. Esping-Andersen (1990) the classification of welfare state regimes and care for the elderly (Old Age) as given follows;

(a) The Liberal Welfare Regime

The liberal regime rests on the market and the personal responsibility to provide welfare. Individual savings, private insurance, private care services are at the heart of welfare and these formulas are encouraged by the State (tax relief, subsidies). The other formulas of welfare must remain limited not to disturb the market, the State interferes as less as possible, and this role is ‘residual’. The services poured by the State are modest, and granted under resources, they aim at constituting a low “net of safety” (flat-rate benefits). The public social services are less developed. Social policies are residual, the role of the market is essential. This regime encourages employment, including not well-paid jobs.

The welfare reflects the inequalities produced by the market, with a protection according to the revenue level and the assets level, which minimize the "decommodification", and a limited social assistance for the poorest. In the liberal regime, old age welfare must be founded on non-mandatory personal pension schemes, private insurance and/or company pension funds. It must also include a weak basic regime. Seniors employment is encouraged; rate of employment remains high for the fifty years old and over. The supply of services for old age long-term care is dominated by the private sector-the risk coverage is based on personal responsibility and public assistance only in the case of insolvency of the person and family failure.

(b) The Conservative-Corporatist Regime

The conservative-corporatist welfare regime, according to Esping-Andersen, takes its roots in corporatism and catholic social policies. It is characterized by interventions intended to preserving the status of its memberships (conservative), and to reinforce the distribution resulting from the market. So, the level of de-commodification in this regime is moderate. Its financing is largely done by mandatory social insurance. This model discourages women employment, and encourages the male-breadwinner type of family. Housewives and children are welfare beneficiaries because the family man is insured. Services for family (children care, old age care) are little developed. The finality of the regime is to guarantee the revenue of the worker, on the basis of the former revenues. It thus contributes to the maintenance of the differences of status and the inequalities of income. It is described as "supporter of corporatism" because it is founded on an organization by "corporation" or "employment status". The professional solidarity plays an essential role, centred on the people well positioned on the labor market, providing to the workers social security benefits in relation to their professional position. That's why we'll prefer to use the terms of "mandatory social insurance" to qualify this model insofar as its financing is widely based on social contributions.

The mandatory social insurance model perfectly protects the insiders on the job market. On the other hand, it badly protects the outsiders excluded both from work and social protection. This model is also questioned by the purpose to guarantee the equality between men and women and by the individualization of the social protection rights.

Old age welfare in this model is based on a system of compulsory insurance for the employees (and often self-employed workers). Retirement pensions depend on the former income, the contributions, and the duration of insurance. Several distinct pension schemes coexist according to the status (corporatism). For the old age long-term care, social insurance-based welfare must logically leads towards the idea of a risk covered by a new mandatory social contribution, or an increase in the existing social contributions.

(c)The Social-Democratic Welfare Regime

In the social-democratic welfare regime, the social rights are founded on the principles of universalism and egalitarianism. The Welfare state guarantees a high level of living conditions, high welfare transfers and wide public services, all financed by high levels of taxation. This regime results in a mix of highly decommodifying programs and

universalistic programs. It leads towards individual emancipation, from both market and traditional family. The welfare state directly takes the responsibility of collective public services (children care, old people care), it follows a “de-familialisation policy”. The public services allow meeting the needs of the families and at the same time allow women choosing to be engaged in a profession rather than achieving care services. Employment in the medical and social services is then particularly high. The financing is largely ensured by high taxation. The strong public support to the families encourages the employment of women and releases women from the dependence of the patriarchal model. The welfare expenditures serve a strategy of “de-familialisation”.

In this regime, old age welfare must be based, for retirement, on a hybrid system, associating a universal scheme delivering fixed allowances and mandatory schemes related to the income or to the contributions. The rate of employment for seniors is high, without implying an increase in precarious work or non-standard employment, thanks to life-long learning policies, prevention and adaptation of jobs. The old age long-term care must be largely ensured by a supply in local public services. Long-term care founded on public services allows to create jobs with standard employment relationship (i.e. full-time and continuous work with one employer).

CHAPTER FIVE
REVIEW OF RELATED LITERATURE

5.1 Theoretical Literature

5.1.1 Historical Perspectives of Aging and Caring for the Elderly

According to Hindu ideology, life span (which is of one hundred years) is divided into four stages. First 25 years is called "Brahmacarya" or the student life, the life of a celibate. In the next stage "Grhastha" or the life of a householder, a man marries, begets children and pays of his debt to society, gods and to parents. The third stage is called "Vanaprastha". The fourth stage is called “Samnyasa". Each stage had its duties and goals. The stages of life correlated with the aging process so that by the end of a life time, a person's experience would have provided time for reflection and moving to greater truth. This also provided a smooth transition of generations. As a person grew old, he moved away from familial, personal to more social and spiritual thus allowing the young to replace him in power positions. Youth and middle age are for fulfilling one's desires and duties; old age is for spiritual liberation or "Moksha". Filial piety and caring for old was reinforced in culture. Caring for an aged relative was a way of fulfilling duties of a householder and paying one's debt owed to elders and as such was a valued activity. There were also several 'rites of passage' to initiate people into different stages. For example a person who completed his 60th year would be felicitated in a religio-social ceremony. Similar ceremonies were held at the 70th year and after completing 83rd year. This was called 'Sahasra Poorna Chandra Darshana'- that is the person would have seen one thousand (Sahasra) full moons (Poorna Chandra) by then. The great grandson would honor the great grandparent by showering leaves made of gold on them in a ceremony called "Kanakabhisheka". These were cultural ways of helping people cope with the aging process and also the cultural practice of honoring longevity.

Nepal had its own method of dealing with the process of aging and dying. The views on life, life cycle and aging emerged within the Nepalese social historical setting over a long period. Nepalese thought has been influenced by the Vedas, Upanishads, by Buddhist ideology and has incorporated several world-views.

*When Buddha was still **Prince Siddhartha** he often escaped from the splendid palace in which his father kept him shut up and drove about the surrounding countryside. The first time he went out he saw a tottering, wrinkled, toothless, white-haired man, bowed, mumbling and trembling as he propped himself along on his stick. The sight astonished the prince and the charioteer told him just what it meant to be old.*

*'It is the world's pity' cried **Siddhartha,** 'that weak and ignorant beings, drunk with the vanity of youth, do not behold old age! Let us hurry back to the Palace. What is the use of pleasure and delights, since I myself am the future dwelling place of old age.' (Christopher Foote and Christine Stanners, 2002, p.25).* For the above description, old age is one of the dependent ages, which is transparent of the less economic activities and

deficient of mental and physical abilities and capacities.

Saito (2007) states caring process as of Buddha's caring thought is shown in the following figure 7.

Basic needs:	Clothes, Cleanliness
Spiritual support:	Get close to each other, Caring
Self-realization:	Acceptance of death and end of life

Figure 7: Buddha's Care for the Elderly

Source: Saito (2007)

Here we can see the visualization of care: Satisfying of basic needs, getting close to each other and helping one to accept his own situation (to die). Moreover, Buddhism inspires us to meditate on the aged, who will die and need care, but also on the carer. Saito (2007) cited from Shinmura (1991) that in Japan the dignity was traditionally maintained through an understanding of their practical usefulness to the community/family through their manpower for labor, wisdom & experience, ability to coordinate groups of people, and so on. Moreover, in the Japanese tradition seniors took a central role in memorial services, and by telling stories about the deceased, they create a connection between the living and those who passed before. In passing away themselves, they would become guardians, constantly looking over the family to protect them. These perceptions retained the dignity of aged members of the family and community. Family memorial services installing the deceased family member as a guardian are an institution that continues even today. But in our current modernization, perception of the practical usefulness of our aged members is being lost, and even the traditional ceremonies/institutions are undergoing changes. Similarly, he further discusses the views of Zhou (1993) to the traditional Japanese idea of respecting the aged is related to Confucianism. According to the teaching of Confucius, Japanese have natural feelings of love and respect for those nearest to us others, children, and other near relatives. However, training and conscious discipline are necessary to amplify and apply these feelings to the extended family, region and country. And this process was considered part of study and learning in Confucianism. However, the idea of respect for the aged is based on a weak foundation and, nowadays, in fact that dignity seems to be steadily decreasing (pp.29-30). In Buddhist culture, the children believe that "up keeping of the elderly parents and pay high respect" brings the high merits for them. The eldest son would inherit the family residence and assets and in turn would be responsible for his parents in their old age (Siddhisena, 2005).

Confucius described old age in chronological terms: *'At fifteen, I applied myself to wisdom; at thirty, I grew stronger at it; at forty I no longer had doubts; at sixty there was*

nothing on earth that could shake me; at seventy I could follow the dictates of my heart without disobeying the moral law.' In the family, which the Chinese viewed as a microcosm of society, all members owed strict obedience to the oldest man. A man's fiftieth birth day in ancient China and for centuries thereafter was marked with great ritual and reverence. Maturity, declared the stages, deepened an elder's affinity to family ancestors. Because the age was critical in the Confucian world view; older women prevailed over their sons and daughters. Likewise, the ancient Greeks believed that specific diseases afflicted certain stages of life. Hippocrates catalogued old age maladies in his *Aphorisms* (400 BC): ' To old people, dyspnoea, catarrhs accompanied with cough, dysuria, pains of joins, nephritis, vertigo, apoplexy, cachexia, pruritus of the whole body, insomnolency, defluxions of the bowels, of the eyes and of the nose, dimness of sight, cataracts.' Cicero (106-43) acknowledged, but did not accentuate, the negative consequences of aging. He argued in *De senectute* that years of experience more than compensated for the physical decline that came with advancing age (Johnson, 2005:22).

The life course perspective insists that to make sense of old age, we need to understand the entire life history. As people move through the life course, they are socialized to act in ways appropriate to successive different social roles. But these structural factors only set boundaries; the meaning and experience of aging varies significantly by culture and influenced by powerful factors such as gender, socio-economic status and ethnicity. There is also room for individual variety and freedom of choice as human beings interpret age-related roles in distinctive ways.

The simplest concept of the life course has been a division into two stages: childhood and adulthood. But as societies become more complex, they tend to develop a greater number of life stages. Greek and Roman ideas were influential in shaping how we think today about aging and the life course. One of the greatest Greek tragedies is the three part Oedipus cycle, the last play written its author, Sophocles, was nearly 90 years old. In this story, Oedipus became king because he solved the famous riddle of the Sphinx: "What creature walks on four legs in the morning, two legs at noon, and three legs in the afternoon?" The answer is the human being at successive life stages: infancy (crawling on four legs), adulthood (walking on two), and old age (using a cane, a third leg, to support the other two). The Greek medical writer Hippocrates described four stages of life, or "ages" corresponding to the four seasons of the year. The Roman astronomer Ptolemy developed an idea of seven stages of life, which had great influence during the middle ages. Christian civilization balanced the image of multiple stages with the metaphor of life as a journey or a spiritual pilgrimage. From the standpoint, no single stage of life could be viewed as superior to another. Just as the natural life cycle was oriented by the recurrent cycle of the seasons, so the individual soul would be oriented toward the hope of an afterlife. The human life course as both cycle and journey was thereby endowed with transcendent meaning and wholeness (Cole, 1992, Moody, 2006).

Aging is progressive attainment of ages of last stage of maximum life span of human being. Despite its universality, aging is difficult to define. *Shakespeare* probably

characterized it best in his elegant description of the seven stages of man. It begins at the moment of conception, involves the differentiations and maturation of the organism and its cells at some variable point in time, leads to the progressive loss of functional capacity characteristic of senescence, and ends in death. With age, there are physiological and structural alternations in almost all organ system. Aging in individuals is affected to a great extent by genetic factors, social conditions and the occurrence of age related diseases. In addition, there is good evidence that aging -induced alternation in cells is an important component of aging of the organism. To Shakespeare, the periods of life were merely "roles" acted out on the stage of society, and the role losses of old age appeared as the final act of the play. Thus, a theatrical metaphor replaced the ideal of a cosmic cycle or a spiritual journey. A generation after Shakespeare, drawings and engravings began to depict the stages of life in a new way. The traditional image promoted the idea of life as a "career," in which individuals could exercise, and capital accumulated through, for example, extended education, good health care and capital accumulated through savings during earlier stages. By the 20th century, as the practice of retirement became well established, old age became a distinct phase as well. Today, new distinctions are made between the young-old, the old-old and oldest-old. Age grading refers to the way that people are assigned different roles in society depending on their age. Theorist of age stratification emphasize that a person's position in the age structure affects behavior or attitudes (Moody, 2006).

According to Foote and Stanners (2002:17) the status of older people in their life journey are relevant to classify into different phases: *Those entering old age:* People who have completed their career in paid employment and/or child rearing and are active and independent. *Those in a transitional phase:* People who are in transition between healthy active life and frailty. *Those who are frail:* People who are vulnerable as a result of health problems or social needs. *Those at the end of their lives:* People who are facing social, health and emotional issues in the last years or months of their lives. In essence, the perceptions of aging remain in transition. Older persons today, and increasingly in the twenty-first century, will have added years to fill that their parents and grandparents did not have. This extension of the 'average' life-course permits greater individual differentiation than ever before.

5.1.2 Theories of Aging

It is important to understand that different theories offer different levels of understandings, particularly in relation to human circumstances and human behavior within any given society or culture. At the micro level, theories attempt to make sense of the broad characteristics of elderly people as a group. At this level, theories profound a particular view of old age within its societal context-that is, they construct an image of old age. The image created by the various theoretical perspectives-biological, psychological, sociological, political-economic-are intrinsically different and create quite distinct pictures of the experience and social condition of the older people. However, as practitioners and

people interested in understanding and helping older people, we also need a range of theories at the 'micro' level to help us make sense of the particular situation of an individual older person. At this level, we might need to draw upon theories of gender and race and how these factors interact with old age; knowledge and theory about mental health, family dynamics, systems theory or crisis intervention.

Gerontology has a number of streams within each of which different perspectives are discernible: biological, psychological and social. Biological or biomedical perspectives have generally focused upon the search for the reasons why and how human beings change over time in terms of their biological and physiological characteristics.

Bromley (1988) suggest that 'human aging can be conveniently defined as a complex, time-related process of psychological deterioration occupying the post-development (adult) phase of life'. Similarly, Strehler's (1962) attempt to define aging more precisely and to distinguish aging form other biological processes. In so doing, four criteria of the aging were identified:

a) **Universality**- the process must happen to every person.

b) **Internality**- the process must be initiated from within the organism and not by some external hazard or consequence of lifestyle.

c) **Progressiveness**- the processes occur gradually, over time and the effects are cumulative.

d) **Degeneration**- the process must have a harmful effect on the person.

A number of biological theories have attempted to explain why human organisms change biologically as they age:

1) Programmed cellular activity. Human cells are thought to have a pre-programmed fixed life and a self-generative capacity that decreases with age. Thus, as a person ages, so the capacity of cells to reproduce decreases and the time taken to reproduce increases, resulting in a gradual loss of functional abilities.

2) Mutation consequences. As cells divide, errors and unprogrammed mutations occur, producing cells not designed and therefore less efficient, for sustaining the functional activities essential to life.

3) Immune system activity. The immune system produces antibodies in response to invading cells or organisms. However, these antigens themselves are thought to catalyze aging changes, as a byproduct to their immune response activity.

The broader points of view there are three main perspectives towards the study of aging: the biological, the psychological and the social;

Biological theories address aging processes at the organism, molecular and cellular levels. These biological theories also help to understand why and how aging occurs. Biologist refers to aging as 'senescence'(normal biological aging). This describes decreases in the efficient functioning of an organism with age as a result of natural processes rather than abnormal processes which bring about pathology and disease (Ebrahim and Kalache, 1996). There have been various attempts to define the biological changes and characteristics which accompany growing older in all forms of life. Aging is

viewed as an involuntary phase in the development of the organism which brings about a decrease in adaptive capacities and ultimately death. Aging is a normal process; distinguishing this normal process from pathology and disease remains a key challenge. Disease and age-related change have been linked together and have contributed to many of our negative views of aging by a concentration upon decline and dysfunction (Victor, 2005).

Psychological perspectives of all varieties have been much more concerned with understanding childhood and child development and the behavior of younger people generally, than illuminating the process of aging from a psychological perspective. Theories which define aging as development rather than degeneration imply a different set of assumptions and propositions. Erikson (1965) hypothesized that each individual's life progresses through a series of psychological stages, each of which involves a psychological conflict, the successful resolution of which is important in determining how the individual is able to meet the challenges and conflicts of subsequent stages of life. Victor (2005) states the psychological approach concentrates upon examining personality, mental function and notions of self and identity. The psychologist is interested in both differences in behavior between individuals and changes within individuals with the passage of time. Hence this perspective is distinguished from the cellular/organ system approach of the biologist and the structural/social factors approach of the sociologist.

Social gerontology in all its forms has sought to understand elderly people and their life-worlds within a societal context, different generations of social gerontological theory have conceptualized the individual–societal dialectic in different ways. The sociology of aging is concerned with using sociological perspectives to understand aging. Social gerontology is a wider discipline in that it is concerned with approaching aging from a variety of social science perspectives in order to achieve a better understanding of aging and old age rather than for developing sociological theory and insights. As such social gerontology incorporates three distinct perspectives; individual, social and societal-at two levels of analysis, the micro scale and macro scale. The micro scale approach is concerned with understanding and explaining aging as an individual experience, as changes in perceived age identity as the individual progresses through the life course. Likewise, aging occurs within a social context ranging from the micro scale of the family to the macro scale of the whole society or culture or increasingly of a globalized world. The study of aging examines the social context which defines aging and seeks to understand the position of and experience of older people within society and how this is shaped by major structural factors such as class, gender and ethnicity. The meaning and impact of the constraints operating upon the older adult are highly dependent upon the social environment in which the individual encounters them. The societal aging is concerned with the demographic, structural, cultural and economic transformation resultant from the increase in the number and proportion of older people within society (Victor, 2005: pp. 5-6).

Theories of aging not only offer competing perspective for understanding the aging process and circumstances and experiences associated with old age, they each

embody a particular view of the relative importance of individual characteristics and social factors. Each is also based on an underlying assumption about what it is to be human in general and what it is to be an old human in particular.

1. Modernization Theory

According to modernization theory of aging the status of the elderly declines as societies become more modern. The status old age was low in hunting and gathering societies, but it rose dramatically in stable agricultural societies, in which older people controlled the land. With the coming of industrialization, it is said, modern societies have tended to devalue older people. Modernization theory of aging suggests that the role and status of the elderly are inversely related to technological progress. Factors such as urbanization and social mobility tend to disperse families, whereas technological change tends to devalue the wisdom or life experience of elders, leading to a loss of status and power (Cowgill, 1986).

The dramatic demographic shift which is taking place in the country directly and indirectly affects every sector of society as well as health and well-being of the elderly. The aging and care for the elderly seems to be influenced by the modernization theory. The modernization theory of Cowgill & Holmes (1972) as applied to aging states that symptoms causing societies to evolve from rural and agrarian social and economic systems to urban and industrial ones also cause change in the position that the elderly occupy in the society and the esteem afforded to them. The general thesis of the theory is that modernization results in a relatively lower status of the elderly in any society. Modernization results in increased life expectancy and decrease in fertility because modern technology brings with it means to improve life and birth control. Cowgill (1986) further defined modernization as the transformation of a total society from a relatively rural way of life based on animate power, limited technology, relatively undifferentiated institutions, parochial and traditional outlook and values, toward a predominantly urban way of life based on inanimate sources of power, highly developed scientific technology, highly differentiated institutions matched by segmented individual roles and a cosmopolitan outlook which emphasizes efficiency and progress. The consequences of modernization and urbanization will certainly contribute to the loss of a great deal of power and prestige of the elderly and also affect the care of elderly (p. 54~55).

2. Disengagement Theory

Disengagement theory of aging looks at old age as a time when both the older person and society engage in mutual separation, as in the case of retirement from work. This process of disengagement is understood to be a natural and normal tendency reflecting a basic biological rhythm of life. In other words, the process of disengagement is assumed to be “functional,” serving both society and the individual. Disengagement theory is in fact related to modernization theory. It was assumed that the status of the elderly must decline as society became more modern and efficient, so it was natural for the elderly to disengage (Moody, 2006:8). Disengagement theory is a functionalist perspective, portraying the mutual withdrawal of old people and society as a process which ensures continuity of the

system and the equilibrium between different social groups.

Successful aging is defined as the acquiescent, tranquil acceptance of social withdrawal and the characteristics or quality of life which follows such withdrawal. Implicit within this prospective is the view, therefore, that old people differ from younger people in their desires, wishes and needs, especially in terms of purposeful roles, social interaction and activity. The results demonstrated that meaningful roles, activities and relationships were equally important to satisfaction with life in old age as at younger ages. Thus, while not commenting on the social conditions which lead to withdrawal, 'activity theory' challenged the underlying assumption of disengagement theory that old people are essentially a different breed and that old age is existentially, a qualitatively different time of life. Activity theory re-attached old age to the continuum of life and reconnected old people to their own histories and to the rest of the population.

3. Activity Theory

Activity theory of aging argues that the more active people are, the more likely they are to be satisfied with life. Activity theory assumes that how we think of ourselves is based on the roles or activities in which we engage: We are what we do, it might be said. Activity theory reorganizes that most people in old age continue with the roles and life activities established earlier because they continue to have the same needs and values (Moody, 2006:9-10).

Activity theory is a prescriptive view of aging which argues that activity and engagement offer the path to successful aging. This is a socially based manifestation of the 'use it or lose it' conceptualization of successful aging and is the mirror image of disengagement but is equally judgmental and prescriptive. There are two central assumptions of activity theory. First, that morale and life satisfaction are positively related to social integration and high involvement with social networks: those with high levels of activity and integration are more satisfied. Second, role losses such as widowhood or retirement are inversely correlated with life satisfaction and such losses need to be compensated for by the substitution of compensatory activities (Victor, 2005: pp, 24-25).

4. Continuity Theory

The continuity theory of aging makes a similar point, nothing that people who grow older are inclined to maintain as much as they can the same habits, personality, and style of life they developed in earlier years (Costa and McCrae, 1980). According to both activity theory and continuity theory, any decreases in social interaction are explained better by poor health or disability than by some functional need of society to "disengage" older people from their previous roles. Continuity theory suggests that in the process of aging, the person will strive to preserve the habits, preferences and lifestyle acquired over a lifetime; that there will be a process of evolution of activities as the individual grows older (Atchley, 1999). Continuity theory, in contrast, starts from the premise that the individual will try to preserve the favored lifestyle for as long as possible. It then suggests that adaptation may occur in several directions according to how the individual perceives his/her changing status.

5. Age Stratification Theory

This is another good example of a theory which is concerned with the adaption of groups, rather than of individual older people. Society is often conceptualized as being stratified or divided, along a number of dimensions such as social class or ethnic status and these factors are used to allocate social roles. Age stratification theory uses chronological age as the defining and role allocation variable (Riley, 1971). Three basic issues dominate age stratification theory: first, the meaning of age and the position of age groups within any particular social context, second transitions which individuals experience over the life cycle because of these social definitions of age and third, the mechanisms for the allocation of roles between individuals. Riley further argues that each age group (young, mid-life and old) can be analyzed in terms of the roles that members of that group play within society and how these are valued. The use of chronological age in guiding the allocation of social roles is probably universal to all cultures, but the precise nature of these age norms reflects the culture, history, values and structure of specific societies. According to Brown (1996) age stratification is valuable in providing a comprehensive view of aging and in drawing attention to the fact that the situations in which elderly people find themselves do in fact change, in some ways to their benefit and in other ways to their detriment.

6. Wear and Tear Theory

The organic process of life is a delicate balance between forces that wear down structures-forces that lead to cell death, for instance-and those that repair damage at the molecular and cellular level. The structure and metabolism of each living thing maintain this balance over time. But over time, the balance begins to shift: Damage occurs faster than it can be repaired. Moreover, repair capacity is not unlimited; mechanisms for maintenance and repair can be maintained only at a certain cost (Moody, 2006:18).

Like the effect of wear and tear, the action of free radicals contributes to physical aging. As they engage in metabolism, all cells produce waste products. Among those waste products, or molecules of ionized oxygen, which have an extra electron. Those ionized oxygen molecules cause damage because they more readily bond with proteins and other physiological structures. Certain physiological processes can fight the effects of free radicals, but over time the reduction of functional capacity damages the organism. Free radicals have been implicated in many processes of physical aging (Moody, 2006:19).

Moody (2006) further discusses that the decline of the immune system is another important mechanism of physical aging. The immune system's job is to defend the body from invaders like viruses, bacteria and parasites. To perform this job, it sends a variety of cells, which are categorized as T-cells, B-cells and accessory cells, coursing through the body. These cells interact in complex ways to destroys or neutralize antigens, the foreign organisms that trigger an immune response. The cells of the immune system also remove damaged and mutant cells produced within the body, which may become cancers. With normal aging, the immune system's ability to fight off invaders and mutants gradually declines (pp.19-20).

7. The Collagen Theory

Collagen is a substance found in connective tissue (Atchley, 1977). Large amount of collagen are found in the skin, bones and tendons. Collagen is an important component of the walls of blood vessels and contributes to their strength as well as the strength of scars. Collagen stiffens with age, and as a result, tissues containing collagen lose elasticity. The increased stiffness is caused by change over time in the cross linkages between the strands of the collagen molecules. The actual amount of collagen in tissues may decrease with age, or there may be proliferation of collagen due to some stimulus, such as death of parenchynal cells, inflammation or physical injury (Beaver, 1983).

8. Cognitive Theory

The cognitive theory of aging argues that it is perception of change, rather than actual objective change itself, that that has the most impact on behavior. Cognitive, emotional, and motivational factors shape the way we perceive any event, and adjustment depends on a balance that changes over the course of life. Studies of stress and coping in old age reveal individual differences in mastery depending on perception and adaptation . Cognitive functioning is a critical issue because it is the aspect of psychological functioning most affected by aging. In addition, cognition has a greater effect than the other types of psychological functioning on the ability to perform the activities of daily living. Cognitive skills such as remembering, solving complex problems, paying attention and processing language are affected by age and disease-related changes in the brain (Moody, 2006:21-22). Although much research remains to be done on cognitive capacity in old age, particularly among the oldest-old, it is safe to say that the old stereotype of feeble-minded seniors is not only counterproductive but also inadequate as description of cognitive functioning in later life. Older people do lose some thinking abilities, but the losses through normal aging are gradual and for the most part can be accommodated until very late in life.

9. Lifespan Development Theory

Lifespan development theory conceptualizes ontogenetic development as biologically and socially constituted and as manifesting both developmental universals (homogeneity) and inter-individual variability (differences in genetics and in social class). Using the lifespan development perspective, Baltes and smith (1999) identify three principles regulating the dynamics between biology and culture across the ontogenetic life span: first, evolutionary selection benefits decrease with age; second, the need for culture increases with age; and third, the efficiency of culture decreases with age.

10. Personality and Aging Theories

Theories of personality and aging focus on the extent and nature of personality stability and change over the lifespan. There are two categories of explanation of age related changes in personality; the developmental explanations and the personality trait explanations. The developmental explanations as represented by Erikson's (1950) stages of development (adulthood and old age, the stages of generativity vs stagnation and integration vs despair). The personality explanations, based on the "big five" factors of

personality (neuroticism, extroversion, openness to experience, agreeableness and conscientiousness). The personality theories postulate that people show a high degree of stability in basic dispositions and personality, particularly during the latter half of their life course. There is growing consensus that personality traits tend to be stable with age whereas key aspects of self such as goals, values, coping styles and control beliefs are more amenable to change.

Personality refers to the complex psychological processes occurring in a human being as he functions in his daily life, motivated and directed by a host of internal and external forces. The processes referred to include perception, cognition, memory, learning and the activation of emotional reactions as they are organized and regulated in the individual.

The individual's personality is shaped by his environment and his response to a variety of situations. It reflects his unique adaptation to his past experiences. An individual's inner core is seen as fairly consistent once it is formed and it is this unique set of personality characteristics that are sufficiently stable across different situations such as school, work, family and old age- to make an identifiable personality that is generally consistent. As a variety of social roles becomes available to older people when they retire and as more people are encouraged to remain in the labor force once they reach their sixty-fifth birthday, both the internal and external aspects of the personality may come to be equal significance (Beaver, 1983).

11. Subculture Theory

Cultures are made up of a number of different subcultures. A subculture can be defined as a group or segment within a society of persons of the same age, social or economic status and ethnic background. People belonging to a subculture share similar interests, friendships, and values. Subcultures develop when certain members of a given category of the population interact with one another more than they interact with persons in other categories. The more older people are excluded from interaction with other age categories, the greater the extent and depth of subculture development. Within the subculture of the elderly, two distinctive and related factors have special value in conferring status. One is physical and mental health. Good health is rare among the elderly and becomes rarer with advancing age. The second distinctive factor in the status system of the aging is social activity.

12. Social Exchange Theory

This micro level theory has been useful in many recent studies in the sociology of aging, particularly those focusing on intergenerational social support and transfers. Applied to aging, this perspective attempts to account for exchange behavior between individuals or different ages as a result of the shift in roles, skills and resources that accompany advancing age.

13. Political Economic Theory of Aging

This theory attempts to explain the situation in which elderly people find themselves today in terms of the conflict over economic and political power having to do

with age-related issues and policies. On the one hand, it analyzes how the policies of providing older retired people with financial resources are actually set to improve the economy and benefit the economically powerful, and, on the other hand, how those policies then become the basis for blaming the relatively powerless elderly for economic crises. It has also been used to explain how the resources allocated to implement age-related social and health service policies have been used to fund the creation of huge self-serving special interest networks more than to serve the elderly themselves.

Political economist theorists point out that part of the consequence of this kind of approach is that it tends to create unnecessary dependency among the elderly. As a social gerontological theory, however, it does not explain all aspects of aging experience, because politics and economics do not determine everything about aging. For example, it does not explain why there is so much diversity in social participation on the part of those elderly with similar socioeconomic backgrounds and physical and mental capacities (Brown, 1996:105-7).

14. Feminist Theories of Aging

Feminist gerontology gives priority to gender as an organizing principle for social life across the lifespan that significantly alters the experience of aging, often in inequitable ways. At the macro-level of analyzes, feminist theories of aging combine with political economy and critical perspectives to examine differential access to the key material, health and caring resources which substantially alters the experience of aging for women and men. Form a feminist perspective, family care giving can be understood as an experience of obligation, structured by the gender-based division of domestic labor and the devaluing of unpaid work. At the micro-level, feminist perspectives hold that gender should be examined in the context of social meanings, reflecting the influence of the social constructionist approach.

In the quest to understand the diverse phenomena of aging, gerontologists focus on three sets of issues: biological and social processes of aging; the aged themselves; and age as a dimension of structure and social organization.

Theories of aging have played an important part in the evolution of the field of social gerontology in the brief history of that are of study. Without them we would be even less sure than we now are of how to interpret the biological, social and psychological meaning of growing old and being old in today's world.

The theories of those gerontologists have thus far developed have by no means provided all of the answers to the questions that trouble us and that we would like to have answered about aging. As we have seen, some give different and even conflicting answers to the same questions. Two basic problems have kept the existing theories of aging from being universally applicable. First, they have largely been time bound and culture bound, finding their validity only in issues related to particular times and places. Second, they have typically addressed specific issues related to aging and being old and have failed to consider the experiences of aging in an individual sense. In essence, while gerontological theory has made an important contribution, it is also important to recognize that there is a

dire need for more universal theories of aging that are more comprehensive and valid across cultures and over time (Brown, 1996).

5.2 Empirical Literature

5.2.1: Literatures Related to International Comparative Study

Kim & Maeda (2001) in their joint paper titled "A comparative study on socio-demographic changes and long term health care needs of the elderly in Japan and South Korea" compares the socio-demographic changes and long-term health care needs of the elderly in Japan and South Korea. More specifically, this study deals with demographic transition, urbanization, population aging, changing family structure, and cross cultural analysis of socio-demographic aspects of the elderly in Japan and South Korea. This study also examines activities of daily living (ADLs), instrumental activities of daily living (IADLs) and conditions of selected items of long-term health care needs of the elderly in Japan and South Korea. This study uses the data from the surveys done in Japan and South Korea, where the same sets of questions were employed at the same time in 1998. The sample size for the Japanese data is 1673 and that of Korean data is 568. A cross-sectional analysis of the Japanese and Korean frail elderly using the 1998 survey data indicates that the proportions of those who are able to do ADLs and IADLs are much greater among the Japanese elderly than the Korean elderly. The analysis also shows that the proportion of the frail elderly who lie down partly or always is much higher among Koreans than Japanese despite the fact that the mean age of Korean respondents is much lower than that of Japanese respondents. Comparing the long-term health care needs of the Japanese and Korean elderly, it may conclude that socio-demographic status of any individual country in conjunction with socioeconomic environment would significantly affect long-term health care needs of the elderly.

Tracey Reynolds and Elisabetta Zontini (2006) in their working paper titled "A Comparative Study of Care and Provision Across Caribbean and Italian Transnational Families" have shown how caring reciprocal relationships operate in ethnic minority families, taking into account both their local and transnational commitments. They focused on different forms of care circulating within trans-cultural and intergenerational kin networks, encompassing caring about and caring for, and on the boundaries within which responsibilities and obligations are negotiated. This cross-cultural comparative analysis revealed both similarities and differences between (as well as within) Caribbean and Italian transnational families. In both groups they found individuals enmeshed in a complex web of relationships linking them to wider kin groups located in a variety of geographical contexts and to their wider communities both in UK and abroad. In particular, they found caring about to be similar for both the minority ethnic groups studied. Caring for, in both groups, is multi-directional, flowing across and within the generations as well countries. Care is a gendered and selective activity and they have shown the different areas of women's and men's involvement as well as the ways in which care is allocated within

families. They also have shown, care is a crucial social resource in sustaining family and kinship relationships. Care provision also can be discussed in the broader community context and encompasses both unpaid and paid work within community associations. In this sense community care reinforces the interdependent relationship between family and the wider socio-cultural context. They suggested that the future policy agenda for family and kinship care should develop policy initiatives that move beyond simplistic notions of dependency and instead reflect the complexity of care provision within families and communities revealing a myriad of reciprocal, interactional and interconnected relationships.

Jacobzone (1999), highlight the trends in disability in his paper titled "Aging and Care for Frail Elderly Persons: An Overview of International Perspectives, Labor Market and Social Policy." The paper presents the general perception of constraints faced by social policy in addressing the challenge of ageing. It discusses the demographic and socio-economic contexts, as well as the impact of trends in disability. Likewise, it evaluates the policy responses designed to foster an active ageing strategy. It analyses current trends in provision for the frail elderly, both with regard to current arrangements and likely projections of needs for long-term care services. Then, it presents policy responses developed by OECD Member countries, and offers prospective insights towards further reforms.

The paper examines the various constraints which OECD Member countries must now deal with, faced with the prospects of rapid growth in the number of frail elderly persons. It pays particular attention to recent trends in disability. Most of the available cross-country evidence shows trends towards better functional health in older populations, although the magnitude of the gains and their significance need further assessment. In this context, this paper advocates an "active aging" approach to long-term care policies. It provides some rough estimates of the macroeconomic costs of long-term care. It also presents some indicators of public/private financing and institutionalization rates. The public costs of providing long-term care are estimated to be relatively modest as a proportion of GDP (of the order of 1 or 2 per cent or less). However, much care for the frail elderly is provided through informal care-giving arrangements which are not reflected in official figures. An active aging approach requires the provision of long-term care services to be better integrated with other social policies. This is needed both to foster efficiency and to enable equitable access to care for all, and particularly those with the greatest needs.

Tiny (2002) has illustrated that due to the increase in the number of older people and the relatively high cost of institutional care, social care policies for older people today in the seven wealthiest EU countries aim mainly to provide in-home services to allow older people to remain in their own home, postponing institutional care for as long as possible. For the most part, long-term care for the most frail is no longer provided in institutions and often nursing homes are being transformed into sheltered housing, usually with access to services similar to those available in the traditional nursing homes. A common strategy for all seven countries is to strengthen community care, although this term has different

meanings in different countries. In some countries, community care is used to describe the de-institutionalization process, i.e. domiciliary care as an alternative to institutional care to support independence, whereas in others it means involvement by social networks and other actors in the provision of care.

The research team (1999) that provided a comparison of residential and community care in Australia and Japan. A Comparison of Aged Care in Australia and Japan provided a broad historical context of aged care in Australia and Japan together with a comparative overview of population aging, formal and informal care services for older people, aged care financing and the other issues facing both countries. It also provides recommendations on areas where Australia and Japan could share information and continue to work collaboratively.

Yap et al. (2006) in their introductory article titled "Aging in Asia- Perennial Concerns on Support and Caring for the Old" provides background to an understanding of "Aging in Asia" focusing on the demographics of population aging in Asia. It discusses the differences in the magnitude of the aged population in different parts of Asia and highlights the perennial concerns of care and support facing the aged and their families as Asian societies grapple with the graying population. They emphasized the role of family in the care for the elderly. Family members have often been identified as the care providers of choice by individuals and governments, but one is forced to ask whether family care is a sustainable option given various demands on the family and declining family sizes in Asia. Globalization is one important factor presenting new challenges as well as opportunities to aging Asia. The introduction substantiates the discussions in this special issue, which range from an examination of broad issues of support for the aged and policy directions in East and Southeast Asia, to specific concerns relating to activity and elderly in Singapore, Intergenerational relationships in Korea and issues concerning care giving of the old in Singapore. Globalization presents new challenges for the aged, their families and communities, as well as new opportunities. The new global division of labor and ease of mobility increases the likelihood of younger generations migrating elsewhere in search of better job opportunities. Job losses and uncertainty associated with shorter, sharper business cycles are likely to affect fertility decisions as well as the willingness and ability of the younger adult generation to provide for the old. They conclude as Asia is aging rapidly and poses challenges of providing for the growing number who are likely to require support. Population aging is taking place in a context where the traditional support base is being eroded, by demographic processes as well as forces induced by globalization. Future developments would depend on the speed at which institutions can be adjusted to meet the challenges. New institutional arrangements would also have to be developed to cater for the growing number of healthy aged who are likely to live in retirement. The information and communication technology (ICT) revolution could also be exploited to assist the elderly to remain socially engaged.

Elmelech, (2005) an article titled "Attitudes towards Familial Obligation in the United States and Japan" examines the socio-demographic determinants of and attitudes

towards familial obligation in both countries. The United States and Japan are comparable in terms of level of industrialization, education and employment, and are both experiencing dramatic aging processes. In both countries, the aging of the population places a strain on national fiscal resources and influences the government to transfer back to the family the responsibilities of providing for the younger and older cohorts. The two countries however have distinct histories and cultural structures. The United States is a relatively young nation, characterized by cultural and ethnic diversity and a strong ethos of individualism. The Japanese, in contrast, have been traditionally focused on the needs of families, groups, and collectivities. In the United States, support for individual attainment is apparent, research reports that the Japanese are strongly oriented toward the needs of their families, particularly elderly parents and intergenerational support is provided in the context of filial piety. The data show that Americans strongly believe in parental obligation for the provision of education for children. Although age differences in attitudes are more visible in Japan, the data from both countries indicate a strong familial cross-generational obligation between the young and the old. However, in both countries, the "middle generation" is less likely to express attitudes supporting intergenerational transfers of private property. Multivariate analysis revels that demographic and socioeconomic attributes explain only part of the age differentials in attitudes. In both countries, the receipt of an inheritance and the expectation of receiving an inheritance in the future have positive effects on attitudes toward familial responsibility. The article concludes by discussing the implications of the findings for current and future patterns of family support systems and the transmission of economic advantage.

Albert et al. (2006) have published an article titled "Comparative Study of Functional Limitation and Disability in Old Age: Delhi and New York City". This research article demonstrates much poorer grip strength among elderly in a developing country relative to elderly in the US. The differences are all the more impressive in that the Indian sample included elders as young age 60 and drew upon urban as well rural households. Also, minorities were well represented in the American sample. They examined mean grip strength in American and Indian elders using common methodology and found that older adults in India had significantly poorer strength than the US sample even when matched for age, gender, medical conditions and self-rated disability and disease conditions. The difference in performance is likely explained by lifelong differences in nutrition, occupational demands and access to medical care. The difference in grip strength persisted even in such stringent comparisons and in multi variable models that adjusted for socio-demographic, medical and self-reported disability indicators. Also notable were differences across the samples in self-reported difficulty in daily activity. Indian elders were much more likely to report difficulty in household (e.g., light housekeeping) and personal self-maintenance (e.g., bathing) tasks; differences were much less pronounced for reports of difficulty in upper (e.g., using hands to grasp and handle) and lower extremity (e.g., walking a quarter mile) function. Yet results from the grip strength assessment reveal poorer strength in the Indian sample for all four of the domains. The poor grip strength of

Indian elders relative to Americans likely indicates increased risk of disability as well as shorter life expectancy. On the other hand, the comparative data suggest that health and social interventions across the life span can affect health in later life.

Mayhew (2000) states the paper titled "Health and Elderly Care Expenditure in an Aging World". This report, a contribution to the project on global social security reform at the International Institute for Applied Systems Analysis (IIASA), focuses on health and elderly care services. The International Institute for Applied Systems Analysis (IIASA) is building an economic–demographic model for exploring the consequences of population aging on the global economy. So far it has concentrated on impacts mediated through public and private pension systems. It now wishes to extend the model to cover other sectors whose provision is also highly age sensitive, including health and elderly care services. This report explores the consequences of population aging for these vital services and considers the basic mechanisms fueling their growth. These mechanisms fall into essentially two categories: The first is related to the biomedical processes of aging, which can lead to chronic illness and disability in old age. The second concerns the costs of treatment and long-term care, which in turn is a function of medical technology and institutional factors, how services are delivered, and who bears the costs. The key policy related conclusions are as follows:

• Aging will overtake population growth as the main demographic driver of health expenditure growth, but its effect will be less than that of technological and institutional factors.

• Health expenditure will expand rapidly in Least Developed Countries (relative to gross domestic product) to reach levels currently observed in Most Developed Countries.

• The number of people with disabilities will grow substantially, but will level out in Most Developed Countries by 2050 (earlier for all but the oldest age groups), while the number of people with disabilities in all age groups will continue to grow in Least Developed Countries. Assuming that most care for the disabled continues to be provided by the family and community; projected increases in disability-related expenditure are modest.

However, in some countries health systems confer universal coverage, the same is not true of elderly care services, which continue to be dominated by care within the family unit or immediate community, the so-called informal sector. A central issue in this case is the extent to which services provided by third parties (state or private residential and nursing homes, etc.) in the formal sector should be paid for out of personal income, sales of assets, and so forth. Again, the picture varies substantially, even within countries, because of differences in income and social factors such as deprivation and home and family circumstances.

Martin (1990) discusses in his paper titled "The Status of South Asia's Growing Elderly Population". The paper presents demographic, social, and economic characteristics of the elderly in Bangladesh, India, Nepal, Pakistan, and Sri Lanka, and reviews evidence on whether or not the family situation and status of the elderly have changed in recent decades. There is not strong evidence that the status of the elderly has

declined nor that it was uniformly high in the past, but there is indication that economic power has long been an important determinant of status. Although fertility and population growth rates remain relatively high in the countries of South Asia, most of their populations are beginning to age. By the year 2025, just 35 years from now, ten percent of the populations of India and Sri Lanka will be over age 65 years. Bangladesh, Nepal, and Pakistan will age more slowly, but in all five countries, the absolute numbers of elderly persons will approximately triple between 1990 and 2025 (United Nations 1986). Given the poverty of many of the people of South Asia and the pressing need to provide for the still growing numbers of young people, the governments of South Asia must make difficult choices as they allocate their resources, and the needs of the elderly are unlikely to take priority. At the same time, there is a sense that the ability and/or willingness of families to support the elderly is declining and that the elderly themselves have suffered a loss of status in the course of economic and social change. The paper concludes with a discussion of how future elderly may be different from today's, the limits on developing programs for the elderly in countries at relatively low levels of economic development, and the need for additional research on the elderly of South Asia.

5.2.2: Literatures Related to Japan

The review of the related literature is an important aspect in the development of any research, which provides deeper knowledge about the problem. The researcher would like to briefly review literature from both the international comparative perspective as well as what previous researchers have done in the study directly and indirectly related to the field of elderly care in Japan.

Brown (1988) examines long-term care for the elderly in the Kyoto context and government efforts to support home and institutional care. This is a descriptive study based on interviews and personal experiences of the author in Kyoto, Japan. Because of cultural values and prevailing health care system, Japan today maintains a tradition of providing long-term care at home. However, medical and social supports for home-based care are insufficient or fall far short of need in Kyoto. Those who cannot afford home care or have no one at home to provide their care, rely upon institutional care. In order to cope with future needs for more long-term care, Japan is rapidly expanding its system of institutional care. However, redistribution of some funds to improve support services for home care is recommended.

Peng (2002) examines the nature of welfare state restructuring in Japan in the 1990s from the perspective of social care reforms, where he used the term *care no shakaika* "the socialization of care". He also highlighted this as contributing to the family care crisis and also political economy of care in Japan. He further discussed Daly and Lewis's (2000) concept of social care as lying at the intersection of public and private, formal and informal, paid and unpaid and involving cash and service provisions required to meet the needs of the individual. The social care is considered to embody three sets of analytical questions such as; care as labor, an obligation and responsibility and also as activities with

financial costs and benefits, which are inter-related between family, community, state and market in Japan. Peng summarized, the welfare state restructuring of the 1990s has resulted in important changes in the mixed economy of social care. The Japanese welfare state's policy responses to gender and demographic pressures, though clearly significant, have yet to show signs of success, that of reversing or even slowing the decline of fertility. It seems that the policy reforms have been largely focused on relieving women of undue care burdens by putting most of the effort on expanding social care.

According to Aratame (2007), while the community-oriented welfare is only one of many methodologies to provide elderly care services, it has become more than a policy deal; now that the legal foundation is laid out and procedures are clearly spelled out, the ideal has a policy tool that guides the present welfare regime in Japan. In the earlier system, elderly care was primarily the responsibility of family and the elderly with minor disabilities were not accepted by institutions, unless they were poor and without families. Now, however, the public long-term care insurance tapped the latent demands of the elderly and their families to enhance the well-being of the elderly at a community level. Some types of long-term insurance are being provided by the formal organizations run by both local and semi-governmental organizations, NGOs, informal organizations, senior citizen's clubs, families and also by elderly themselves. Aratame further discusses that the informal support networks are wanting; it is not only difficult but dangerous for the elderly to live alone in depopulated rural areas without the help of formal community health care and welfare services. In urban areas, it is also difficult for elder persons and their families to maintain their lives without community-oriented welfare services, since the elderly are often left alone at home during the day time while the family members work outside. The rising interest in the welfare services for the elderly provided in the vicinity of the elderly stems from such situations.

Watson et al. (2004), in their article titled "(Inter) Dependence, Needs and Care: The Potential for Disability and feminist Theorists to Develop an Emancipatory Model" critically explore the ways in which care has been conceptualized by feminists and debated within disability studies. Thereafter they identify and consider tensions between feminist and disability studies perspectives on care. From the feminist perspectives, caring, as a combination of feelings with tasks, has been conceptualized in two ways: as 'caring about'- the feeling part of caring; and 'caring for'- the practical work of tending for others. And the other side, from the perspective of disability activism, care is not enabling nor a social relationship to be valorized. The feminist tradition has sought to describe care as emotional as well as practical labor and to theorize it in terms of embodiment and affection. The disabled people's movement has attempted to develop a much more instrumental view of the processes that constitute the caring relationships. They argued that an emancipatory model of care is one that must address these tensions between feminist and disability studies perspectives. Drawing on the work of Fraser (1989), they propose that the notion of `needs cape` can be used to construct a `discourse bridge` that will mediate between the disability studies and feminist perspectives on care. However, the notions of care and

caring have been subject to criticism by feminist and disability theorists. There is a presumption by some that care is an activity to which women are naturally suited and this forms a starting point for the claim associated with the feminist view that care is a source of women's exploitation. For disability activists notions of care are dis-empowering. The person in receipt of care is often assumed to be passive and dependent. This is exemplified in the limited access of disabled people to choices over the nature and form of the social support that they may need. This article has sought to create a 'discourses bridge' between feminist and disability perspectives so as to bring renewed scrutiny and debates to the issues of needs, care and (inter)dependence across the life course.

Ito (2008) has written an article titled "Population ageing and new challenges in health care systems for the elderly in Japan." The author explores long-term care insurance and new medical insurance systems that have been tried thus far with an eye towards their effectiveness and financial impact. This article attempts to give a general overview of population ageing and some of the new approaches to health care systems for the elderly in Japan. Because the wages of those working in long-term care insurance facilities have been low in order to keep insurance costs low, the number of workers leaving these jobs has significantly increased in the past few years. As a result, it has become difficult for facilities managed by the long-term care insurance system to attract experienced, high quality workers. This is a major problem the system is facing right now. He further argued that the restriction on long-term admission for the elderly, the promotion of home care, especially for elderly patients with terminal-stage malignancies, the promotion of consistent medical fee systems for chronic diseases by family doctors and the limits on frequent consultations with specialists under the new system have also been criticized. A torrent of harsh criticisms has led the government to quickly plan and carry out amendments. It seems that more time is needed for the new insurance system for the old elderly to mature. The increase in the elderly population, especially the old elderly, has raised many serious social and medical issues in Japan.

Mitchell et al., (2004) presented a paper titled "Aged-Care Support in Japan: Perspectives and Challenges". They highlight the context of long-term care (LTC) benefits become an important public policy issue with extraordinary fiscal implications as the world ages. The paper explores economic aspects of the market for long term care with a special focus on Japan. Their analysis of long-term care in the Japanese context has pointed out several interesting aspects of the LTC system launched in 2000. Experts differ in terms of what they mean by LTC, but the Japanese approach to LTC has focused mostly on providing at-home (non-medical) services, as well as room and board for those requiring institutionalization. They also identified some upcoming challenges, and there are undoubtedly several clouds on the horizon. Their projections indicate that LTC costs will probably rise substantially in the future, which will, no doubt, be a central focus of the full-scale review of the Japanese LTC system planned for 2005. Some predict that the aging population and perception of LTC as an entitlement program will drive demand up and boost cost pressures. While deductibles, co pays, and caps do tend to curtail demand and hence expenditures somewhat, the substantial subsidies for LTC will surely boost future utilization

rates. They also predict that the cost pressures and evasion problems will potentially also require extending the mandatory premiums to workers under age 40 who are not currently included in the system. Another issue they have raised is the fact that the decentralized system tends to reflect regional disparities in the concentration of elderly and frail elderly. While some cross-subsidization does occur at the level of the central government, it is unclear how this will work if there are national LTC shortages. It may also be necessary to set national LTC quality standards for institutional and at-home care services, which then could be used for informing taxpayers, consumers, and potentially investors. Finally, they identified a potential role for reverse mortgages, which could be a means of financing services and provide care for an increasingly long-lived and numerous Japanese elderly populations. In other words, Japan appears likely to experience important shortfalls in LTC in the future.

5.2.3: Literatures Related to Nepal

The aging of population is now a worldwide phenomenon. In various countries of the world, people are gradually taking interest in and commuting on the problems faced by elderly people. In the context of Nepal, books and writings having depth analysis of the functional and socio-economic condition of elderly people are rare. However on one hand, some pioneer scholars have started to focus on elderly issues, on the other hand, the declaration of "International year of old person" by the United Nations has hit the government to be serious and conscious on the matter. Accordingly, Government of Nepal has been celebrating the International Day of Older Persons.

In Nepal, for the first time, Nepal Participatory Action Network (NEPAN) with the technical support from Help Age International conducted a participatory research of older persons in 2001. It was a major landmark to analyze, document and advocate the voices of the older people at the national, regional and district levels. However, more efforts are crucial to creating an enabling and supporting environment for the advancement of health and well-being of older people. International initiatives to improve the lives of the majority of the elderly need to be critically reviewed to accelerate collective actions. In this context, Help Age International, which is a global network striving for the rights of disadvantaged older people to economic and physical security, health care and social services, is playing an important role in advocating, networking and researching a wide range of elderly issues in many countries.

As Nepal is taking some strides towards industrialization with the consequent urbanization and revolutionary changes in the political system and in the socio-economic structure it would be wise to assess the condition of the aged and aging to gauge the nature and proportion of the problems that attend the transformation. Only then we will be able to put the problems in their proper prospective and to find effective means to tackle them. Full and clear grasp of the whole problem is basic to the successful planning in this regard. The growing momentum of the accelerating progress of development is shaking simultaneously from the traditional mooring, all the section of the diverged people in diverged ways, and leaves a trail of problem in its wake. These problems are big, deep and many and each

section insists on the highest priority and quickest action for the problems that affect it in particular. Study of gerontological problems in Nepal has to start from the base, which should avoid the assumption that it is the same in character and degree as in the western developed countries tempting analogous treatment.

Scholars and policy makers have expressed concern that the demographic, social and economic changes occurring throughout Asia are threatening the well-being of the elderly, particularly women, by undercutting their systems of social support. One primary concern is that the changes are weakening the institution of the family, which has historically held primary responsibility for the care of the elderly when disabilities or illness limit their ability to care for themselves. Another concern is that the changes have contributed to a weakening respect for the elderly and commitment to supporting one's parents. However, empirical evidence of the linkages between social and economic changes and the well-being of the elderly is lacking. A common topic in the literature on care for the elderly in Asia is the particularly vulnerable position of elderly women. It is argued that the demographic and socioeconomic changes especially threaten the well-being of elderly women because of their inferior social standing throughout the life course (Eckerman and Brauner, 2007).

Bisht (2006), in his PhD. dissertation entitled "The Condition of the People in Kathmandu City" has examined the condition of the elderly people within the socio-economic and demographic context. He concluded the demographic status of the elderly reveals that majority of elderly people are active and do not need help to perform their activities of daily living (ADL). The economic condition of the elderly is not very encouraging. A large number of the elderly feels that they are well cared in the family but few elderly experiences neglected, isolated, hated and abandoned. A large number of elderly have their own houses and they live there in joint family. Most of the elderly have do not have any severe problems except physical weakness, but a very few elderly have problems like a fear of physical security and loneliness. The elderly people want free check-up, free treatment and medicine from the government. They also want mobile health camps, financial support and health insurance from the government for the better improvement of the elderly health. The elderly people of Nepal have a great desire that their old age be easier and secured with family members. He further recommends that the family support system should be strengthening for to take care of the elderly people within the family. However, due to modernization and urbanization, increased rate of women employment and nuclear family system, the care for elderly in family becoming challenge in Nepalese society.

According to Khanal (1998) care to elderly has still been considered in Nepal as a religious, charity and philanthropic. In comparison to males, females have less access to disposable old age income due to lack of entitlement to property and pension. Therefore, special support measures should be adopted to save elderly females (particularly widows and divorcees) from being exposed to extreme destitution and vulnerabilities (Subedi, 1999). Likewise, Acharya (2007), in his paper titled "Senior Citizens and the Elderly

homes: A Survey from Kathmandu has surveyed the physical, economic status of different homes, their problems and challenges as well as the personal feelings of senior citizens living in seven elderly homes in Kathmandu, Bhaktapur and Kavre district. The survey has tried to clarify the problems and challenges of elderly homes are helpful in providing proper care and support for the senior citizens. The survey's results indicate that in number of respects elderly homes are favorable for the residents and the society as a whole despite of some problems, particularly for those who are uncomfortable in their family.

Maharjan (2001) in her dissertation paper "Ageing Situation in Newar Community of Kirtipur Municipality, Kathmandu" has made an analysis of social, economic health and educational aspects of elderly people. She concludes, "The proportion of widow is high. Their attitude is differing from those who have spouse. Those elderly people having spouse seem happy than single, separated and widow or widower. Most of elderly people do not have any kind of income resources. They are interested in religious and social activities, traveling and talking with others. Illness, isolation, disrespect by family members, lack of appropriate entertainment are the main problems faced by the elderly people in Newar Community of Kirtipur Municipality area."

Subedi (1999) has raised the problem of caring for elderly population in the journal "Population Development in Nepal", here he highlights the socio-economic characteristics of elderly population in attempt to understand some issues of new generation of Nepalese population. He comes to the conclusion that the ageing is really a demographic challenge and he makes aware that it is prime time for policy makers to work for the mechanism to protect elderly from socio-economic suffering from aging process. He comes to end that population aging is quite new in Nepalese society and neither the family nor the government is well versed to handle the issues, therefore he suggests that there is need to take elderly issue seriously.

Uprety and Paudel (2007) highlight the aging and social security system in Nepal. They argued that, on one hand, depleting socio-cultural value system, diversification in occupation basically agricultural to non-agricultural, higher mobility of economically active persons for seeking job and better education, and replacing existing joint family system by nuclear family system have been causing problematic for the security of aged people particularly above 65 years in Nepal. Since, children and those elder groups mostly rely on familial support in Nepal. On the other hand, Government's social security system is also poor and that could not cover all such elder groups of society.

Regmi (1993) has written on the "Socio-economic and Cultural aspects of Aging in Nepal". He describes the problems caused by the aged appearing to be of increasing importance. His article is broken down describing Nepalese tradition caring for aged, the population situation, the social integration of elderly, tradition in caring the aged, the social honoring of dying elderly, the elderly and health care in traditional Nepal, Nepalese structure of family institution for the aged. The crux of his writing is that in a subsistence economy like ours, there is hardly any scope for the majority of the people in rural areas to save for old age support, therefore under such circumstances many children of them were

serving as old age security. Finally, his logic to solve the problem is to reduce the reliance of parents in sons as old age security.

Poudel (2005) also highlight that there are various factors that make a person old. Decrease in physical strength, increase in mental tension, decrease in immunity power and getting sick to a large extent are the major features that make a person aged. Elderly people also experience many physical changes. There is gradual drying and wrinkling of skin, decrease in touch feeling and taste sensation, extensive food indigestion, decrease in range of color and intensity of vision, failure of ability to distinguish color, loss of hearing power and weakening immune system. With the increase in age, people lose their creativity level, problem solving ability and learning skills as well as short-term memory. Elderly people also have to face economic and social difficulties. Nepalese society is in a phase of modernization. The traditional joint family is slowly being replaced by nuclear family in urban areas. The caring of elderly population is a major problem. Because of this trend of nuclear family, the older members of family are being isolated. Old people long for love, proper nourishment, happiness and relaxing conversations from other family members. This system of nuclear family and busy lifestyle of people have secluded them from other family associates. There is modification in the cultural norms and traditional family support systems for elderly in Nepal have been placed under substantial strain.

A research conducted by the Help Age International (2009) titled the universal social pension in Nepal: An assessment of its impact on older people in Tanahun district. The primary objective of this study was to assess social and economic impact of the non-contributory pension in Nepal, commonly known as Old Age Allowance (OAA). Both qualitative and quantitative data were collected from one urban and two rural settings of Tanahun District. Despite being small in amount, the pension is recognized as an important part of older people's life and found to be highly valued. It has contributed to sustaining older people's lives through the purchase of medicine, food, and/or clothing. However, the socio-economic impact on beneficiaries was found to be different according to the situation of the older person. Rural dwellers valued the pension more highly than the urban dwellers. Older people living alone also valued the pension more than those living with others.

The report concludes that the OAA has received considerable attention in Nepal as a State-sponsored measure that contributes to the recognition of older people in the society. Beneficiaries and prospective beneficiaries both were familiar with the pension. Despite being small in amount, it is perceived as an important income support for older people, contributing to their wellbeing and income security in later life. The distribution has enabled older people to have a sense of security in meeting their daily needs. Older people have utilized the pension for different purposes. A significant portion, according to the beneficiaries, is used to purchase personal supplies and meet healthcare needs. However, some key informants were somewhat critical of the universal approach, all of the older people beneficiaries were highly supportive of the distribution, regardless of

their income level.

A paper presented by representative of Government of Nepal,Ministry of Women, Child and Social Welfare to the Five-Day Training in Geriatric Care Giving for SAARC ***(South Asian Association for Regional Co-operation) Countries,*** held in New Delhi on 21st - 25th July 2008. The paper recommended that the Government of Nepal should be sincere of the following aspects;

- Enhance advocacy and awareness program.
- Incorporate elderly issues in research and studies-exclusion of 59+ years
- Increase access of elderly people to information about their rights at home and in the society including their rights to government service provisions
- Increase access of elderly persons to basic rights and facilities (food, shelter, clothes, education and health) at home and in the society
- Improve quality of services with simple procedures for elderly people with an effective implementation of government plan and policies which is to be monitored by elderly peoples association
- Develop mechanism for collaboration, linkages/referral services among agencies to be coordinated by women development office in all 75 districts and by Ministry of Women, Child and Social Welfare (MoWCSW) at national level
- Pilot ageing education in schools to minimize generational gaps- mainstream ageing issues as children and youth could play instrumental roles to respect elderly people as grandparents and think-tank of the society
- Ensure inclusion and representation of elderly people in policy dialogue and in resource allocation from local to national levels and in institutions
- Advocate with government for resource allocation with a priority and educate donors on ageing issues

The present study concerns the Kyoto (Japan) and the Kathmandu (Nepal) Metropolitan City (KMC) and significantly differs from the above mentioned literatures. This study basically concerns with the elderly care practice of Kyoto and Kathmandu Metropolitan City (KMC). It covers all dimensions of aging as well as policy and programs related to elderly people of both countries.

CHAPTER SIX
METHODOLOGY

6.1 Research Design

The mixed research design carried out for this study of both qualitative and quantitative. In other words, the research was descriptive and explorative. Mixed methods research resides in the middle of the continuum because it incorporates elements of both qualitative and quantitative approaches. The results from one method can help the other method. The qualitative and quantitative data can be merged into one large database or the results used by side by side to reinforce each other. Thus, it is more than simply collecting and analyzing both kinds of data; it also involves the use of both approaches in tandem so that the overall strength of a study is greater than either qualitative or quantitative research (Creswell, 2009).

6.2 Source of Data

Two different sources of information were consulted for this dissertation, namely primary and secondary. The former consisted of the experiences and views of governmental officials, policy makers, professionals, social workers, university teachers, medical doctor, staff nurses, and head of the elderly homes as well as elderly people by way of interview. The secondary information comprised research reports produced on the issues of aging and caring for the elderly by various types of national and international organizations as well as the published books, dissertations, journal, magazines by individual and scholars as well. A limited amount of information was obtained from the Internet.

6.3 Geographic and Demographic Context of the Study Area

The study area of this research was Kyoto and Kathmandu city. As the largest of the municipalities, Kyoto city has an area of 827.90km squire, representing 17.9% of the area of the prefecture. The Kyoto Basin is surrounded on three sides by mountains known as Higashiyama, Kitayama and Nishiyama. There are 11 wards under Kyoto city named Kita ward, Kamigyo ward, Sakyo ward, Nakagyo ward, Higashiyama ward, Yamashina ward, Shimogyo ward, Minami ward, Ukyo ward, Nishikyo ward and Fushimi ward.

The total population of Kyoto city was 1,472,511 as of October 2006. The population was 1,463,822 in 1995. The elderly population of Kyoto city was 20.8% of total population in 2006, which was 14.7% in 1995. The productive population aged 15-64 years was71.6% in 1995 and it is decreased 2006 i.e.67.1%. Similarly, the younger population of aged less than 15 years also decreased from13.8% in 1995 and 12.1% in 2006.The elderly female are always greater than male population. As of October 2006 the female and male population of 65 years and over was 23.3 % and 18.0% respectively. According to Kyoto General Planning Bureau (2003), the total number of households in Kyoto city was 610,665. Among them total single occupant in vast majority those were 229,280 and single parent with children were 47,173.These demographic phenomenon certainly can affect

caring process of elderly as well.

Kathmandu is the capital city of the country. The Kathmandu district one of the 75 districts of Nepal. According to 2001 census, there are 235,387 households in the metropolitan city. Kathmandu metropolitan authorities estimate the number of people living in the city to be around 1,081,845 with 576,010 males and 505,835 females. The total population of Kathmandu metropolitan city was 671,846 with 360,103 (53.6%) males and 311,743 (46.4%) females. It was 422,237 in 1981 and reached 671,846 in 2001. Likewise, the population aged 65+ of KMC was 15,414 in 1981 and has increased to 22,703 in 2001. The total population of elderly aged 65+ of KMC was 3.37 percent in 2001.The district has one metropolitan city (Kathmandu) and one municipality (Kirtipur).The Kathmandu Metropolitan City alone had 23 per cent of the total urban households of the country in 2001 and massive influx of population every year from all parts of the country has further increased its population. It already has a highest population density (13,586 persons per square Km. in 2001) in the country. The largest ethnic groups are Newars, Brahmins and Kshetris. The major religions are Hinduism and Buddhism. Hence, it has been chosen as the most suitable area for study. The population growth rate of Kathmandu is quite significant, which is more than 6 percent. Urbanization has been increasing in a rapid and unplanned way, putting pressure on the problem of urban basic health service.

6.4 Sample Size

Determination of Sample Size

Choosing a study sample is an important step in any research since it is rarely practical, efficient or ethical to study whole populations. Sample sizes may vary enormously. The smallest quantitative surveys comprise less than 100 interviews (often 60 is cited as the smallest sample); while the largest surveys comprise many thousands of interviews. In deciding on the sample size, we need to take into account a number of factors.

The determination of sample size is a common task for many organizational researchers. Inappropriate, inadequate, or excessive sample sizes continue to influence the quality and accuracy of research. The alpha level used in determining sample size in most educational research studies is either .05 or .01. In Cochran's formula, the alpha level is incorporated into the formula by utilizing the t -value for the alpha level selected (e.g., t-value for alpha level of .05 is 1.96). An alpha level of .10 or lower may be used if the researcher is more interested in marginal relationships, differences or other statistical phenomena as a precursor to further studies (Bartlett, et al., 2001).

For determination of sample size, the researcher used Cochran's sample size formula;

For Kyoto (Japan)	For Kathmandu (Nepal)
Elderly population 65 over =21%	Elderly population 65 over=3.37%
p=21% (0.21)	p= 3.37% (0.033)
q=1-p	q= 1-p
=1-0.21	=1-0.033

=0.79
d=0.10
t=1.96
n=?
n= (t)2 *(p) (q) / (d) 2
Where t= value for selected
Alpha level= 1.96
(p) (q) = estimate of variance
d= acceptable margin of error
for mean being estimated = 0.10
n = (1.96)2 * (0.21) * (0.79)/ (0.10)2
=3.84 * 0.21 * 0.79/ 0.01
=0.637056/0.01
=63.7 or 64 (Therefore the sample size is at least 64 elderly)

=0.96
d= 0.10
t= 1.96
n=?
n= (t)2 *(p) (q) / (d) 2
= (1.96)2 * (0.033) * 0.96/ (0.10)2
=3.84 * 0.033 *0.96/ 0.01
= 0.12165/0.01
=12.16
or 12
Therefore the sample size = 12 elderly (at least)

The above mentioned sample size is minimum number of respondents. So I took 66 elderly from Kyoto and 100 from Kathmandu. If the population size is small, than we need a bigger sample size, and if the population is large, then we need a smaller sample size as compared to the smaller population. Sample size calculation will also differ with different margins of error.

6.5 Tools and Instruments

In order to collect necessary information from the elderly people through interview, I developed structured and semi-structured questionnaire. A carefully prepared, pre-tested and modified 95 item structured questionnaire (set A) for the elderly and 16 item mixed questionnaire (set B) for policy makers, professionals, social workers etc. was administered. The questionnaire for the elderly contained demographic characteristics 10 items, 14 items on physical health status, 6 items on mental,11 items on psychological, 17 items on social and supports, 11 items on economic condition, 8 items on housing, 5 items on living arrangement, 4 items on employment and 9 items on activity and entertainments of the elderly. Similarly, the mixed questionnaire contained 11 items on the different aspects such as; main issues of the elderly, policies and welfare programs, model of cares and also the role and responsibilities of the family, community and the state towards elderly well-being. A computer software program, SPSS version-17, was utilized to tabulate the quantitative data.

6.6 Sampling Procedure

A purposeful sampling technique was investigated in this research. Purposeful sampling enabled the selection of subjects who best aided in achieving the research objective (Merriam, 1988). Purposive sampling may also be used with both qualitative and quantitative research techniques (Tongco, 2007). Campbell (1955) also states that both qualitative and quantitative sampling methods may be used when samples are chosen purposively. In this perspective, the researcher selected both types of samples from Kathmandu and Kyoto city. To collect quantitative data, the researcher visited to elderly

people for face to face interview. The geographical coverage within which the information was collected includes all the 35 wards from Kathmandu Metropolitan and 11 wards from Kyoto municipality. At least two elderly people from every wards of KMC and six elderly from Kyoty city were consulted for interview.

In order to receive the qualitative data, the researcher went to the respondent's office for taking interview. I took an interview with government officials from the Ministry of Women, Child and Social Welfare, head of social welfare division of Kathmandu metropolitan city, director of council of social welfare, head of elder care homes, social worker, professor and so on. Similarly, I met to the chief of the elderly welfare section and professionals, policy makers, social workers of Kyoto city. I provided bi-lingual questionnaire to the respondent on the first meeting and confirmed the appointments for interview. According to appointment schedule I went to meet respondents for taking interview. I had an interview with 6 heads of the Elderly Section of the Ward Office, 1 head of the Senior Citizen of Kyoto City Municipal Office, 1 Director of the Social Welfare Association of Kyoto, 1 University Teacher, 1 Doctor and 1 Staff Nurse.

6.7 Data Analysis and Interpretation

I analyzed the qualitative data manually and for quantitative by SPSS version-17 from both countries. For quantitative analysis I used chi-square t-test and used the simple statistical tools, such as frequency, distribution, average and percentages. I made tables and charts according to questionnaire. To enable the assessment of Tronto’s theory of care in the comparative perspective the researcher developed an analytical framework that consists of the demographic characteristics, physical, mental, social and psychological status, living arrangements, housing, education, economic and employment status of the elderly. I also described the main policies and programs of both countries. The data were analyzed in a series of steps designed to allow sorting out, classification and description and as a final step, interpretation of the data.

CHAPTER SEVEN
QUALITATIVE DATA AND INTERPRETATION

7.1 The Qualitative Data from Kyoto City

The researcher has taken interview with 6 heads of the Elderly Section of the Ward Office, 1 head of the Senior Citizen of Kyoto City Municipal Office, 1 Director of the Social Welfare Association of Kyoto, 1 university teacher, 1 doctor and 1 staff nurse. Responses from the professional respondents are as given below;

Main Issues among the Japanese Elderly

Most of the professional respondents have responded that psychological and emotional aspects are the most serious problems in terms of caring for the elderly in Kyoto. Most studies have examined psychological well-being in terms of life satisfaction and morale. The comparative approach to assessment of well-being is frequently employed to portray the dynamic qualities of life, satisfaction and morale. Gerontologists have emphasized life satisfaction as an important indicator of psychological well-being (Wan, et al., 1982). The respondents also revealed that there were serious concern about economic problems, which might affect every day lives of the elderly. Although some of them stressed that a very old person caring for another old person is a bigger issue. Likewise, some of them have argued that they are worrying about increasing of individualistic nature of people. Doshisha university doctor said that the increasing of single elderly households also a big problem. He thinks that living alone at home might be psychologically depressed to the elderly. The head of the elderly section of Kyoto city municipal office has argued that changing family pattern is a big issue alongside current slowdown of the national economic. He observes that the patterns of breaking of traditional care practice mainly by family members, friends and relatives will certainly impact on the well-being of the elderly.

Almost all the respondents argued that both men and women are facing similar problems, mainly financial problems. The head of the Fushimi Ward office, Welfare Section said that elderly people didn't want to bother one another when they became ill. They worried about increasing hospital charges for long-term hospitalization. The problem is the same in terms of caring for women, but women are more vulnerable than men because women are also caring for their husband. After the death of their husband, they also face financial problems. They suggested that the local or central government should pay attention to widows and widowers so that they can live the rest of their lives effectively. Likewise, on the one hand, Japanese traditional bathing tabs are small for caring to the elderly and lack of sufficient skilled care takes on the other. Now, the Japanese elderly with financial security through pension and other sources are searching for their own “Ikigai” (aim of life or worthwhile life), which is difficult to obtain.

Society's Views towards the Elderly

Most of respondents suggested that society's views are normally not so cooperative and all respondents claimed people want to be more independent. In almost every place in the world, the urban characteristics of neighborly relationships and mutual assistance prerequisites for living are becoming weaker and weaker, not just in Japan. Some respondents expressed their views that they didn't belong to their society. For the social well-being perspective of the elderly, it is necessary to obtain dynamic social support from society. The Director of Kyoto Welfare Service Association, Mr. Fujimoto argued that those family members who have job, they don't want to care their parents. In other words, they feel burden and their attitude also seemed not so positive.

Regarding the current welfare policies and programs most respondents were of the opinion that current welfare programs are nearly sufficient in that they could choose according to need and earning capacity. However, some respondents emphasized that current policies and programs are not sufficient and lack of nursing homes, shortage of hospital beds and they thought it was becoming more difficult to hire a home care-taker due to increasing numbers of older people. On the other hand, when they need to enter institutions, they have to wait for a long time and there are not sufficient numbers of institutions for caring for the elderly. Some respondents stressed that the government should pay a larger amount and that elderly people's tax money should be used only for their welfare, because their generation (the baby boomers) is over ninety years old now. These respondents, due to these problems, are searching for a new reason for living.

Possible Solutions for Intra-family Care Problems

Although the researcher could not find concrete solutions to solve the intra-family care problems, most of the respondents emphasized that the proper use of formal care services with community-based services could solve this problem somehow. They suggested that the Government should review the current services and develop more community homes for the elderly. Home care-takers should be increased and their salaries should also be increased. Currently, elderly people who are sick can stay up to 3 months in the hospital and after they become healthy, they should go back to their homes because there will be more elderly people who want to enter the hospital. Many respondents were not in favor of this provision. Other respondents stressed their views that the informal networks and community support services should increase for caring for the elderly. The local government should appoint sufficient full and part-time care-takers and volunteers for caring. Similarly, tax-free (among other) incentives also can be increased for those children who want to live with their parents. Restructuring of the society and family policy should be revised for a better solution.

Who is Responsible of care for the elderly: Family or Society or the State?

When asked about the responsibility of care, most of the respondents stressed that local and central government should be more responsible but some others

emphasized that the elderly themselves as well as family should be more responsible. However, the Japanese family has long been regarded as a care institution that bears the main responsibility for looking after the elderly (Wu, 2004, p.7). Similarly, Brodsky et al., (2003) emphasized that many long-term care policy issues revolve around the issue of whether the individual and family, or society as a whole should be responsible for providing caring for persons with disabilities. Some people believe that the primary responsibility for care of people with disabilities belongs to individuals and their families and that government should act only as a payer of resort for those unable to provide for themselves (p. 10). Traditionally, in Nepal the youngest male child in the family inherited the ancestral house and was expected to coreside with parents and take care of their old age with the voluntary material and emotional support of siblings. In the case of the elderly who do not have their own children, close relatives look after them, providing material and emotional support. This cultural value system of taking care of elders at home and in the community at large is mostly perpetuated in religious societies especially Hindu and Buddhist. According to Hinduism, Buddhism, Christianity and Islam norms and practices, the elderly "preserves the highest esteem in the society". Especially in Buddhist culture, the children believe that "up-keeping of the elderly parents and pay high respect" brings the high merits for them. The eldest son would inherit the family residence and assets and in turn would be responsible for his parents in their old age (Siddhisena, 2005). As Rindfuss et al., (1992) argued that the traditional Japanese system the practice of primogeniture gave status to sons over daughter and first borns over others. The eldest son would inherit the family residence and assets and in turn would be responsible for his parents in their old age.

Options That May Provide for Better Care in the Future

Most of the respondents expressed their view that community-based care practice might be a good way for caring for the elderly. In Japan, community based care intends varieties of services such as; day centers, short stay service, group homes, home help services etc. However, most Japanese elderly people want to live in their home in later life and their second option would be a community home which should be located close to their home. They emphasized that community homes should maintain 24 hour service with specialized manpower. The head of Fushimi Ward, Senior Citizen Section Mr. Taniuti Hirosi opined that if elderly are healthy enough then community based care would be better. If they were ill or disabled with any health impairments, then hospital might be better option. However, other respondents suggested that without informal family support, they cannot feel well. Nursing homes are also good options for caring if their fees can be affordable to poor elderly people, too.

About the Mixed Care Model

All respondents agreed the mixed care model that includes family/home, community and state would be a better option for elderly care. Kyoto city Senior Citizen

Chief Mr. Matsui Hisao has strongly recommended the family, community and the state mix care model. Likewise, Director of Kyoto Welfare Association Mr. Fujimoto added NGOs and NPOs in proposed mixed care model. According to Daly and Lewis (2000), there has been increased recognition that care is very much a 'mixed economy', involving the state, the market, the family, and the voluntary sectors. They focused on the term social care where it lies at the intersection of public and private (in the sense of both state/family and state /market provision); formal and informal; paid and unpaid; and provision in the form of cash and services (p.282). Therefore, it is important to make the connection of all the aspects of mixed economy in terms of caring for the elderly.

Participation and Empowerment of Eldery

As elderly persons continue to constitute an ever-greater proportion of the total population, they have the potential to be more influential in society. Empowerment and political participation of older people vary greatly across countries: There are countries where older people carry great social and political weight, mostly associated with the important concentration of economic resources and a tradition of political participation; in many other countries, however, older people are not organized and experience great difficulty in voicing their concerns and incorporating them in the public debate and the policy agenda.

Elderly people are expected to participate fully in the development process and share in its benefit. This provides elderly persons with the opportunity to make a continuous contribution to society. All the respondents have emphasized that providing jobs for those elderly people who are physically and/or mentally capable would also contribute to elderly people being able to fend for themselves. Similarly, the proper communication with lonely elderly people would be another way to empower them. Society should not neglect their interests, aspirations, as well as their experience. The concerned authority should think about the future of senior citizens and increase more opportunities for elderly employment.

International and national non-governmental organizations have been actively promoting the organization of older persons as a mechanism through which to influence the design and implementation of policies that affect them. As literacy and continuing education, including information about human rights, constitute important elements of empowerment, efforts to organize older persons should be coupled with larger programs encompassing these elements (United Nations, 2007).

About the Public Long-Term Care Insurance (PLTCI) and the New Gold Plan

When asked about strong and weak points of elderly related policies and programs including the New Gold Plan, the respondents expressed positive views towards Public Long-Term Care Insurance (PLTCI) that would serve as a basic and concrete framework for implementation of elderly welfare in the community. It supports the independence of the elderly and aims at establishing the community that guarantees a

secure life to all people. It is a need based care provision to a rights based universal insurance scheme that significantly expands the number of recipients. It enables an elderly individual, regardless of financial and family status, to have access to the elderly care services by means of a social insurance so that they can continue to live a self-reliant life in a community. Under this system there are two types of services, which include community care services and institutional care services. The elderly themselves decide to purchase care services with a small co-payment. Similarly, Long-Term Care Insurance makes a clear departure from earlier systems in that it promotes the community care services such as home help, day services and short stays as a primary means of elderly care. This scheme intends to enable the elderly residents of the community to lead self-reliant lives at home as long as possible. While not denying access to more conventional institutional care services PLTCI has shifted the emphasis in elderly care from the institution to the community. The pluralism on PLTCI aims at improving the quality of care services by introducing a market mechanism while responding to the demand of an increasing number of its users with a variety of service needs.

Japan's elderly care is now moving towards market-based elderly welfare through public long-term care insurance (PLTCI). However, elderly welfare is more than care services provided through PLTCI; there are many areas that cannot be addressed effectively by PLTCI, one being to provide care and domiciliary services to the elderly whose physical conditions require care or assistance. When welfare needs of the elderly are more or less than the care services defined by PLTCI, when the kind of service expected is unprofitable for service providers, or when service needs are not so much physical as social and cultural, the elderly care through PLTCI is not appropriate.

In concerning the New Gold Plan there is a lack of sufficient trained manpower and adequate budget that could not fulfill the demands of the elderly. Although a one room apartment system is not sufficient for living, on the other hand, it is also becoming too difficult to find apartments because the elderly population is increasing. Two respondents argued that the New Gold Plan has failed to gather money from consumer taxes. Therefore, the New Super Gold Plan is needed very soon.

For many feminist, the Gold Plans proved too inadequate and underscored the desirability of a social insurance scheme as a way to ensure individual rights to social care. With the introduction of long-term care insurance most of the services covered by the Gold Plan were transferred to the insurance program, and the means-tested care services are being left for low income elderly receiving social welfare (*seikatsu hogo*) and for disabled, who are not covered under the insurance scheme. In principle, the introduction of the insurance has meant that all elderly requiring care now have the right to receive care, regardless of income or family situation (Peng, 2002 p.430).

7.2 Qualitative Data from Kathmandu

The researcher has taken interview with ten people such as professionals, policy makers, social workers, nurses, and so on. Only significant responses are presented below;

Main Issues of Nepalese Elderly

In Nepal, the traditional extended family system is gradually breaking down into nuclear family. In this context, family support and family care is becoming an issue due to the increasing of nuclear systems. Likewise, poverty is one of the major constraints which impact the well-being for the elderly. Mr. Upendra Prasad Adhikari, who is under secretary of the Ministry of Women, Children and Welfare, further argues that the social degradation and the impact of modernizations are the main causes for the worsening situation of the elderly in terms of caring. However, modernization has a positive impact in the caring of elderly. Similarly, Mr. Raju Joshi, Director of Council of Social Welfare, pointed out, that females face a higher risk than males; they are psychologically dominated in society due to male dominated culture. Some academicians argue that Nepal has a culture that respects and honors the elderly even after their death. But as a byproduct of cultural pollutions, the new generation does not like to live with elderly. Nepalese widow elderly are also neglected or have less priority and access in social activities. It seems that females are more vulnerable than males and therefore need more care attention. Some professionals have argued that the health care of the elderly is the big issue in Nepalese society. In remote areas of Nepal, traditional beliefs are still blocking the formal approach to health care. Poor elderly are always seen as needy and they need materialistic support.

The main challenges in gender mainstreaming are traditional cultural practices and customs which perpetuate patriarchy, discriminatory social practices, gender stereotypes, prevalence of gender-based violence, lack of concern for gender disparities in the practice of governance, women's lack of equitable access to productive resources in comparison to men, prevalence of discriminatory legal provisions, lengthy amendment processes, and a lack of gender sensitivity in legislation. A recent assessment of the major changes in women's lives in Nepal over the past decade has shown that despite higher rates of attainment of literacy, social mobility and awareness, women still remain confined to the roles prescribed by the traditions of Nepalese society.

The challenge for public policy is to assess the viability of family support systems and to devise programs that will be supportive or complementary. Several governments have adopted such policies. In Singapore, children are now legally responsible for the support of their elderly parents. Many East and Southeast Asian countries are providing adult day care and other support services aimed at helping adult children care for their elderly parents. Malaysia and Singapore have revised their public housing policies to accommodate multi-generational living arrangements, and Malaysia also provides families with tax incentives for elderly care (World Bank 1994). However, in Nepal, now the health has been written as a fundamental human right in the interim constitution 2006

is a big way forward. Similarly, the health sector has been consistently seeking more funds to address the problems of the poor and to reach the un-reached. Government health budget was 4.93 % of the total national budget in 2003/4 and later in 2006/7 increased to 6.4 %. It has further moved up to 7.14 % of the national budget in this year amounting to 12.099 million rupees. Free public health interventions have become virtually universal (e.g. Vitamin A). Health sector strategy: an agent for reform has been instrumental in pool funding as well as joint planning and ministry health programs (Nepal Population Report, 2007).

Societies' Views towards the Elderly

Some professional respondents have the opinion that the society's view is normal towards the elderly mainly in urban areas. However, others have argued that despite the westernization of culture, the society has good sense of cooperation towards the elderly. Their view of society is positive, but there is a trend, that these values are changing rapidly mainly in urban areas. Some others were worrying about the increasing individualistic characteristics of urban people. Community ties are becoming weaker than before which can impact on life of people. Nepalese society is also in the phase of transforming from a traditional way of living into a modern one.

How to solve intra-family care?

Although it is difficult to identify the solution of the intra family care issue, there are some measures suggested by the respondents such as Mr. Upendra Adhikari and Mr. Raju Joshi. They have suggested that to maintain good morale relationship between elderly and other family members, easy access to formal services could be helpful in caring for the elderly. Likewise, Deuja, head of the biggest old age home run by the government, has suggested that home care taker service should be employed in order to address the intra family care issue. He further suggests that the elderly should keep the property-right, concerning land, houses etc. If we put this suggestion in practice through national policies then elderly might be respected. In Nepal, after 70 years, elderly persons lose their property-rights. Some academicians have argued that other family members and relatives can assist the elderly as care takers if the government provides them with a salary. Likewise, a senior staff nurse Mrs. Bimala Subedi has opined that day care center for the elderly persons may reduce the problem of intra-family care for the elderly. She further emphasizes that the formal morale education of the new generation is needed to solve intra-family care problem in some extent. Government should encourage those who want to live with their parents in terms of providing incentives and as well as other legal provision in main policies.

Better Options Concerning the Care of Elderly

The age structure of Nepal is recently changing with an increasing number of elderly. That is why something has to be done for the care of elderly without delay.

Policy makers and academicians of Nepal have opined that the family or home care would be the better option of caring for the elderly in many respects. After that the community also would be an option in the long run. In normal conditions, the family would be an option but in severe or problematic cases old age homes or community homes might be the better option of caring for the elderly. However, such kind of homes should be well equipped. They further argued that the district level health care system should also be established for regulating the health care for the elderly. In urban areas, day care centers also envisaged a good practice of caring for the elderly, including community homes/old age homes. That means that there should be a need of day care centers and also home visit type services in Nepal.

Community-Based Care Practice

All respondents agreed that, in the long run, the community based care practice might be a good practice of caring for the elderly. However, they further stressed that developed community based care practices for the elderly should work together with other sectors such as government and private sectors. Raju Joshi opined that partnership between NGOs and society to care for the elderly would be more productive for the well-being of the elderly. In Nepal, many NGOs are involved in the caring of elderly. And this practice is being more popular than before in Nepal. Academicians also stressed that the government supported community based practice would be better than the ever changing patterns of families. The Government of Nepal has initiated strengthening public private partnership for proving better, quality health care service and covering more people. In order to materialize this, there is a need to give more attention in the area of human resource development working in the private sector and their involvement in public sector. The private sector should join hand with the government for delivery of health care. Full community participation is recognized as an essential characteristic of an effective, efficient and sustainable community based care system. Community participation is not viewed as simply compliance to program activities nor the mere provision of resources. Rather, community participation includes the community in decision making at various levels through its representatives and organizations. Within the context of full community participation, central, regional and district level personnel are expected to fulfill a supportive role in assisting and enabling the community to carry out their responsibilities.

Who should be more responsible for caring the Elderly?

All sectors of society should be responsible for caring for the elderly. Elderly are living history. We can learn many things from them. Mr. Upendra Adhikari stressed that the family members, mainly their son/daughter in law should be more responsible for caring for and supporting the elderly. Mr. Raju Joshi argues that family as well as the government should be responsible. Some others have stressed that everyone should be responsible but that the government should be even more than others.

Many long-term care policy issues revolve around the issue of whether the individual and family, or society as a whole should be responsible for providing and caring for persons with disabilities. Some people believe that the primary responsibility for care of people with disabilities belongs with individuals and their families and that government should act only as a payer of last resort for those unable to provide for themselves. People who believe that long-term care is a societal responsibility and that, while individuals and families should do their part, formal care and public support for informal caregivers should play a large role in meeting the long-term care needs of disabled people. In this view, societally-supported services should be available to all who need them regardless of financial status; in the same way that health insurance should be universally available. According to this view, the fact that one has a disabled relative should not result in an undue financial or care burden to the family (Brodsky, et al., 2003). This perspective is characteristic of the long-term care systems in Germany, Scandinavia, and recently in Japan. Indeed, the enactment of the new social insurance program in Japan was a deliberate decision to shift the burden of long-term care from the family to society as a whole (Campbell & Ikegami, 2000). So that the ‘‘socialization of care’’ for the frail elderly under the long term care insurance either in home or community (also institutions) is a major focus for the Japanese government.

The term ‘aging in place’ also used for long-term care in reference to frail and elderly people, to solving their needs for assistance with independent living in their current housing or an appropriate level of housing and preventing a costly, traumatic and often inappropriate move to a more dependent care facility (Heumann and Boldy, 1993).Under this widespread directives for “aging in place” and “community care,” older persons are encouraged to remain living in their homes for as long as possible, assisted by community support services when needs arise. Though almost all these programs rely on public funding, they are not cost-effective and specific enough to meet individual needs. Many countries wanting to rebuild family care in order to reduce the burden on institutional systems have to incorporate a more structured approach, with higher-level skills training and support for informal caregivers (Chan et al., 1992). If the family would be unable to care their elderly then government should have an overall responsibility to care for the elderly. People who believe that long-term care is a societal responsibility and that, while individuals and families should do their part, formal care and public support for informal caregivers should play a large role in meeting the long-term care needs of disabled people.

Mixed Care Model

Health and social care for the elderly should not be considered as the sole responsibility of Government but to improve the health status a multi-sectoral development is necessary. It therefore, calls for coordination and participation of public sector, NGOs, INGOs for providing and financing a sustainable health service delivery.
Most of the respondents and policy makers have named it the Partnership Model, where a public private partnership can be made in Nepalese context. The public private

partnership model is popular in other sectors in Nepal. Mr. Adhikari was in favor of mixed model where NGOs, CBOs, Voluntary organizations etc. are included in this model as well. It seems that the Public Private Partnership Model (PPP Model) can be effective to cater the well-being of the elderly in Nepal.

Opinions Regarding the Long-Term Care

All respondents are in favor of family or home care supported by formal community long-term care. Mr. Raju Joshi also was in favor of family care supported by formal care but thought that NGOs should also be included in this model. Some policy makers also suggested that community hospitals could be helpful in the long term care of the elderly. However, the community participation is remarkably increasing in many sectors in Nepal such as education, health, cooperatives etc.

Empowering Elderly Members of Society

The International Federation on Ageing refers to the empowerment of older persons as "the ability to make informed choices, exercise influence, make continuing contributions to society, and take advantage of services" (Thursz, Nusberg and Prater, 1995). In this sense, empowerment is closely related to participation. There are several factors that preclude the more active participation of older persons in society including poverty, poor health, low educational levels, lack of transportation and access to services, negative stereotypes about ageing, and overt or subtle age discrimination (ibid.). The goals in empowering older persons are to overcome these numerous barriers, make optimal use of their potential societal contributions and enhance their life satisfaction (United Nations, 2007:46).

In Nepal, there is the need to support the elderly, which are one of the vulnerable groups. Access to electronic media, provide peer group education, adult education, health education, proper communication can be empowering to the elderly people. Likewise, utilization of elderly's knowledge, skills and experiences for community and national development also can empower them. Mr. Raju Joshi advised that elderly resource centers should be opened for empowering the elderly. At the same time, Mr. Dauja also advised that cultural and awareness programs should be launched in every ward and village of the country. Mrs. Bimala opined that providing job opportunity and equal participation in social activities of male and female elderly people can empower them. United Nations, (2007) recommends that an important element in the empowerment process is the enforcement of legislative measures to guarantee the rights of older persons that are laid out in national constitutions and international human rights conventions.

Nepalese Policies and Programs

Mr. Adhikari says that the Senior Citizen National Work Plan is very good but its implementation is poor due to improper networking and inadequate resources. Nepalese policies regarding the problems of the elderly are too ambitious. It means that the policies

are good ones but their implementation has always been valued as weak. He further stressed that government policies are good ones but programs have not been able to address the needs of the elderly due to the lack of good projects.

Mr. Deuja argues that the lack of clear rules and regulations in the cope of health and social care problems is hindering such issues. He further argues that there are 240 elderly currently living in Pasupati Bridhashram (Elderly Home) but due to few skilled care takers and low staffing it has been difficult to maintain the quality of care for the elderly. Bimala said that the elderly-care taker ratio in any community home or any old care home should be 10:1. There are no policies and provisions for it. The lack of availability of trained professionals and resources has been a key hindrance for the care of the elderly in old age homes. However, the constitutional right to health care is being translated into a policy of universal free essential health care in Nepal. In December 2006, emergency and inpatient services were declared free for the disadvantaged, destitute, under-served, the elderly, the people living with physical and psychological disability, and Female Community Health Volunteers (FCHVs), at district hospitals and primary health care centers (PHCCs). Moreover, outpatient care was declared free in 35 low human development indicator districts. In October 2007, Government of Nepal further decided to offer essential health care services free of charge to all citizens at all health and sub-health posts from mid-January 2008.

Nepal's current rights based model for the well-being of the elderly looks good to some extent. All respondents opined that the government's old age allowance and partial health check-up system for the elderly is good but not sufficient for their well-being. Mr. Deuja opined that the Nepalese model cannot evolve due to the lack of substantial policy directed towards the care of elderly. Some academician sees flaws in the national policies and programs. They argues that without a provision of skilled manpower such as health personnel and social workers in the caring process, the quality of care cannot progress even in old age homes or community homes. The physical facilities for delivery of service are not adequate and are in process of development. Majority of the fore-front health facilities are in the make shift basis specially sheltered by VDCs and other organizations. There is lack of facilities for maintaining privacy due to inadequate space in these facilities. The assistance rendered by the local bodies (DDC, VDC and Municipalities) are notable in this area.

CHAPTER EIGHT
QUANTITATIVE DATA ANALYSIS AND INTERPRETATION

This chapter presents results of the questionnaire-based interview conducted in Kyoto (Japan) and Kathmandu (Nepal). The results cover demographic characteristics of the respondents followed by their health conditions, health care seeking behaviors, most trusted persons, friends and relatives, care providers, social networks and participation, elderly violence, perceived societal perceptions, life ratings and satisfaction, worries, safety arrangements at home, and participation in leisure and religious activities. In other words, this chapter is focused on the physical, mental, psychological, social, economic, housing condition living arrangements as well as activity and entertainment status of the elderly.

1. Demographic Characteristics

The demographic characteristics of the elderly are shown in the following Table 9.

Table 9: Demographic Characteristics of Elderly Population

Variables	City (Country)			X^2 Value	P value
1.Sex	**Kyoto (Japan)**	**Kathmandu (KTM) (Nepal)**	**Total**		
Male	34(51.5)	50(50.0)	84(50.6)		
Female	32(48.5)	50(50.0)	82(49.4)		
Total	**66(**100.0**)**	**100(**100.0**)**	**166(**100.0**)**	0.037	n.s.
3.Education					
Elementary	14(21.2)	25(25.0)	39(23.5)		
Junior High school	22(36.4)	20(12.0)	42(21.7)		
Senior High school	24(36.4)	12(12.0)	36(21.7)		
Higher education	6(9.1)	13(13.0)	19(11.4)		
No Schooling	0(.0)	30(30.0)	30(18.1)		
Total	**66(**100.0**)**	**100(**100.0**)**	**166(**100.0**)**	34.25	p<0.001
2.Age(years)					
61-70	11(34.4)	21(65.6)	32(100.0)		
71-80	27(31.8)	58(68.2)	85(100.0)		
81-90	20(50.0)	20(50.0)	40(100.0)		
91-100	8(88.9)	1(11.1)	9(100.0)		
Total	66(39.8)	100(60.2)	166(100.0)	13.477	p<0.01
4.Family Type					
Nuclear	62(93.9)	45(45.0)	107(64.5)		
Joint	4(6.1)	55(55.0)	59(35.5)		
Total	**66(**100.0**)**	**100(**100.0**)**	**166(**100.0**)**	41.566	p<0.001
5.Marital Status					
Married	26(39.4)	31(31.0)	57(34.3)		
Unmarried	2(3.0)	2(2.0)	4(2.4)		
Widowed	24(36.4)	33(33.0)	57(34.3)		
Widower	12(18.2)	21(21.0)	33(19.9)		
Divorced/Separate	2(3.0)	13(13.0)	15(9.0)		
Total	**66(**100.0**)**	**100(**100.0**)**	**166(**100.0**)**	5.654	n.s.
6.Number of Children					
One	13(24.1)	47(50.0)	60(40.5)		
Two	21(38.9)	39(41.5)	60(40.5)		
Three	15(27.8)	6(6.4)	21(14.2)		
Four	4(7.4)	2(2.1)	6(4.1)		
Five	1(1.9)	0(.0)	1(.7)		
Total	**54(**100.0**)**	**94(**100.0**)**	**148(**100.0**)**	20.907	p<0.001
7.Religion					
Hindu	0(.0)	77(77.0)	77(46.4)		
Buddhist	47(71.2)	16(16.0)	63(38.0)		
Christian	10(15.2)	4(4.0)	14(8.4)		
Muslim	0(.0)	3(3.0)	3(1.8)		
None	9(13.6)	0(.0)	9(5.4)		
Total	**66(**100.0**)**	**100(**100.0**)**	**166(**100.0**)**	1.042	p<0.001

Table 9 describes demographic characteristics of the respondents. Accordingly, the male participants were 50.5% from Kyoto and 50.0% from Kathmandu. Similarly, female were 48.5% and 50.0% respectively. By education, nearly one third of the respondents from Nepal had no schooling (30.0%) while Japanese elders had junior and senior high school education (36.4%). Japanese were concentrated on higher age group (50% and 88%) while in Nepal, the higher concentration was in lower age groups (65.6% and 68.2%). Data across the family type shows, about all of the Japanese elders lived in nuclear family whereas majority of Nepalese elders lived in joint family (55.0%) **(X^2 value=**41.566, P<0.0001).By marital status widowed were found about in similar proportion in both countries (36.4%) and (33.0%). However, married elders were a bit more in Japan (39.4%) compare to Nepal (31.0%). Few Nepalese elders had three or more children (6.1%) contrarily; this was higher in Japanese (27.8%).By religion, significant proportion of Nepalese elders was Hindu (77.0%) while Japanese were Buddhist (71.2%). Although small proportion of Japanese respondents reported that they were not belongs to any religion (13.6%).

2. Health status of the Elderly

Good health is undeniably an important factor in feeling happy and satisfied with life. To a limited extent, discomfort and disease in old age can be combatted with medical treatment, but attention to preventive health measures before and during old age is a more effective defense. The truth of the proverbs that " an ounce of prevention worth a pound of cure" is particularly evident with respect to health in old age (Aiken, 1995: 83). The succeeding few table present elderly person's health status of Kyoto (Japan) and Kathmandu (Nepal).

The present health status of the elderly people of Kyoto and Kathmandu is shown in Table 10.

Table 10: Distribution of Respondents by Present Health Status

Variables		Health Status, N=166(%)					X^2 Value	P value
1.Gender		**Excellent**	**Good**	**Fair**	**Poor**	**Total**		
Male		3(3.6)	40(47.6)	33(39.2)	8(9.5)	84(100)	17.474	p<0.001
Female		2(2.4)	15(18.3)	52(63.4)	13(15.8)	82(100)		
2.Type of Family								
Nuclear		4(3.7)	37(34.6)	52(48.6)	14(13.1)	107(100)	2.66	n.s.
Joint		1(1.7)	18(30.5)	33(55.9)	7(11.9)	59(100)		
3. City(Country)								
Kyoto (Japan)		5(7.6)	24(36.4)	30(45.5)	7(10.7)	66(100)	10.093	p<0.005
Kathmandu(Nepal)		0(.0)	31(31.5)	55(55.0)	14(14.0)	100(100)		
4.Age (Years) and City					0.672			n.s.
61-70	Kyoto	2(18.2)	4(36.4)	3(27.3)	2(18.1)	11(100.0)		
	Kathmandu	0(.0)	11(52.4)	9(42.9)	1(4.8)	21(100.0)		
71-80	Kyoto	2(7.4)	13(48.1)	10(37.0)	2(7.4)	27(100.0)		
	Kathmandu	0(.0)	15(25.9)	35(60.3)	8(13.8)	58(100.0)		
81-90	Kyoto	1(5.0)	6(30.0)	12(60.0)	1(5.0)	20(100.0)		
	Kathmandu	0(.0)	5(25.0)	10(50.0)	5(25.0)	20(100.0)		
91-100	Kyoto	0(.0)	1(12.5)	5(62.5)	2(25.0)	8(100.0)		
	Kathmandu	0(.0)	0(.0)	1(100.0)	0(.0)	1(100.0)		
5.Marital Status								
Married	Kyoto	3(11.5)	10(38.5)	11(42.3)	2(7.7)	26(100.0)		
	Kathmandu	0(.0)	17(54.8)	14(45.2)	0(.0)	31(100.0)		
Unmarried	Kyoto	0(.0)	2(100.0)	0(.0)	0(.0)	2(100.0)		
	Kathmandu	0(.0)	0(.0)	2(100.0)		2(100.0)		
Widowed	Kyoto	0(.0)	5(20.8)	16(66.6)	3(12.5)	24(100.0)		
	Kathmandu	0(.0)	3(9.1)	24(72.7)	6(18.2)	33(100.0)		
Widower	Kyoto	2(16.7)	6(50.0)	2(16.7)	2(16.7)	12(100.0)		
	Kathmandu	0(.0)	8(38.1)	8(38.1)	5(23.8)	21(100.0)		
Divorced/Separated	Kyoto	0(.0)	1(50.0)	1(50.0)	0(.0)	2(100.0)		
	Kathmandu	0(.0)	3(23.1)	7(53.8)	3(23.1)	13(100.0)		
Total		**5(3.0)**	**55(33.1)**	**85(51.2)**	**21(12.6)**	**166(100.0)**	29.488	p<0.01

Table 10 describes present health status of the respondents on the basis of gender, family, country, age and marital status. Accordingly, nearly half of the respondents feel fair health at present (51.2%), followed by good (33.1%), and poor (12.6%). However, a small proportion of them expressed excellent health (3.0%). Disaggregating data into different sex, females were significantly higher reporting fair health (63.4), than male (36.9%). This reflects, female were healthier than male. With regards to family type, majority of them living in joint family had fair health (55.9%) which was 48.6% for nuclear family. By country, excellent and fair health status was

reported by 7.6% and 36.4 % respectively while for Nepal none of them had reported excellent health and 39.4% had good health, as reported. Disaggregating age group data by country, significant proportion of elders of Nepal aged 61 to 100 reported that they had fair health at present. By country, excellent and fair health status was reported by 7.6% and 36.4 % respectively while for Nepalese elderly, none of them had reported excellent health. However, About 31.5% elderly were enjoying with good health. Considering overall health condition of the respondents by country, significant proportion of elders of Japan aged 61 to 100 reported that they had good health at present. According to marital status, all the unmarried Japanese were found with fair health (100.0%),followed by Nepalese widowed (72.7%) and divorcee Nepalese (53.8%) compare to Japanese(0.0%),(50.0%) and (50.0%).

Table 11: Eyesight and Hearing Status

Variable	**Eyesight**						
1.Gender	**Excellent**	**Good**	**Fair**	**Poor**	**Total**	**X^{2} Value**	**P Value**
Male	1(1.2)	42(50.0)	37(44.0)	7(8.3)	84(100.0)		
Female	2(2.4)	18(22.0)	54(65.9)	8(9.7)	82(100.0)		
Total	**3(1.8)**	**60(36.1)**	**91(54.8)**	**15(9.0)**	**166(100)**	30.887	p<0.001
2.City							
Kyoto	2(3.0)	23(34.8)	36(54.5)	5(7.6)	66(100.0%)		
Kathmandu	1(1.0)	37(37.0)	52(52.0)	10(10.0)	100(100.0%)		
Hearing							
Male	1(1.2)	49(58.3)	27(32.1)	7(8.3)	84(100)		
Female	1(1.2)	20(24.4)	51(62.1)	10(12.2)	82(100.0)		
Total	**2(1.2)**	**69(41.6)**	**78(47.0)**	**17(10.2)**	**166(100)**	20.59	p<0.001
City							
Kyoto	1(1.5)	29(43.9)	30(45.5)	6(9.1)	66(100.0)		
Kathmandu	1(1.0)	40(40.0)	48(48.0)	11(11.0)	100(100.0)		
Total	**2(1.2)**	**69(41.6)**	**76(45.8)**	**17(10.2)**	**166(100)**	0.681	n.s.

Table 11 presents the distribution of respondents by their eyesight and hearing status. These data show that females have fair eyesight (65.9%) and hearing (62.1%) than that of the males, i.e. (44.0%) and (32.1%) respectively. However in good eyesight, male's proportion was found to be significantly higher (50.0%) whereas female were only (22.0%). The overall results indicate the need of hearing aids and eye glasses for the elders. By country, hearing status of the elderly belonging to each category was almost similar(X2=0.681, P=0.878, df=3).

Aids and appliances are meant for assisting an elderly person to do his activities of daily living independently. Common aids and appliances are cane, spectacles, hearing aid,

crutches, walker, knee-brace, corset and soft-added shoes. These aids and appliances are used by otherwise disease free elderly person.

Table 12: Need of Aids Currently Not Having

Variable	**Need for Assistive Devices**					
1.Sex	**Yes**	**No**	**Not answered**	**Total**	**X^2 Value**	**P Value**
Male	17(20.2)	66(78.6)	1(1.2)	84(100.0)		
Female	22(26.8)	60(73.1)	0(.0)	82(100.0)		
Total	**39(23.5)**	**126(75.9)**	**1(0.6)**	**166(100)**	2.658	n.s.
2.City						
Kyoto	15(22.7)	50(75.7)	1(1.5)	66(100.0)		
Kathmandu	24(24.0)	76(76.0)	0(.0)	100(100.0)		
Total	**39(23.5)**	**126(75.9)**	**1(0.6)**	**166(100)**	1.862	n.s.
Family Type						
Nuclear	23(21.3)	84(77.7)	1(.9)	108(100.0		
Joint	16(27.6)	42(72.4)	0(.0)	58(100.0)	1.401	n.s.
Total	**39(23.5)**	**126(75.9)**	**1(0.6)**	**166(100)**		

Looking at Table 12, a lion's share of respondents doesn't need any aids (75.9%). Of those who required assistive devices, the proportion from Nepal was slightly more (24.0%). However, slightly more than a quarter of female elders and those who were living in joint family reported as need of assistive device (26.8%) and (27.6%).

There are different types of assistive devices for example; walking aids, hearing aid, wheel chair, toilet device, surgical shoes, urinary bag, braces, speech device etc. In the following table I have examined four types of aids.

Table 13: Types of Assistive Devices needed by the Elders

	Types of needed Aids						
1.Sex	**Spectacles**	**Hearing aid**	**Walker**	**Wheel chair**	**Total**	**X^2 Value**	**P Value**
Male	8(47.1)	7(41.2)	0(.0)	2(11.8)	17(100.0)	4.754	n.s.
Female	5(22.7)	10(45.4)	3(13.6)	4(18.2)	22(100.0)		
2.City							
Kyoto	10(66.6)	5(33.3)	0(.0)	0(.0)	15(100.0)	18.696	p<0.001
Kathmandu	3(12.5)	12(50.0)	3(12.5)	6(25.0)	24(100.0)		
3.Family Type							
Nuclear	10(43.5)	8(34.7)	2(8.7)	3(13.1)	23(100.0)		
Joint	3(18.8)	9(56.2)	1(6.2)	3(18.8)	16(100.0)	3.648	n.s.
Total	**13(33.3)**	**17(43.5)**	**3(7.7)**	**6(15.4)**	**39(100)**		

Of those who expected assistive aids preferred hearing aids (43.5%); this is followed by spectacles (33.3%) and wheel chair (15.4%). Interestingly, Nepalese women prefer walker (12.5%), also half of the Nepalese found to be using hearing aid (50.0%) than by the Japanese elders (33.3%) (Table 13).It shows poor health status of Nepalese elderly person in comparison to the Japanese elders.

Chronic Illness or Health Impairments

With the population ageing, care for chronically ill and geriatric patients has become the key issue for the policy development of the countries. Efforts are made to provide health care services to the needs of the elderly people so that they could lead healthy and productive lives (Geriatric Center Nepal, 2010). A chronic or acute health problem such that the physiological capacity to function is significantly limited or impaired. The term shall include health impairments due to asthma, attention deficit disorder or attention deficit with hyperactivity disorder, diabetes, paralysis, a heart condition, cognitive impairment if such health impairment adversely affects a elderly people's daily living. Older people are undeniable less healthy than younger adults. Most have one or more chronic conditions. The biological decline in the functioning of organs makes older people more vulnerable to illness. Table 14 shows the chronic illness of the elderly.

Table 14: Chronic Illness or Health Impairments

Chronic Illness/Physical Disabilities, N=166(%)				X^{2} Value	P value
Variable	**Yes**	**No**	**Total**		
1.Gender					
Male	74(88.1)	10(11.9)	84(100.0)		
Female	74(90.2)	8(9.8)	82(100.0)		
Total	**148(89.2)**	**18(10.8)**	**166(100.0)**	0.199	n.s.
2.Type of Family					
Nuclear	97(90.7)	10(9.3)	107(100.0)		
Joint	51(86.2)	8(13.8)	59(100.0)	0.68	n.s.
Total	**148(89.2)**	**18(10.8)**	**166(100.0)**		
3.City					
Kyoto	57(86.4)	9(13.6)	66(100.0)		
Kathmandu	91(91.0)	9(9.0)	100(100.0)	0.868	n.s.
Total	**148(89.2)**	**18(10.8)**	**166(100.0)**		

	Yes			**No**			X^{2} Value	P value
4.Age (Years)	**Kyoto**	**Kathmandu**	**Total**	**Kyoto**	**Kathmandu**	**Total**	0.673	n.s.
61-70	9(15.8)	19(20.9)	28(18.9)	2(22.2)	2(22.2)	4(22.2)		
71-80	22(38.6)	53(58.2)	75(50.7)	5(55.6)	5(55.6)	10(55.6)		
81-90	18(31.6)	19(20.9)	37(25.0)	2(22.2)	1(11.1)	3(16.7)		
91-100	8(14.0)	0(.0)	8(5.4)	0(.0)	1(11.1)	1(5.6)		
Total	57(100.0)	91(100.0)	148(100.0)	9(100.0)	9(100.0)	18(100.0)		

Table 14 indicates the overwhelming share of respondents living with physical disabilities/chronic illness (89.2%). The impairments were found to be slightly lower among the male respondents (88.1%) compared to females (90.2%).Similarly; this proportion was higher in respondents living in nuclear family (90.7%). While compared age group across the two countries, Nepalese aged 61-70(20.9%) and 71-80(58.2%) were found to be more than Japanese (15.8% and 38.6%). While compared across the two countries, there was no significant difference between Kathmandu (Nepal) (91.0) and Kyoto (Japan) (86.4%) (X^2 =0.868, P=0.352 at df=1).

Table 15: Types of physical disability/Chronic Illness

Physical Disabilities	**Sex, N=148(%)**			X^2 **Value**	**P value**
1. Gender	**Male**	**Female**	**Total**		
Partial paralysis	2(2.7)	2(2.7)	4(2.7)		
Missing/non functional limbs	8(10.8)	5(6.8)	13(8.8)		
Broken bones	0(.0)	7(9.5)	7(4.7)		
Heart disease	20(27.0)	7(9.5)	27(18.2)		
Respiratory diseases/Asthma	11(14.9)	18(24.3)	29(19.6)		
Diabetes	10(13.5)	7(9.5)	17(11.5)		
Diabetes and Heart diseases	9(12.2)	10(13.5)	19(12.8)		
Gastric	7(9.5)	12(16.2)	19(12.8)		
Mental	2(2.7)	4(5.4)	6(4.1)		
Any other	5(6.8)	2(2.7)	7(4.7)		
Total	74(100.0)	74(100.0)	148(100.0)	19.491	p<0.05
2.City					
	Kyoto	**Kathmandu**	**Total**		
Partial paralysis	1(1.8)	3(3.3)	4 (2.7)		
Missing/ non functional limbs	9(15.8)	4(4.4)	13 (8.8)		
Broken bones	6(10.5)	1(1.1)	7 (4.7)		
Heart disease	11(19.3)	16(17.6)	27 (18.2)		
Respiratory diseases/Asthma	6(10.5)	23(25.3)	29 (19.6)		
Diabetes	3(5.3)	14(15.4)	17 (11.5)		
Diabetes and Heart diseases	9(15.8)	10(11.0)	19 (12.8)		
Gastric	4(7.0)	15(16.5)	19 (12.8)		
Mental	3(5.3)	3(3.3)	6 (4.1)		
Any other	5(8.8)	2(2.2)	7 (4.7)		
Total	**57(100.0)**	**91(100.0)**	**148 (100)**	25.759	p<0.01

As seen in Table 15, respiratory disease/asthma commonly prevailed in the respondents (19.6%), followed by heart disease (18.2%). Next to these, diabetes and heart diseases including gastric were found to be similar in the respondents (12.8%). Fewer respondents were living with mental diseases (4.1%), partial paralysis (2.7%) and broken bones (4.7%). The differences of proportion of respondents suffering from respiratory disease across the two countries were visible. Accordingly, Nepalese elders were suffered from respiratory diseases (25.3%), gastric (16.5%) and partial paralysis (3.3%), while the tendency of heart disease, physical deformities i.e. missing or non-functional limbs and broken bones were considerably high in Japanese elders i.e. 19.3%, (15.8%) and (10.5%) respectively. In contrast, these were found in relatively fewer Nepalese elders (4.4% and (1.1% respectively).

Table 16: Duration of Suffering from Physical Impairment

Variables		Duration						
1.Marrital Status		**For last 5 yr**	**For last 10 yr**	**For last 15 yr**	**More than 15 yr**		**X^{2}Value**	P value
Married		9(18.0)	16(32.0)	17(34.7)	6(12.0)	48(100.0)		
Unmarried		2(50.0)	1(25.0)	1(25.0)	0(.0)	4(100.0)		
Widowed		8(15.4)	20(38.5)	19(36.5)	5(9.8)	52(100.0)		
Widower		2(6.9)	14(48.3)	8(27.6)	5(17.2)	29(100.0)		
Divorced/Separated		1(6.7)	7(46.7)	5(33.3)	2(13.3)	15(100.0)		
Total		**22(14.8)**	**58(38.9)**	**50(33.7)**	**18(12.1)**	**148(100.0)**	11.009	n.s.
2.Gender								
Male		9(12.0)	32(42.7)	22(29.3)	11(14.7)	74(100.0)		
Female		13(17.6)	26(35.1)	28(37.8)	7(9.5)	74(100.0)		
Total		**22(14.8)**	**58(38.9)**	**50(33.7)**	**18(12.1)**	**148(100.0)**	4.51	n.s.
3.Age(Years) and Country								
61-70	Kyoto	4(36.4)	2(22.2)	2(28.6)	1(100.0)			
	KTM	7(63.6)	7(77.8)	5(74.4)	0(.0)			
71-80	Kyoto	2(50.0)	8(25.8)	5(17.9)	7(58.3)			
	KTM	2(50.0)	23(74.2)	23(82.1)	5(41.7)			
81-90	Kyoto	4(66.7)	6(42.9)	5(38.5)	3(75.0)			
	KTM	2(33.3)	8(57.1)	8(61.5)	1(25.0)			
91-100	Kyoto	1(100.0)	4(100.0)	2(100.0)	1(100.0)			
	KTM	0(.0)	0(.0)	0(.0)	0(.0)			
Total		**22(100.0)**	**58(100.0)**	**50(100.0)**	**18(100.0)**		20.371	n.s.
4.City								
Kyoto		11(19.0)	20(34.5)	14(24.1)	12(20.7)	57(100)		
KTM		11(12.1)	38(41.8)	36(39.6)	6(6.6)	91(100)		
Total		**22(14.8)**	**58(38.9)**	**50(33.7)**	**18(12.1)**	**148(100)**	11.754	p<0.05
5.Family Type								
Nuclear		17(17.3)	39(39.8)	26(26.5)	15(15.3)	97(100)		
Joint		5(9.8)	19(37.3)	24(47.1)	3(5.9)	51(100)		
Total		**22(14.8)**	**58(38.9)**	**50(33.7)**	**18(12.1)**	**148(100)**	9.074	n.s.

Table 16 presents the duration of health impairment or disability among elders. The figure significantly shows that nearly half proportion of respondents were suffering from physical disability for ten years (38.9%), followed by 15 years (33.6%). However, few of them (14.8%) were suffered from last 5 years. About 12% had severe disability (12.1%). The tendency of suffering was higher among widower (48.3%) and

divorced/separated (46.7%). Unmarried elders were found less suffered (25.0%). By gender, more than one third women were suffering from last 15 years (37.8%).The majority of Nepalese respondents in the age 61-70 years had suffered for last 10 years (77.8%), followed by last 15 years (74.4%) and for last 5 years(63.6). These proportion was found in very few among Japanese elders (22.2%, 28.6% and 36.4). Likely, the age group 71-80 follows the same trend. This shows that the chronic illness was higher in Nepalese elders than Japanese. (^{X2} =20.371, P=0.060, df=12).

Table 17: Health appointments with a doctor in the past six months

Variables	**Frequency of visiting a doctor, N=166(%)**						**X^2 Value**	**P value**
1.Gender	1−2	3−4	5−6	**6>**	**None**	**Total**		
Male	13(15.7)	49(59.0)	12(14.5)	5(6.0)	5(4.8)	84(100)		
Female	31(37.8)	31(37.8)	13(15.9)	5(6.1)	2(2.4)	82(100)		
Total	**44(26.7)**	**80(48.5)**	**25(15.2)**	**10(6.1)**	**7(4.2)**	**166(100)**	12.383	p<0.05
2.City							29.779	p<0.001
Kyoto	8(12.3)	28(43.1)	17(26.2)	9(13.8)	3(4.6)	66(100)		
KTM	36(36.0)	52(52.0)	8(8.0)	1(1.0)	4(4.0)	100(100)		
Total	**44(26.7)**	**80(48.5)**	**25(15.2)**	**10(6.1)**	**7(4.2)**	**166(100)**		
3.City and Frequency	61-70 (Yrs)	*71-80* (Yrs)	81-90(Yrs)	91-100(Yrs)	Total			
1-2 times (Kyoto)	2(22.2)	2(22.2)	4(44.4)	1(11.1)	9(100.0)			
1-2 times (KTM)	10(27.8)	19(52.8)	6(16.7)	1(2.8)	36(100.0)			
3-4 times (Kyoto)	5(17.9)	15(53.6)	8(28.6)	0(.0)	28(100.0)			
3-4 times (KTM)	7(13.5)	32(61.5)	13(25.0)	0(.0)	52(100.0)			
5-6 times (Kyoto)	3(17.6)	6(35.3)	4(23.5)	4(23.5)	17(100.0)			
5-6 times (KTM)	1(12.5)	6(75.0)	1(12.5)	0(.0)	8(100.0)			
> 6 times (Kyoto)	1(11.1)	2(22.2)	4(44.4)	2(22.2)	9(100.0)			
> 6 times (KTM)	1(100.0)	0(.0)	0(.0)	0(.0)	1(100.0)			
None (Kyoto)	0(.0)	2(66.7)	0(.0)	1(33.3)	3(100.0)			
None (KTM)	2(66.7)	1(33.3)	0(.0)	0(.0)	3(100.0)			

The frequency of visiting doctors during the past six months is presented in Table 17. Accordingly, majority of respondents visited a doctor three to four times during the past six months (48.5%); a slightly more than a quarter respondents had visited twice (26.7%) while only 15.2 % had seen five to six times. Male respondents who visited 3-4 times was about two third (59.0) but only 37.8% females had visited doctor seeking

health care. It indicates that females have low access to health services. According to age category, huge proportion of respondents aged 81-90 from Japan had seen a doctor frequently (44.0%). Similarly, this proportion was higher in Nepalese age group 71-80 (X^2=25.886,P=0.011,df=12).

Table 18: Hospital stay in the past six months (Overnight or Longer)

Variables	**Hospital Overnight or Longer (in days)**						**N=166**	**$X^{2\ Value}$**	**P Value**
1.Marrital Status	**1−7**	**8−14**	**15- 21**	**22- 29**	**30>**	**None**	**Total**		
Married	3(5.3)	3(5.3)	2(3.5)	0(.0)	0(.0)	49(86.0)	57(100)	51.93	p<0.001
Unmarried	2(50.0)	0(.0)	2(50.0)	0(.0)	0(.0)	0(.0)	4(100)		
Widowed	13(22.8)	7(12.3)	2(3.5)	1 (1.8)	3(5.3)	31(54.4)	57(100)		
Widower	1(3.0)	5(15.2)	4(12.1)	0(.0)	0(.0)	23(69.7)	33(100)		
Divorced/Separated	6(40.0)	1(6.7)	1(6.7)	0(.0)	0(.0)	7(46.7)	15 (100)		
Total	**25(15.1)**	**16(9.6)**	**11(6.6)**	**1(0.6)**	**3(1.8)**	**110**	**166(100)**		
2.Gender									
Male	6(7.1)	9(10.7)	9(10.7)	0(.0)	0(.0)	60(71.4)	84(100)		
Female	19(23.2)	7(8.5)	2(2.4)	1(1.2)	3(3.7)	50(61.0)	82(100)		
Total	**25(15.1)**	**16(9.6)**	**11(6.6)**	**1(0.6)**	**3(1.8)**	**110(66.3)**	**166(100)**	18.6	p<0.01
3.Age(Years)									
61-70	2(6.2)	1(3.1)	0(.0)	0(.0)	1(3.1)	28(87.5)	32(100)		
71-80	10(11.8)	10(11.8)	5(5.9)	1(1.2)	1(1.2)	58(68.2)	85(100)		
81-90	13(32.5)	4(10.0)	5(12.5)	0(.0)	1(2.5)	17(42.5)	40(100)		
91-100	0(.0)	1(11.1)	1(11.1)	0(.0)	0(.0)	7(77.8)	9(100)		
Total	**25(15.1)**	**16(9.6)**	**11(6.6)**	**1(0.6)**	**3(1.8)**	**110(66.3)**	**166(100)**	16.32	p<0.05
4.City									
Kyoto	6 6(9.1)	11(16.7)	5(7.6)	1(1.5)	3(4.5)	40(60.6)	66(100)		
Kathmandu	19(19.0)	5(5.0)	6(6.0)	0(.0)	0(.0)	70(70.0)	100(100)		
Total	**25(15.1)**	**16(9.6)**	**11(6.6)**	**1(0.6)**	**3(1.8)**	**110(66.3)**	**166(100)**	14.95	p<0.05

Table 18 describes respondents' overnight hospital stay. Surprisingly, a large share of respondents never stayed in a hospital overnight (66.3%). The remaining stayed for one week (15.1%), two weeks (9.0%) and three weeks (6.6%) and more than one month (1.8%). One remarkable finding is that unmarried (50.0%) and divorcee respondents (40.0%) were most likely to be admitted in hospital. In terms of gender, there were significant differences between male and female i.e. 23.2% and 7.1% respectively (X2 =18.6, P=0.002,df=5). More interestingly, none of the respondents age 91-100 lived in hospital for one week, they were lesser in number even for staying two and three weeks(11.1%)

Satisfaction towards Health Care Services

Elderly people are prone to a number of chronic diseases and recurring acute illnesses from these diseases. As a result, medical costs for elderly people are almost five

times higher than those for young people in Japan. Due to the increase of the elderly population aged 65 years and over, medical costs for elderly people are increasing yearly and now constitute more than 50% of total medical costs in Japan (Ito, 2008).
Good medical care for the elderly parent typically requires a focus on the maintenance of functional independence in the presence of chronic and age-related disease.

Table 19: Satisfaction towards Received Medical Treatment

Variables		Level of Satisfaction						
1.Sex		**Very satisfied**	**Somewhat satisfied**	**Somewhat dissatisfied**	**Very dissatisfied**	**Total**	**X^{2} Value**	**P Value**
Male		8(9.5)	44(52.4)	19(22.6)	13(15.5)	84(100.0)		
Female		10(12.2)	21(25.6)	28(34.1)	23(28.0)	82(100.0)		
Total		**18(10.8)**	**65(39.2)**	**47(28.3)**	**36(21.7)**	**166(100.0)**	13.065	p<0.01
2.Education								
Elementary	Kyoto	3(21.4)	9(64.3)	2(14.3)	0(.0)	14(100.0)		
	KTM	0(.0)	6(24.0)	10(40.0)	9(36.0)	25(100.0)		
Junior High School	Kyoto	7(31.8)	13(59.1)	2(9.1)	0(.0)	22(100.0)		
	KTM	0(.0)	3(15.0)	9(45.0)	8(40.0)	20(100.0)		
Senior High school	Kyoto	7(29.2)	12(50.0)	5(20.8)	0(.0)	24(100.0)		
	KTM	0(.0)	4(33.3)	4(33.3)	4(33.3)	12(100.0)		
Higher Education	Kyoto	1(16.7)	5(83.3)	0(.0)	0(.0)	6(100.0)		
	KTM	0(.0)	11(84.6)	2(15.4)	0(.0)	13(100.0)		
No schooling	KTM	0(.0)	2(6.7)	13(43.3)	15(50.0)	30(100.0)		
Total		**18(10.8)**	**65(39.2)**	**47(28.3)**	**36(21.7)**	**166(100.0)**		
3.City								
Kyoto		18(27.3)	39(59.1)	9(13.6)	0(.0)	66(100.0)	70.487[a]	p<0.001
KTM		0(.0)	26(26.0)	38(38.0)	36(36.0)	100(100.0)		
Total		**18(10.8)**	**65(39.2)**	**47(28.3)**	**36(21.7)**	**166(100.0)**		

With regard to the satisfaction of medical treatment received as Table 19 above reveals, majority of the respondents were somewhat satisfied with the treatment they received (39.2%). where as little more than a quarter of them were somewhat dissatisfied (28.3%), followed by very dissatisfied (21.7%) and very satisfied (10.8%).The results show that the significantly higher respondents who replied somewhat satisfied had higher education was from Nepal (84.6%) and Japan (83.3%). Likewise, Japanese elderly were reported very satisfied 27.3% and somewhat satisfied 59.1% while, Nepalese 26.0% elderly were somewhat satisfied and rest of the Nepalese elderly were somewhat (38.0%) and very dissatisfied (36.0%) to their health care systems. However, only Nepalese respondents with no schooling were found to be very dissatisfied (50.0%). As compared to the Japanese cohort of the elders, Nepalese elders were very dissatisfied (36.0%) with the health services they had received in their last visit. The high cost of medical care is one of the greatest worries of older adults.

Table 20: Elderly People's Rating of the Health Care System

Variables		Rating					X^{2} Value	P value
Age (years)	**Country**	Excellent	Good	Fair	Poor	Total		
Elementary	Kyoto	2(14.3)	10(71.4)	2(14.3)	0(.0)	14(100.0)		
	KTM	0(.0)	2(8.0)	12(48.0)	11(44.0)	25(100.0)		
Junior High School	Kyoto	6(27.3)	11(50.0)	5(22.7)	0(.0)	22(100.0)		
	KTM	0(.0)	0(.0)	10(50.0)	10(50.0)	20(100.0)		
Senior High school	Kyoto	5(20.8)	18(75.0)	1(4.2)	0(.0)	24(100.0)		
	KTM	0(.0)	1(8.3)	3(25.0)	8(66.7)	12(100.0)		
Higher Education	Kyoto	0(.0)	6(100.0)	0(.0)	0(.0)	6(100.0)		
	KTM	0(.0)	4(30.8)	9(69.2)	0(.0)	13(100.0)		
No schooling	KTM	0(.0)	0(.0)	9(30.0)	21(70.0)	30(100.0)		
Total		**13(7.8)**	**52(31.3)**	**51(30.7)**	**50(30.1)**	**166(100)**	55.737	p<0.001
City								
Kyoto		13(19.7)	45(68.2)	8(12.1)	0(.0)	66(100.0)		
KTM		0(.0)	7(7.0)	43(43.0)	50(50.0)	100(100.0)	1.125	p<0.001
Total		**13(7.8)**	**52(31.3)**	**51(30.7)**	**50(30.1)**	**166(100.0)**		

Table 20 discloses the ranking of the existing health care system by the elders. Surprisingly, there is not any significant difference in ranking, as similar proportion of respondents perceived that the health care system was fair (30.7%), good (31.3%) and poor (30.1%) respectively. The rest constitutes excellent on the ranking (7.8%). The cross data across the education level shows that the significant Japanese respondents with elementary education(71.4%),senior high school(75.0%) and higher education(100.0%) rated as good health care system while the proportion of Nepalese was only 8.0%, 8.3% and 30.8%. Moreover, none of Nepalese elderly opinioned excellent health care system in their country. Through the country wise data, half of Nepalese respondents expressed poor health care system in Nepal (50.0%) while no Japanese reported this category (0.0%). More interestingly, the proportion of respondents from Japan categorized as good (68.2%) whereas only fewer Nepalese ranked this category (7.0%). It is because Japan has a generous system of social security health care. The elderly in Japan enjoy health care services with very low user charges (co-payments).

Table 21: Measures might have adopted to maintain Health

Variables	Measures					X^{2} Value	P Value
1.City	Exercise	Balance diet	Avoidance of certain habits	No any fixed habits	Total		
Kyoto	20(30.3)	24(36.4)	1(1.5)	21(31.8)	66(100.0)		
KTM	20(20.0)	27(27.0)	5(5.0)	48(48.0)	100(100.0)	6.727	n.s.
Total	**40(24.1)**	**51(30.7)**	**6(3.6)**	**69(41.6)**	**166(100.0)**		

The table 21 describes the measures that can be adopted in young age to maintain health. Interestingly, 41.6% of respondents reported no any fixed habits; about one third of them adopted balance diet (30.7%), while a little less than a quarter did exercise (24.1). Remarkably, Nepalese elder were higher for not adapting any fixed habits (48.0%) to Japanese (31.8%) whereas Japanese were ahead for doing exercise (30.3%) and having balance diet (36.4%).

Psychological Health Status

Psychologist theorizes that elderly people have not lost the capacity to function but the level attained in their young adulthood becomes obsolete by age 65. Some theorist emphasize social breakdown in the aging process. Older people who are susceptible to psychological problems find that interaction with their social world serves to reinforce everyone's conceptions of incompetence. The concerns with family and social support and with health and well-being overlap to the extent that both assume a tripartite structure of the health construct- family and social support as a social health dimension and health and well-being as physical and mental dimensions, respectively.

The term caregiver refers to anyone who provides assistance to someone else who experiences limitations in activities of daily living (ADLs) and/or instrumental activities of daily living (IADLs). Informal caregiver and family caregiver are terms that refer to unpaid individuals such as family members, friends, neighbors and volunteers who provide help or arrange for help. These individuals can be primary or secondary caregivers, full time or part time, and can live with the person being cared for or live separately. They provide help with household chores, finances, or with personal or medical needs. This definition does not include formal caregivers who are paid care providers associated with a service system. This section describes the psychological and emotional status of the respondents.

Table 22: Main Care Giver

Variables	City				
Care Givers	**Kyoto**	**Kathmandu**	**Total**	**X^{2} Value**	**P value**
Husband	3(12.5)	0(.0)	3(4.7)		
Spouse	3(12.5)	2(5.0)	5(7.0)		
Daughter	8(33.3)	8(20.0)	16(25.0)		
Daughter in-law	3(12.5)	18(45.0)	21(32.8)		
Son	1(3.2)	4(10.0)	5(7.8)		
Relatives	2(8.3)	2(5.0)	4 (6.2)		
Home helper/Servant	4(16.6)	4(10.0)	8(12.5)	**21.029**	**p<0.01**
Grand Child	0(.0)	2(5.0)	2(3.1)		
Total	**24(100.0**	**40(100.0)**	**64(100.0)**		

Data from Table 22 shows daughter (33.3%) and home helper (16.6%) as the main care givers while for Nepalese elderly daughter in law (45%) and daughters (20%) were reported as the prime care givers(significant X^{2}**=21.029,P= 0.004 at 7 df)**. Interestingly in Nepal, husband (none) and spouse (5.0%) were not mentioned as the main care providers but it they were mentioned by 12.5% each in Japan.

Table 23: Care givers' Attitudes as Self-reported by the Elders

Variables	Care Givers' Attitude					X^{2} Value	P value
1.City	**Very good**	**Not so good**	**Normal**	**Don't want to say**	**Total**		
Kyoto	14(58.3)	6(25.0)	4(16.7)	0(.0)	24(100.0)	7.839	p<0.05
Kathmandu	12(30.0)	8(20.0)	18(45.0)	2(5.0)	40(100.0)		
Total	**26(40.6)**	**14(21.9)**	**22(34.4)**	**2(3.1)**	**64(100.0)**		

Considering care givers' attitude towards the elders, more than one third elder categorized very good attitude of care givers (40.6%), this is followed by normal attitude (34.4%). Significantly, Japanese elders liked their care givers' attitude very good (58.3%) while only a little more than a quarter Nepalese elder liked that much(30.0%). It is because they were their daughters at the most. This was found a bit lower among Nepalese elders (30.0%).It may be due to lack of elderly care training and awareness in Nepal. **(X^{2} Value**7.839 **P value**0.049, df=3).

Types of service currently receiving by Elderly

Elderly people can easily lose their independence through various circumstances, either related or unrelated to illness. Therefore, along with the increase in the elderly population, the number of elderly people who need various kinds of help in their lives is constantly increasing (Ito, 2008). Types of service currently receiving by the elderly person of Kyoto and Kathmandu is shown in the following Table 24.

Table 24: Types of service currently receiving

Variables		Services					X^2 Value	P value
1.Sex and Country		Home help	Day and day care services	Home help and day service	None	Total		
Male	Kyoto	3(8.8)	23(67.6)	2(5.9)	6(17.6)	34(100.0)		
	KTM	2(4.0)	1(2.0)	0(.0)	47(94.0)	50(100.0)	3.872	n.s.
Female	Kyoto	6(18.8)	15(46.9)	4(12.5)	7(21.9)	32(100.0)		
	KTM	3(6.0)	0(.0)	0(.0)	47(94.0)	50(100.0)		
2.City								
Kyoto		9(13.6)	38(57.6)	6(9.1)	13(19.7)	66(100.0)	1.008	p<0.001
Kathmandu		5(5.0)	1(1.0)	0(.0)	94(94.0)	100(100.0)		
3.Age (Yrs)								
61-70		2(6.2)	5(15.6)	0(.0)	25(78.1)	32(100.0)		n.s.
71-80		6(7.1)	16(18.8)	3(3.5)	60(70.6)	85(100.0)	0.573	
81-90		5(12.5)	12(30.0)	2(5.0)	21(52.5)	40(100.0)		
91-100		1(11.1)	6(66.7)	1(11.1)	1(11.1)	9(100.0)		
Total		**14(8.4)**	**39(23.5)**	**6(3.6)**	**107(64.5)**	**166(100)**		

Regarding the services currently being received, about two third of them had not received any services (64.5%). The large part of this share was composed by Nepalese (94.0%). However, nearly a quarter got day services and day care services (23.5%). Among the receiver, 5.0% of the Nepalese received home help and day services (1.0%). It indicates Nepalese were isolated from these sorts of services. Cross-tabulation of data by gender and country shows double proportion of participants ,both male and female of Japan, got home help services (8.8%) and (18.8%), this was only 4.0% and 6.0% among Nepalese male and female participants. Out of 66 Japanese elderly 80.3% were receiving different kind of services. Among them, the great bulks i.e. 57.6% were receiving day and day care services. Surprisingly, just 6.0% Nepalese elderly were taking home help and day services. ($\mathbf{X^2}$ Value=1.008 P value0.000, df=3).

Preference for Long-Term Care provider

Long-term care is basically a social service directed at persons with severe chronic health problems. As such, these people are also likely to require active medical care, which should be closely coordinated with their supportive care. Everyone may, at some point in life, be called upon to provide long-term care for someone in their circle of relatives and friends. When this happens, the offer of help is usually spontaneous. Changing demography, epidemiology, and social realities such as urbanization, growing poverty, migration, changes in family structures and growing participation of women in the labor force must all be taken into account when planning human resources for growing long-term care needs. The opinion of the elderly about long-term care is shown in Table 25.

Table 25: Preference for Long-Term Care provider to the Dependent Elderly

Variables		Opinion						
1.Sex		Family members (Informal care).	Home care supported by Govt. (formal home care)	Community settings supported by Govt.(formal community care)	Institutional settings (hospital, nursing homes).	Total	X^{2} Value	p Value
Male	**Kyoto**	2(5.9)	10(29.4)	15(44.1)	7(20.6)	34(100.0)	3.953	n.s.
	KTM	14(28.0)	27(54.0)	8(16.0)	1(2.0)	50(100.0)		
Female	**Kyoto**	0(.0)	12(37.5)	12(37.5)	8(25.0)	32(100.0)		
	KTM	7(14.0)	28(56.0)	14(28.0)	1(2.0)	50(100.0)		
Total		23(13.9)	77(46.4)	49(29.5)	17(10.2)	166(100)		
2.Marital Status								
Married		12(21.1)	27(47.4)	13(22.8)	5(8.8)	57(100.0)	26.239	p<0.05
Unmarried		0(.0)	0(.0)	4(100.0)	0(.0)	4(100.0)		
Widowed		6(10.5)	33(57.9)	13(22.8)	5(8.8)	57(100.0)		
Widower		5(15.2)	13(39.4)	10(30.3)	5(15.2)	33(100.0)		
Divorced		0(.0)	4(26.7)	9(60.0)	2(13.3)	15(100.0)		
Total		23(13.9)	77(46.4)	49(29.5)	17(10.2)	166(100)		

Regarding the opinion of respondents about long term care for dependent elderly, majority perceive that the care should be done in home with support from the government (46.4%). About one third of them opined for community setting supported by the government (29.5%). However, small proportion of them considers family member (13.9) and institutional settings such as hospital and nursing homes (10.2%). Both male and female elders who reported home care supported by government were higher from Nepalese i.e.54.0% and 56.0% respectively (Disaggregating data into marital status of respondents, widowed liked formal home care (57.9%).This is 47.4%, 39.4% for married widower and divorcee respectively. Contrary to this, the preference of all the unmarried respondents goes to formal community care (100.0%).

Present Emotional Health

The following table explains the emotional health status of the elderly.

Table 26: Present Emotional Health

Variables		Present Emotional Health							
11.City		**Excellent**	**Good**	**Fair**	**Poor**	**No response**	**Total**	**X^{2} Value**	**P value**
Kyoto (Japan)		2(3.1)	27(41.5)	32(49.2)	3(4.6)	2(3.0)	66 (100)	23.306	p<0.001
Kathmandu (Nepal)		0(.0)	14(14.0)	76(76.0)	10(10.0)	0(.0)	100(100)		
2.Marital Status and Country									
Married	Kyoto	0(.0)	15(57.7)	9(34.6)	1(3.8)	1(3.8)	26(100.0)	36.581	p<0.001
	KTM	0(.0)	10(32.3)	21(67.7)	0(.0)	0(.0)	31(100.0)		
Unmarried	Kyoto	0(.0)	1(50.0)	1(50.0)	0(.0)	0(.0)	2(100.0)		
	KTM	0(.0)	0(.0)	0(.0)	2(100.0	0(.0)	2(100.0)		
Widowed	Kyoto	1(4.2)	5(20.8)	16(66.7)	1(4.2)	1(4.2)	24(100.0)		
	KTM	0(.0)	0(.0)	27(81.8)	6(18.2)	0(.0)	33(100.0)		
Widower	Kyoto	1(8.3)	5(41.7)	5(41.7)	1(8.3)	0(.0)	12(100.0)		
	KTM	0(.0)	3(14.3)	16(76.2)	2(9.5)	0(.0)	21(100.0)		
Divorced/Separated	Kyoto	0(.0)	1(50.0)	1(50.0)	0(.0)	0(.0)	2(100.0)		
	KTM	0(.0)	1(7.7)	12(92.3)	0(.0)	0(.0)	13(100.0)		
Total		**2(1.2)**	**41(24.8)**	**18(65.5)**	**13(7.9)**	**2(1.2)**	**166(100.0)**		
3.Age(years) and									
61-70	Kyoto	0(.0)	6(22.2)	2(6.2)	1(33.3)	1(100.0)			
	KTM	0(.0)	7(50.0)	13(17.1)	1(10.0)	0(.0)			
71-80	Kyoto	2(100.0)	9(33.3)	16(50.0)	0(.0)	0(.0)			
	KTM	0(.0)	6(42.9)	48(63.2)	4(40.4)	0(.0)			
81-90	Kyoto	0(.0)	11(40.7)	8(25.0)	1(33.3)	0(.0)			
	KTM	0(.0)	1(7.1)	14(18.4)	5(50.0)	0(.0)			
91-100	Kyoto	0(.0)	1(3.7)	6(18.8)	1(33.3)	0(.0)		19.361	n.s.
	KTM	0(.0)	0(.0)	1(1.3)	0(.0)	0(.0)			
Total		**2(100.0)**	**41(100.0)**	**108(100.0)**	**13(100.0)**	**1(100.0)**			

Table 26 shows present emotional health of the respondents. It was found to be fair on nearly two third of the respondents (65.5%). By marital status, significantly higher Nepalese divorcee (92.3%) had fair health at present compared to Japanese divorcee (50.0%).Like this; the elderly from Nepal aged 61-70(17.1%) and 71-80 (63.2%) also perceived that they had fair emotional health at the moment.

3. Social Status and Networks of the Elderly

Elderly people are socially engaged with wider community and embedded within a network of family and friendship relations. For elderly a feeling of social support is positively correlated with both physical and mental health. Those elderly people without such relationships report poorer physical and mental health and poor quality of life (Victor, 2005). This section identifies the social status and support networks of the elderly.

Table 27: People know well Enough

Variables	Number of People					
1.City	**None**	**One or two**	**Three or more**	**Total**		
Kyoto	5(7.6)	34(51.5)	27(40.9)	66(100.0)		
Kathmandu	2(2.0)	22(22.0)	76(76.0)	100(100.0)		
Total	**7(4.2)**	**56(33.7)**	**103(62.0)**	**166(100.0)**	21.089	p<0.001
2.Sex						
Male	2(2.4)	27(32.1)	55(65.5)	84(100.0)	1.809	n.s.
Female	5(6.1)	29(35.4)	48(58.5)	82(100.0)		
Total	**7(4.2)**	**56(33.7)**	**103(62.0)**	**166(100.0)**		

As mentioned in Table 27 significantly high proportion of elder knew three or more people well enough who visited at home(62.2%), about half of this figure knew one or two people(33.7%). Surprisingly, the gap between Nepalese elder and Japanese elder who knew three or more people was notably visible (76.0%) and (40.9%) respectively. Crossing this data by gender, male were higher (65.5%) to female (58.5%).

Table 28: Frequency of talking with friends or relatives in the past

	Frequency of talk on Telephone							
1.City	**Not at all**	**Once**	**2-6 times**	**Once a day or more**	**Not Answered**	**Total**	**X^{2} Value**	**P Value**
Kyoto	5(7.6)	19(28.8)	34(51.5)	7(10.6)	1(1.5)	66(100.0)	11.072	p<0.05
KTM	22(22.0)	37(37.0)	33(33.0)	8(8.0)	0(.0)	100(100.0)		
Total	**27(16.3)**	**56(33.7)**	**67(40.4)**	**15(9.0)**	**1(.6)**	**166(100.0)**		

Table 28 Indicates the frequency of times talking with friends, relatives and neighbors through telephone. Accordingly, majority of elder talked two to six times in the

past (40.4%), followed by once (33.7%), 16.3% of them never talked. Japanese elder talked more on telephone (51.5%) than Nepalese elder (33.0%). This data reflects that Nepalese elders had less telephone talked in the past.

Table 29: Someone can be trusted in

Variables						
1.City	**Yes**	**No**	**Don't know**	**Total**	**X^2 Value**	**P Value**
Kyoto	51(77.3)	3(4.5)	12(18.2)	66(100.0)	9.873	p<0.01
Kathmandu	92(92.0)	0(.0)	8(8.0)	100(100.0)		
3.Age(years)						
61-70	28(87.5)	1(3.1)	3(9.4)	32(100.0)	10.642	n.s.
71-80	72(84.7)	2(2.4)	11(12.9)	85(100.0)		
81-90	38(95.0)	0(.0)	2(5.0)	40(100.0)		
91-100	5(55.6)	0(.0)	4(44.4)	9(100.0)		
Total	**143(86.1)**	**3(1.8)**	**20(12.0)**	**166(100)**		

Table 29 indicates that the significant proportion of respondents have a nearest one to believe in (86.1%). A large proportion of age 81-90 years have someone to trust (95.0%), next to this group, the age 61-70 years occupy the second position(87.5%) followed by the age 71-80 years (84.7%). Similarly, Japanese have fewer trustworthy people (77.3%) as the Nepalese elders have (92.0%).

Table 30: Relatives and Friends Seen at the Most

1.City	**As often as wants**	**Like to see more**	**Not answere**	**Total**	**X^2 Value**	**P Value**
Kyoto	41(62.1)	23(34.8)	2(3.0)	66(100.0)	4.509	n.s.
Kathmandu	77(77.0)	22(22.0)	1(1.0)	100(100.0)		
2.Marital Status						
Married	44(77.2)	11(19.3)	2(3.5)	57(100.0)	13.827	n.s.
Unmarried	2(50.0)	2(50.0)	0(.0)	4(100.0)		
Widowed	35(61.4)	22(38.6)	0(.0)	57(100.0)		
Widower	23(69.7)	9(27.3)	1(3.0)	33(100.0)		
Divorced/Separated	14(93.3)	1(6.7)	0(.0)	15(100.0)		
Total	**118(71.1)**	**45(27.1)**	**3(1.8)**	**166(100)**		

As seen in Table 30, huge proportion of respondents meet their relatives and friends as often as they want (71.1%) and the rest like to see more (27.1%). By country wise data, Nepalese elders visit friends and relatives more often (77.0%). Like this,

divorcee/separated (93.3%), widower (69.7%) and married (77.2%) also see their friends more often.

Table 31: Feeling as part of the Neighborhood

Variables	Feelings As part of the Neighborhood				
1. City	**Feel a part of**	**Just a place to live**	**Total**	**X^2 Value**	**P value**
Kyoto	27(40.9)	39(59.1)	66(100.0)		
Kathmandu	58(58.0)	42(42.0)	100(100.0)	4.669	p<0.05
Total	**85(51.2)**	**81(48.8)**	**166(100)**		
2.Sex				**X^2 Value**	**P value**
Male	57(67.9)	27(32.1)	84(100.0)		
Female	28(34.1)	54(65.9)	82(100.0)	19.246	p<0.001
Total	**85(51.2)**	**81(48.8)**	**166(100)**		

In terms of attachment with the neighborhood, majority proportion of respondents feels that they are as part of the neighborhood (51.2%). However, considerable share of female think the neighborhood just a place to live (65.9%). More Nepalese elderly felt that they were a part of neighborhood (58%) in comparison of their Japanese counterparts (40.9%).

Table 32: Care providing by husband/wife, family member or friends

Variables	Care providing during sickness				
1. City	**Yes**	**No**	**Total**	**X^2 Value**	**P Value**
Kyoto	64(97.0)	2(3.0)	66(100.0)		
Kathmandu	100(100.0)	0(.0)	100(100.0)	3.726	n.s.
Total	**164(98.8)**	**2(1.2)**	**166(100)**		
	Care providers				
2.City	**Kyoto**	**Kathmandu**	**Total**		
Husband	5(7.6)	1(1.0)	6(3.6)		
Wife	18(27.3)	5(5.0)	23(13.9)		
Daughter	15(22.7)	13(13.0)	28(16.9)		
Son	10(15.2)	15(15.0)	25(15.1)		
Friends/Neighbors	6(9.1)	0 (0.0)	6(3.6)		
Daughter in law	5(7.6)	52(52.0)	57(34.3)		
Relatives	4(6.1)	14(14.0)	18(10.8)		
Home helper	3(4.5)	0(0.0)	3(1.8)		
Total	**66(100)**	**100(100)**	**166(100)**	68.342	p<0.001

Table 32, almost all respondents have husband/wife, family members or friends (98.0%) as the care providers, if they are sick or disable. Most commonly daughter- in-law was reported as a care giver for the elders (34.3%). This proportion is even higher in Nepal (52.0%). However, in Japan; daughters constitute this share less (22.7%).Interestingly; husbands (7.6%) and spouses (27.3%) were more reluctant to help their counterparts in Japan.

Table 33: Need of Someone to Look After

	Need of Someone to look after						X^{2} Value	P Value
1.City	**Yes**		**No**	**Total**				
Kyoto	40(60.6)		26(39.4)	66(100.0)				
Kathmandu	32(32.0)		68(68.0)	100(100.0)			13.247	p<0.001
Total	**72(43.4)**		**94(56.6)**	**166(100.0)**				
	Yes			**No**				
1.Age(Years	**Kyoto**	**KTM**	**Total**	**Kyoto**	**KTM**	**Total**	X^{2}Value	P value
61-70	5(83.3)	1(16.7)	6(100.0)	6(23.1)	20(76.9)	26(100.0)		
71-80	16(47.1)	18(52.9)	34(100.0)	11(21.6)	40(78.4)	51(100.0)		
81-90	13(52.0)	12(48.0)	25(100.0)	7(46.7)	8(53.3)	15(100.0)		
91-100	6(85.7)	1(14.3)	7(100.0)	2(100.0)	0(.0)	2(100.0)		
Total	40(55.6)	32(44.4)	72(100.0)	26(27.7)	68(72.3)	94(100.0)	5.576	n.s.

With regards to need of a person to look after elders, more than a half of them didn't need anyone to look after them (56.6%). This proportion even higher in Nepalese elders (68.0%) comparing to Japanese (39.4%). Surprisingly, there was a significant gap between Japanese elders and Nepalese elders aged 91-100 who reported need of someone to look after (85.7) and (14.3%), $X^{2Value=}$ 5.576, P value=.134,df=3). However, the proportion was not that much variant among the Nepalese respondents who doesn't feel of someone to look after them all time.

Table 34: Duration of living in the present neighborhood

Variables									
1. City	**< 1 yr**	**1- 2 yr**	**3 - 5 yr**	**5 -10 yr**	**10 -15 yr**	**20 yr or more**	**Total**	**X^{2}Value**	**P value**
Kyoto	2(3.0)	5(7.6)	7(10.6)	6(9.1)	8(12.1)	38(57.6)	66(100.0)	30.640	p<0.001
Kathmandu	0(.0)	0(.0)	2(2.0)	1(1.0)	27(27.0)	70(70.0)	100(100.0)		
Total	**2(1.2)**	**5(3.0)**	**9(5.4)**	**7(4.2)**	**35(21.1)**	**108(65.1)**	**166(100)**		
2. Family									
Nuclear	2(1.9)	5(4.6)	8(7.4)	6(5.6)	19(17.6)	68(63.0)	108(100.0)	13.768	n.s.
Joint	0(.0)	0(.0)	1(1.7)	1(1.7)	15(25.9)	40(69.0)	58(100.0)		
Total	**2(1.2)**	**5(3.0)**	**9(5.4)**	**7(4.2)**	**34(20.5)**	**108(65.1)**	**166(100)**		

Table 34 explains the duration of living in the neighborhood. A large bulk of respondents has been living in the neighborhood from more than twenty years (65.1%). This tendency is a bit higher among Nepalese (70.0%) than in Japanese (57.6%). The p value is 0.000 and the degree of freedom is 6 i.e. the data is statistically significant. Looking the same data across the type of family, there is no significant difference between nuclear family (63.0%) and joint family (69.0%) living for a long time.

Table 35: Number of friends living in the neighborhood

Variables	**Numbers of Friends**						
1. City	**Most**	**Some**	**Not many**	**None**	**Total**	**X^{2} Value**	**P value**
Kyoto	24(36.3)	25(37.9)	16(24.24)	1(1.5)	66(100.0)		
Kathmandu	38(38.0)	41(41.0)	21(21.0)	0(.0)	100(100.0)	2.061	n.s.
Total	**62(37.3)**	**66(39.8)**	**37(22.3)**	**1(.6)**	**166(100)**		
2.Education							
Elementary	8(20.5)	16(41.0)	15(38.5)	0(.0)	39(100.0)		
Junior High School	17(40.47)	14(33.3)	11(26.2)	0(.0)	42(100.0)		
Senior High School	15(41.7)	16(44.4)	4(11.1)	1(11.1)	36(100.0)	24.347	p<0.05
Higher Education	13(68.4)	5(26.3)	1(5.3)	0(.0)	19(100.0)		
No	9(30.0)	15(50.0)	6(20.0)	0(.0)	30(100.0)		
Total	**62(37.3)**	**66(39.8)**	**37(22.3)**	**1(.6)**	**166(100)**		

About none of respondents having friends were found (0.6%) in Table 35. Education wise, two third of the respondents with higher education expressed having most friends (68.4%), this is a bit lower in the respondents with elementary education (20.5%). The cross-country data indicate that the Nepalese respondents had a bit more (41.0%) friends were living in the neighborhood than the Japanese counterparts (37.9%).

Violence/Abuse on Elders

In its Toronto Declaration of 2002 on the Prevention of Elder Abuse, the World Health Organization defined the term as follows: *"Elder abuse is a single or repeated act, or lack of appropriate action, occurring within any relationship where there is an expectation of trust which causes harm or distress to an older person."* There are different types of abuses such as; physical abuse, psychological or emotional abuse, financial abuse, sexual harassment or abuse, neglect etc.

Table 36: Ever been the Victim of Crimes

The following presents whether the sampled elderly had been victims of violence.

Variables	Ever been the Victim of Crimes				
1.City	**Yes**	**No**	**Total**	**X^2 Value**	**P value**
Kyoto	7(10.6)	59(89.4)	66(100.0)	0.422	n.s.
Kathmandu	14(14.0)	86(86.0)	100(100.0)		
Total	**21(12.7)**	**145(87.3)**	**166(100)**		
2.Sex					
Male	10(11.9)	74(88.1)	84(100.0)	0.086	n.s.
Female	11(13.4)	71(86.6)	82(100.0)		
Total	**21(12.7)**	**145(87.3)**	**166(100)**		

In total, 12.7% elders, from Japan and Nepal alike, suffered from violence and crimes from others. Gender wise also similar proportion of male and female were prone to such crimes. It shows elders, both males and females become the victims of crimes. However, the cross-country data indicate that more Nepalese elderly (14.0%) were victimized than Japanese ones (10.6%).

Table 37: Types of Crime Encountered with

Variables	Encountered Crime								
1.Sex	**Home burglary**	**Vandalism**	**Muggling**	**Sexual assault**	**Other**	**Not answered**	**Total**	**X^{2Value}**	**P value**
Male	2(20.0)	2(20.0)	5(50.0)	0(.0)	0(.0)	1(10.0)	10(100.0)	7.702	n.s.
Female	4(36.4)	1(9.1)	1(9.1)	1(9.1)	1(9.1)	3()	11(100.0)		
Total	**6(28.6)**	**3(14.3)**	**6(28.6)**	**1(4.8)**	**1(4.8)**	**4(19.0)**	**21(100)**		
2.Age(yrs)									
61-70	0(.0)	3(60.0)	2(40.0)	0(.0)	0(.0)	0(.0)	5(100.0)	26.45	p<0.05
71-80	2(22.2)	0(.0)	3(33.3)	0(.0)	1(11.1)	3(33.3)	9(100.0)		
81-90	4(66.7)	0(.0)	1(16.7)	1(16.7)	0(.0)	0(.0)	6(100.0)		
91-100	0(.0)	0(.0)	0(.0)	0(.0)	0(.0)	1(100.0)	1(100.0)		
City									
Kyoto	0(.0)	0(.0)	2(28.6)	1(14.3)	1(14.3)	3(42.9)	7(100.0)	11.625	p<0.05
Kathmandu	6(42.9)	3(21.4)	4(28.6)	0(.0)	0(.0)	1(7.1)	14(100.0)		
Total	**6(28.6)**	**3(14.3)**	**6(28.6)**	**1(4.8)**	**1(4.8)**	**4(19.0)**	**21(100)**		

Table 37 shows that home burglary and smuggling were the commonly reported crimes (28.6%). Not surprisingly, females commonly encountered home burglary (36.4%), while male came across smuggling (50.0%). In terms of age composition of respondents, the group age 81-90 was likely to be suffered from home burglary (66.7%).By country, surprisingly similar proportion elders from both countries felt smuggling as a common crime they encountered (28.8%).

Table 38: Safe Neighborhood for Living

Variables	Safe Neighborhood					
1.City	**Yes**	**No**	**Somewhat**	**Total**	**X^2 Value**	**P value**
Kyoto	64(97.0)	0(.0)	2(3.0)	66(100.0)		
Kathmandu	53(53.0)	6(6.0)	41(41.0)	100(100.0)	45.773	p<0.001
Total	**117(70.5)**	**6(3.6)**	**43(25.9)**	**166(100.0)**		
2.Sex						
Male	71(84.5)	3(3.6)	10(11.9)	84(100.0		
Female	46(56.1)	3(3.7)	33(40.2)	82(100.0)	18.328	p<0.001
Total	**117(70.5)**	**6(3.6)**	**43(25.9)**	**166(100.0)**		
	Ever been Treated Unfairly because of Age					
1.City	**Yes**	**No**	**Total**	**X^2 Value**	**P value**	
Kyoto	10(15.2)	56(84.8)	66(100.0)			
KTM	6(6.0)	94(94.0)	100(100.0)			
Total	**16(9.6)**	**150(90.4)**	**166(100.0)**	3.73	n.s.	
2.Sex						
Male	8(9.5)	76(90.5)	84(100.0)			
Female	8(9.8)	74(90.2)	82(100.0)	0.003	n.s.	
Total	**16(9.6)**	**150(90.4)**	**166(100.0)**			

Concerning the safe neighborhood mentioned in Table 38, two third of the elderly expressed the affirmative response (70.0%). Higher proportion of male respondents made this response (84.5%). ($X^{2= 18.3,}$ P<0.001). By comparative perspective, the neighborhood of Japanese respondents was safer than Nepalese ones. Like this, a significant proportion of respondents feel that they were never being treated unfairly due to their old age (90.4%).However, tiny proportions of the elderly i.e. 15.2% and 6.0% from Kyoto (Japan) and Kathmandu (Nepal) respectively were being treated due to aging. Elderly people are being treated due to their age is called ageism. In other words, ageism is discrimination against older people on grounds of age. This means that discrimination in areas such as employment and health care delivery can be widespread.

Elders' Perception of Societal Attitudes towards Them

How the elderly person rate societal attitudes towards them has been given in the Table below.

Table 39: Feeling the Attitude of the People towards Elderly

Variables	Attitude of People						
1.City	**Positive**	**Not so positive**	**Cooperative**	**Negative**	**Total**	**X^2 Value**	**P value**
Kyoto	10(15.2)	21(31.8)	34(51.5)	1(1.5)	66(100)		
Kathmandu	34(34.0)	9(9.0)	57(57.0)	0(.0)	100(100)	19.019	p<0.001
2.Sex							
Male	29(34.5)	16(19.0)	38(45.2)	1(1.2)	84(100)		
Female	15(18.3	14(17.1)	53(64.6)	0(.0)	82(100)		
Total	**44(26.5)**	**30(18.1)**	**91(54.8)**	**1(.6)**	**166(100)**	8.512	p<0.05

According to Table 39, slightly more than half of respondents (54.8%) believe that their society had cooperative attitude towards the elderly people, followed by positive response (26.5%). The cross-country data shows that the Nepalese society (57.0%) was more cooperative than the Japanese ones (51.5%). Likewise, significantly more females experienced cooperative attitude of the neighbors (64.6%), ($X^{2=}$8.512 P value=.037, 3).

Community Volunteer Work

Increasing volunteerism among older adults can produce important benefits for individuals, communities, and states, such as improving the health of older adults and strengthening community ties.

Table 40: Engagement in Community Volunteer Work

Variables	Involve in volunteer Work				
1.City	**Yes**	**No**	**Total**	**X^2 Value**	**P value**
Kyoto	14(21.2)	52(78.8)	66(100.0)		
Kathmandu	7(7.0)	93(93.0)	100(100.0)		
Total	**21(12.7)**	**145(87.3)**	**166(100.0)**	7.118	p<0.01
2.Sex					
Male	16(19.0)	68(81.0)	84(100.0)		
Female	5(6.1)	77(93.9)	82(100.0)		
Total	**21(12.7)**	**145(87.3)**	**166(100.0)**	6.594	p<0.05
4.Age (Years)					
61-70	12(37.5)	20(62.5)	32(100.0)		
71-80	7(8.2)	78(91.8)	85(100.0)		
81-90	2(5.0)	38(95.0)	40(100.0)		
91-100	0(.0)	9(100.0)	9(100.0)		
Total	**21(12.7)**	**145(87.3)**	**166(100.0)**	19.475	p<0.001
	Volunteering Hours per Week				
1.City	**<5 hours**	**5 to 10 hours**	**Total**		
Kyoto	11(84.6)	2(15.4)	13(100.0)		
Kathmandu	5(100.0)	0(.0)	5(100.0)		
Total	**16(88.9)**	**2(11.1)**	**18(100.0)**	1.396	n.s.
2.Sex					
Male	11(84.6)	2(15.4)	13(100.0)		
Female	5(100.0)	0(.0)	5(100.0)	1.396	n.s.
Total	**16(88.9)**	**2(11.1)**	**18(100.0**		

The key observation from Table 40 is that a lion's share of the respondents was not engaged in any community volunteer work (87.3%). This proportion was even higher in Nepal (93.0%) compared to Japan (78.8%). By age group, the tendency to not joining in community volunteer work was slightly increasing up in parallel to age. It shows that the youngest group age 61-70 years was likely to be involved in such works. Moreover, those who contributed in voluntary activities worked less than five hours per week (88.9%). By country wise data shows that Japanese elderly were involving in volunteer work three times more than the Nepalese elderly people. Healthy and active elderly person are increasingly looking to use their professional skills in volunteer settings and typically want to continue developing their knowledge and expertise. Unfortunately, in many cases, volunteering involves roles with lower skill and responsibility levels. States

must encourage organizations to rethink how volunteers and their skills are used.

Table 41: Association in local organization or clubs

Variables	Association				
1.City	**Yes**	**No**	**Total**	**X^2 Value**	**P value**
Kyoto	16(24.2)	50(75.8)	66(100.0)		
Kathmandu	22(22.0)	78(78.0)	100(100.0)	0.091	n.s.
Total	**38(23.0)**	**127(77.0)**	**166(100)**		
2.Education					
Elementary	4(10.3)	35(89.7)	39(100.0)		
Junior High School	9(21.4)	33(78.6)	42(100.0)		
Senior High School	12(33.3)	24(66.7)	36(100.0)		
Higher Education	12(60.0)	8(40.0)	20(100.0)		
No schooling	1(3.4)	28(96.6)	29(100.0)		
Total	**38(23.0)**	**127(77.0)**	**166(100)**	29.107	p<0.001

As described in Table 41, a large proportion of respondents were not associated with any organization or clubs that works for neighborhood activities (77.0%). This is more predominant among respondents with no schooling, only elementary and junior high school (96.6%, 89.7% and 78.6%) respectably.

4. Mental Health Status

Mental health/status is a multifaceted concept and difficult to define. It may include such ideas and terms as life satisfaction, the statistically normal, the ability to cope, positive functioning, finding meaning and purpose in life, self-actualization, and so forth (Haber, 2007:365). The mental well-being of the respondents was difficult to access. I could not ask who suffered from Dementia, because that was not a familiar concept in Nepal. However I asked general questions to identify the mental health status of the elderly of both cities. This section identifies the mental status of the elderly people of Kyoto (Japan) and Kathmandu (Nepal).

Table 42: Worried about life in old-age

Variables	Worried about Old-age Life				
1.Sex	**Extremely**	**Somewhat**	**Not vary**	**Not at all**	**Total**
Male	4(4.7)	43(51.2)	23(27.4)	14(16.7)	84(100.0)
Female	7(8.5)	41(50.0)	24(29.2)	10(12.2)	82(100.0)
Total	**11(6.6)**	**84(50.6)**	**47(28.3)**	**24(14.5)**	**166(100)**
2.City					
Kyoto	3(4.5)	30(45.5)	18(27.3)	15(22.7)	66(100.0)
Kathmandu	8(8.0)	54(54.0)	29(31.0)	9(9.0)	100(100.0)
Total	**11(6.6)**	**84(50.6)**	**47(28.3)**	**24(14.5)**	**166(100)**

From Table 42 the results reveal that about fifty percent respondents were somewhat worried about old age life. The proportion extremely worried and not at all was similar (9.0%) and (9.6%) respectively. By country, the extremely worried Nepalese were 8.0% while Japanese 4.5%. More than fifty percent elderly from Nepal were worried about life in old age.

Table 43: Rating of Life

Variables	Rating of Life					
1.City	**Exciting**	**Pretty routine**	**Dull**	**Total**	**X^2 Value**	**P value**
Kyoto	13(19.7)	43(65.2)	10(15.2)	66(100)		
Kathmandu	7(7.0)	42(42.0)	51(51.0)	100(100)	24.962	p<0.001
2.Educational						
Elementary	1(2.6)	22(56.4)	16(41.0)	39(100)		
Junior High School	4(9.5)	26(61.9)	12(28.6)	42(100)		
Senior High School	6(16.7)	21(58.3)	9(25.0)	36(100)		
Higher	9(47.4)	10(52.6)	0(.0)	19(100)		
No schooling	0(.0)	6(20.0)	24(80.0)	30(100)		
Total	**20(12.0)**	**85(51.2)**	**61(36.7)**	**166(100)**	60.326	p<0.001

Table 43 reveals respondents ratings of their lives. A bit more than a half respondent felt they had pretty routine life (51.2%). However, by education, considerable proportion of respondents with no schooling felt having a dull life (80.0%). The Japanese

elderly felt their life pretty routine (65.2%) while Nepalese just 42.0%.

Worried About Things

As mention in Figure 8, high proportion of respondents worried hardly ever (59.1) Japanese and 36.0% Nepalese. The Nepalese were fairly often worried about things (51.0%).

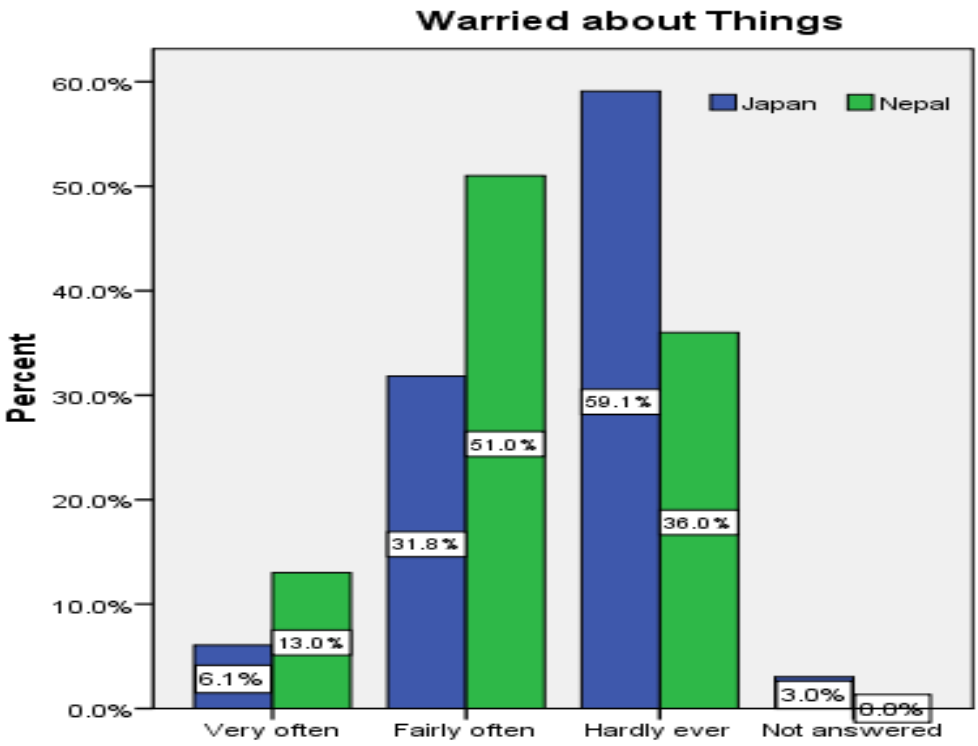


Figure 8: Worried About Things

Feeling of Loneliness

The phenomenon of loneliness occurs in people of all ages but may be a particular problem in the elderly. It is acknowledged that loneliness is not a necessary accompaniment to ageing and that ageing is not solely responsible for the development of loneliness in elderly people. However, there is a relationship between ageing and loneliness.

Table 44: Feeling of Loneliness

	Feeling of Loneliness			X^2 Value	P value
	Yes	**No**	**Total**		
1.City					
Kyoto	17(25.8)	49(74.2)	66(100.0)	6.175	p<0.05
Kathmandu	11(11.0)	89(89.0)	100(100.0)		
Total	**28(16.9)**	**138(83.1)**	**166(100.0)**		
2.Age					
61-70	9(28.1)	23(71.9)	32(100.0)	3.663	n.s.
71-80	12(14.1)	73(85.9)	85(100.0)		
81-90	6(15.0)	34(85.0)	40(100.0)		
91-100	1(11.1)	8(88.9)	9(100.0)		
Total	**28(16.9)**	**138(83.1)**	**166(100.0)**		

The above Table 44 presents the elders' feeling of loneliness, the figures shows that the lion share of proportion didn't feel lonely most of the time (83.1%). This proportion even higher in Nepalese elder (89.0%) to Japanese (74.2%). Across the data on age group, this is raising on lower range of age (71.9%) to higher range of age (88.9%)($\mathbf{X^2}$ =3.663 ,P=0.3 at 3 df).

Table 45: Life Satisfaction among Elders

Variables						
1.City	**Good**	**Fair**	**Poor**	**Total**	X^2 Value	P value
Kyoto	11(16.7)	51(77.3)	4(6.1)	66(100)	23.645	p<0.001
Kathmandu	21(21.0)	45(45.0)	34(34.0)	100(100)		
Total	**32(19.3)**	**96(57.8)**	**38(22.9)**	**166(100)**		
2.Marital Status						
Married	19(33.3)	36(63.2)	2(3.5)	57(100)	36.594	p<0.001
Unmarried	0(.0)	2(50.0)	2(50.0)	4(100)		
Widowed	4(7.0)	29(50.9)	24(42.1)	57(100)		
Widower	7(21.2)	19(57.6)	7(21.2)	33(100)		
Divorced/Separate	2(13.3)	10(66.7)	3(20.0)	15(100)		
Total	**32(19.3)**	**96(57.8)**	**38(22.9)**	**166(100)**		

As shown in Table 45, significant proportion of respondents was fairly satisfied with their lives (57.8%). However, nearly a quarter of them were not satisfied (22.9%) at all. Poorly satisfied Nepalese were higher (34.0%) in comparison to the Japanese respondents (6.1%).

5. Economic Status

Economic status is also a major determinant of well being of the elderly. While poor people of all ages face an increased risk of ill health and disabilities, older people are particularly vulnerable. This section examines the economic status of the elderly people.

Table 46: Main Income Sources

	Age (Years)						
Sources	**61-70**	**71-80**	**81-90**	**91-100**	**Total**	**X^2 Value**	**P value**
Employment	1(3.1)	0(.0)	0(.0)	0(.0)	1(.6)		
Allowance/Pension	11(34.4.)	25(29.4)	14(35.0)	7(77.8)	57(34.3)		
Business/ Investment	3(9.4)	2(2.4)	2(5.0)	1(11.1)	8(4.8)		
agriculture	1(3.1)	6(7.1)	1(2.5)	0(.0)	8(4.8)		
Pension and Saving	1(3.1)	10(11.8)	10(25.0)	1(11.0)	22(13.3)		
House rent	1(3.1)	8(9.4)	0(0.)	0(.0)	9(5.4)		
Children	12(37.5)	32(37.6)	11(27.5)	0(.0)	55(33.1)		
Relatives	2(6.2)	2(2.4)	2(5.0)	0(.0)	6(3.6)		
Total	32(100.0)	85(100.0)	40(100.0)	9(100.0)	166(100.)	32.765	p<0.05

Sources	**Kyoto**	**Kathmandu**	**Total**				
Employment	1(1.5)	0(.0)	1(.6)				
Pension/Allowance	53(80.3)	4(4.0)	57(34.3)				
Business/Investments	0(.0)	8(8.0)	8(4.8)				
Agriculture	0(.0)	8(8.0)	8(4.8)				
Pension and Savings	12(18.2)	10(10.0)	22(13.3)				
House rent	0(.0)	9(9.0)	9(5.4)				
Children	0(.0)	55(55.0)	55(33.1)				
Relatives	0(.0)	6(6.0)	6(3.6)				
					1.277		p<0.001
Total	**66(100.0)**	**100(100.0)**	**166(**100.0**)**				

Table 46 indicate that the allowance/pension was the major source of income (34.3%), followed by children (33.1%) and saving (13.3%). However, some other source of income such as house rent, business/investment, agriculture and relatives were also reported by some tiny proportion of respondents. Crossing the data on two countries, Nepalese elders had children as main source of income (55.0%) while Japanese had Pension (80.3%). The pension/ allowance as source of income were found among nominal Nepalese elders (4.0%).

Table 47: Need Management by Income

Variables	Management of Need				**X^2 Value**	**P value**
City	Very well	Fairly well	Poorly	Total		
Kyoto	4(6.1)	44(66.7)	18(27.3)	66(100.0)		
Kathmandu	8(8.0)	42(42.0)	50(50.0)	100(100.0)		
Total	**12(7.2)**	**86(51.8)**	**68(41.0)**	**166(100.0)**	9.89	p<0.05
Age(years)						
61-70	3(9.4)	15(46.9)	14(43.8)	32(100.0)		
71-80	6(7.1)	42(49.4)	37(43.5)	85(100.0)	2.815[a]	n.s.
81-90	2(5.0)	25(62.5)	13(32.5)	40(100.0)		
91-100	1(11.1)	4(44.4)	4(44.4)	9(100.0)		

As seen in above Table 47 elderly had fairly and poorly managed their need (51.8%) and (41.0%) respectively. The majority of elders' age ranged 81-90 fairly handles their need through current income (62.5%). This proportion is even more in Japanese elders (66.7%) than Nepalese (42.0%). The country wise data shows that fifty percent Nepalese elderly were poorly managed their need while the Japanese 27.3%. More than two third percent (66.7%) of Japanese elderly people managed their need fairly well. It shows that Japanese elderly were managing their needs better than the Nepalese ones (X^2 Value = 9.890 and P <0.05).

Elderlys per Month Income

Elderly persons per month income have been given in the Figure 9 and Table 48.

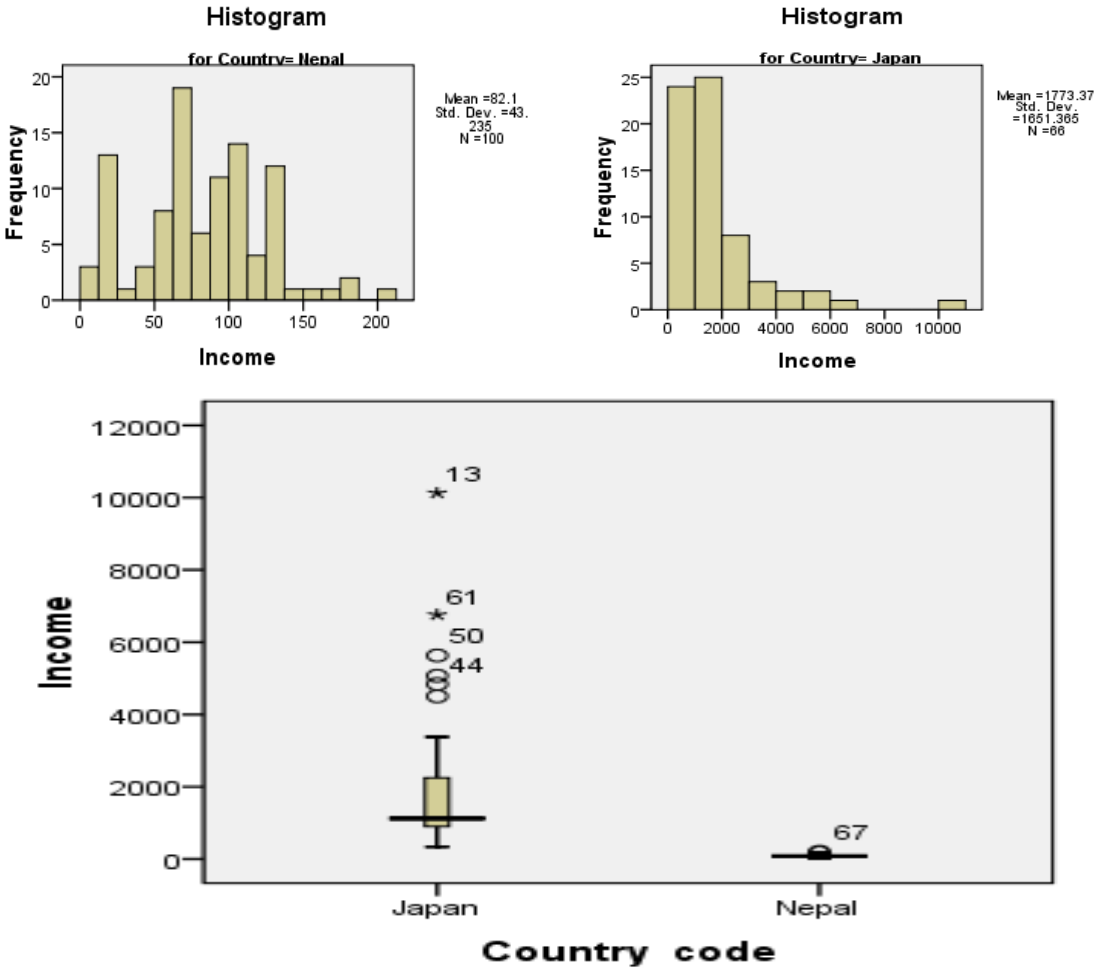


Figure 9 Economic Conditions of the Elderly

Table 48:t- value

Variables	N	Mean	Std	t-test	df	P value	95% confidence interval of the difference	
							Upper Case	Lower Case
Kyoto	66	1773.37	1651.37	10.252	164		1365.54	2016.992
KTM	100	82.1	43.235			P<0.001		

The expense rate of the US Dollars (Universal Currency Converter) according to dated 11/25/2009.

Figure 9 given above shows level of monthly income for elderly in US dollar in Japan and Nepal. The mean monthly income of Japan is US $ 1773.37 while for the Nepalese elders it is US $ 82.1 only. The income level in Nepal is highly scattered but among the Japanese elders it is clustered more around US $ 2000.Almost all Nepalese elders' income lies below US$ 200 per month. The Table 48 shows that the t-test is 10.252, which is significant at df=164, and P<0.001.

Table 49: Enough Money to Buy Those Little "Extras"

Variables	Enough Money				**X^2 Value**	**P value**
1. City	Yes	No	Some how	Total		
Kyoto	12(18.2)	19(28.8)	35(53.0)	66(100.0)		
Kathmandu	13(13.0)	43(43.0)	44(44.0)	100(100.0)		
Total	25(15.1)	62(37.3)	79(47.6)	166(100.0)	3.540[a]	n.s.
2.Age(years)						
61-70	10(31.2)	11(34.4)	11(34.4)	32(100.0)		
71-80	8(9.4)	35(41.2)	42(49.4)	85(100.0)		
81-90	5(12.5)	14(35.0)	21(52.5)	40(100.0)		
91-100	2(22.2)	2(22.2)	5(55.6)	9(100.0)		
Total	25(15.1)	62(37.3)	79(47.6)	166(100.0)	10.426[a]	n.s.

The data shown in Table 49 indicates that nearly half proportion of respondents had somehow enough to buy little extras that are small luxuries (47.6%). However, more than one third of them had not (37.3%), this was reported by majority of Nepalese elders (43.0%).

Satisfaction with the Pension Amount

Elderly person’s satisfaction with the pension amount has showed of the following Figure.

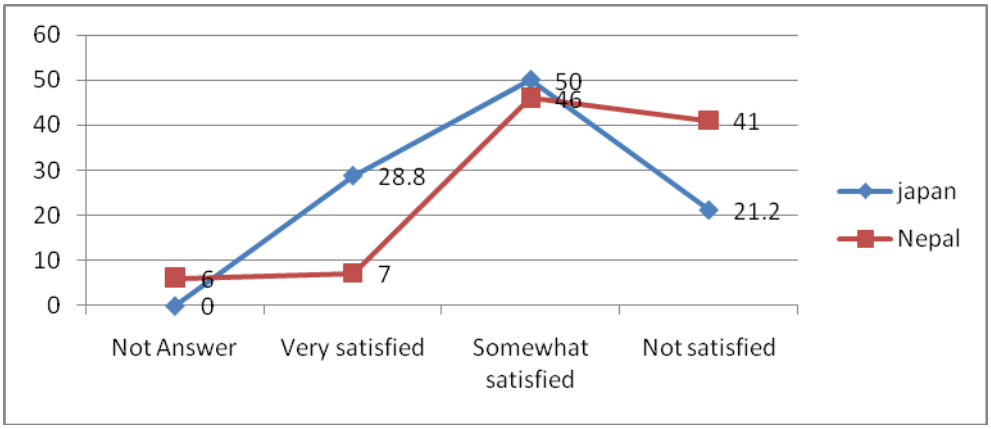


Figure 10: Satisfaction with the Pension Amount (%)

According to the Figure 10, there was a visible gap between Japanese (28.8%) and Nepalese (7.0%) elders who were satisfied with pension amount. About a similar proportion of respondents from both countries somewhat satisfied Nepalese (46.0%) and Japanese (50.0%).however, nearly a double of Nepalese elders were found to be unsatisfied with pension (41.0%) in comparing to Japanese (21.2).

Table 50: Enough Money for the Future

	Enough Money									X^2 Value	P value
	Yes			No			Somehow				
1.City											
Kyoto	10(15.2)			25(37.9)			31(47.0)			66(100.0)	
Kathmandu	7(7.0)			54(54.0)			39(39.0)			100(100.0)	5.35
Total	17(10.2)			79(47.6)			70(42.2)			166(100.0)	n.s.
	17(10.2)			**79(47.6)**			**70(42.2)**			**166(100.0)**	
	Yes			**No**			**Somehow**			X^{2}Value	P value
2..Age	Kyoto	KTM	Total	Kyoto	KTM	Total	Kyoto	KTM	Total		
61-70	3(75.0)	1(25.0)	4(100.0)	4(22.2)	14(77.8)	18(100.0)	4(40.0)	6(60.0)	10(100.0)		
71-80	1(33.3)	2(66.7)	3(100.0)	12(29.3)	29(70.7)	41(100.0)	14(34.1)	27(65.9)	41(100.0)		
81-90	2(33.3)	4(66.7)	6(100.0)	8(42.1)	11(57.9)	19(100.0)	10(66.7)	5(33.3)	15(100.0)		
91-100	4(100.0)	0(.0)	4(100.0)	1(100.0)	0(.0)	1(100.0)	3(75.0)	1(25.0)	4(100.0)		
Total	10(58.8)	7(41.2)	17(100.0)	25(31.6)	54(68.4)	79(100.0)	31(44.3)	39(55.7)	70(100.0)	5.646	n.s.

Table 50 shown above denotes the feeling of elders having enough money to met needs. Nearly half proportion of elders reported that they didn't have that much money (47.6%), this is followed by somehow (42.6%). Looking the data across age group, the affirmative answer for enough money was reported by big proportion of participants aged 61-70 from Japan (75.0%), aged 71-80 and age group 81-90 were Nepalese (66.7%).

Table 51: The Biggest Financial Problem for Elderly People

1.Age(years)	Buying Foods	Housing/Paying House Rent	Medical Expense/Treatment	Social Expenses/ Kousai-hi)	Others	Total	X^2 **Value**	**P value**
61-70	12(41.4)	1(3.4)	14(48.3)	2(6.9)	0(.0)	29(100.0)		
71-80	23(30.7)	7(9.3)	37(49.3)	7(9.3)	1(1.3)	75(100.0)		
81-90	16(47.1)	2(5.9)	10(29.4)	3(8.8)	3(8.8)	34(100.0)		
91-100	3(50.0)	0(.0)	2(33.3)	1(16.7)	0(.0)	6(100.0)		
Total	**54(37.5)**	**10(6.9)**	**63(43.8)**	**13(9.0)**	**4(2.8)**	**144(100.0)**	12.697	n.s.
2.City								
Kyoto	38(65.5)	2(3.4)	6(10.3)	10(17.2)	2(3.4)	58(100.0)		
Kathmandu	16(18.6)	8(9.3)	57(66.3)	3(3.5)	2(2.3)	86(100.0)		
Total	54(37.5)	10(6.9)	63(43.8)	13(9.0)	4(2.8)	144(100)	54.224	P<0.001

Concerning on the biggest financial problem experienced by elders, medical expenses/treatment was realized by majority of proportion (43.8%); this is followed by buying foods (37.5%). However, some others expenses such as housing rent (6.9%) and social expenses(9.0%) also considered as a financial burden by some elders. Looking at the crosswise data, Nepalese elders felt medical expenses as problems whereas buying a food as a problem was realized by Japanese elders (65.5%).

Savings Rates of the Elderly

Savings strongly influence the well-being of the elderly and the rate of a country's economic growth. The elderly may continue to accumulate savings and assets until very late in life because they are more certain about the risks they face. Savings implies that individuals who have a history of health problems will save to pay their eventual health expenses. The risk of living long and facing high medical expenses helps explain savings decisions among the elderly. The following table 52 shows the savings rates for emergencies of the elderly.

Table 52: Savings for Emergencies

1.City	Yes	No	Not answered	Total	X^2 Value	P value
Kyoto	58(87.9)	7(10.6)	1(1.5)	66(100.0)		
KTM	25(25.0)	75(75.0)	0(.0)	100(100.0)		
Total	**83(50.0)**	**82(49.4)**	**1(.6)**	**166100.0)**	73.703	p<0.001
2.Age						
61-70	12(37.5)	20(62.5)	0(.0)	32(100.0)		
71-80	39(45.9)	46(54.1)	0(.0)	85(100.0)		
81-90	24(60.0)	15(37.5)	1(2.5)	40(100.0)		
91-100	8(88.9)	1(11.1)	0(.0)	9(100.0)		
Total	**83(50.0)**	**82(49.4)**	**1(.6)**	**166(100.0)**	13.751	p<0.05
3.Marital Status						
Married	36(63.2)	20(35.1)	1(1.8)	57(100.0)		
Unmarried	2(50.0)	2(50.0)	0(.0)	4(100.0)		
Widowed	23(40.4)	34(59.6)	0(.0)	57(100.0)		
Widower	18(54.5)	15(45.5)	0(.0)	33(100.0)		
Divorced/Separated	4(26.7)	11(73.3)	0(.0)	15(100.0)		
Total	**83(50.0)**	**82(49.4)**	**1(.6)**	**166(100.0)**	12.585	n.s.

With regards to financial savings for emergencies, half of the respondents have some sorts of saving for emergency need (50.5%) while similar proportion of respondents doesn't have any saving (49.4%). The gap of proportion of saving between Japanese (87.9%) and Nepalese (25.0%) was notably visible. The p value is significant at 2 degree of freedom. This proportion across the age groups is decreasing from older age group to younger age groups, from 88.9%, to 60.0%, 45.9% and 37.5%.This results reflect the older were money saver than the younger. Similarly, this is found to be higher on married elders (63.2%), followed by widower (54.5%) and widowed (40.4%) respectively.

Table 53: Preference of Places to live in infirm Old Age and Expected Income Sources

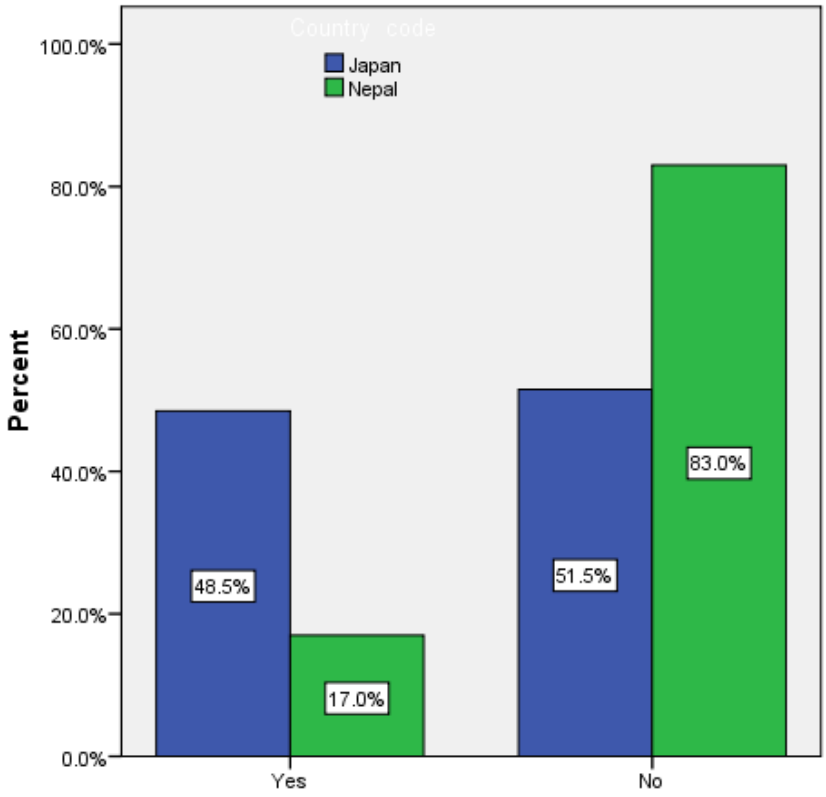
Preferred Places	Male	Female	Kyoto	Kathmandu	Total	X^{2} Value	P value
In own family	47(56.0)	43(52.4)	16(24.2)	74(74.0)	90(54.2)		
In community home	24(28.6)	35(42.7)	38(57.6)	21(21.0)	59(35.5)		
In nursing home	2(2.4)	0(.0)	2(3.0)	0(.0)	2(1.2)		
Hospital	9(10.7)	3(3.7)	7(10.6)	5(5.0)	12(7.2)		
Facility for the elderly home	2(2.4)	1(1.2)	3(4.5)	0(.0)	3(1.8)		
Total	**84(100.0)**	**82(100.0)**	**66(100.0)**	**100(100.0)**	**166(100)**	7.539	n.s.
			Expected Sources of Income				
Age (Years)	**Pension/retirement**	**Help from children**	**Help from relatives**	**Total**		X^{2} Value	P value
61-70	20(62.5)	11(34.4)	1(3.1)	32(100.0)			
71-80	45(52.9)	37(43.5)	3(3.5)	85(100.0)			
81-90	26(65.0)	12(30.0)	2(5.0)	40(100.0)		6.685	n.s.
91-100	8(88.9)	1(11.1)	0(.0)	9(100.0)			
City							
Kyoto	65(98.5)	1(1.5)	0(.0)	66(100.0)			
Kathmandu	34(34.0)	60(60.0)	6(6.0)	100(100.0)			
Total	**99(59.6)**	**61(36.7)**	**6(3.6)**	**166(100)**		68.69	p<0.001

Table 53 presents the preferred place to live and expected source of income in old age. The significant proportion of participants preferred to live in own family (54.2%), followed by community home (35.5%). The remaining liked hospital (7.2%). Crossing the data into country, significant proportion of Nepalese preferred home (74.0%) while this is only 24.2% in Japanese. Concerning sources of income, pension was the major expected source (59.6%) for the future; however, some others expected help from children as well. By country, pension as a main source of income was for nearly all the Japanese whereas only 34.0% Nepalese elders reported so. The majority of Nepalese elderly expected income from children in old age.

Receiving Retirement Pension (public or private)

For elderly, a pension means security. Pensions are safe income for the remainder of life after retirement. The following Figure 11 shows that near about fifty percent Japanese elderly were receiving retirement pension while this figure was just 17.0% for the Nepalese elderly. Large bulks i.e. 83.0% of Nepalese elderly were not receiving the retirement pension.

Figure 11 Rreceiving retirement pension (either public or private)



Old Age Pensions/Elderly Allowance

The following Table 54, apart from age 61-70 years, all the respondents received pension or elderly allowance from government (96.4%). This shows that the elderly people had some sort of allowance or pensions to support financial problems in their lives.

Table 54: Received Old Age Pensions/Elderly Allowance from Government

Variables	Pension/Elderly Allowance			X^{2Value}	P value
1.City	**Yes**	**No**	**Total**		
Kyoto	66(100.0)	0(.0)	66(100.0)		
Kathmandu	94(94.0)	6(6.0)	100(100.0)		
Total	**160(96.4)**	**6(3.6)**	**166(100)**		
2.Age					
61-70	26(81.2)	6(18.8)	32(100.0)		
71-80	85(100.0)	0(.0)	85(100.0)		
81-90	40(100.0)	0(.0)	40(100.0)		
91-100	9(100.0)	0(.0)	9(100.0)		
Total	**160(96.4)**	**6(3.6)**	**166(100)**	16.444	p<0.001

Figure 12 reveals that the significant proportion of respondents doesn't think their family members' feel support them as a burden, to both in Nepal (83.0%) and Japan (71.2

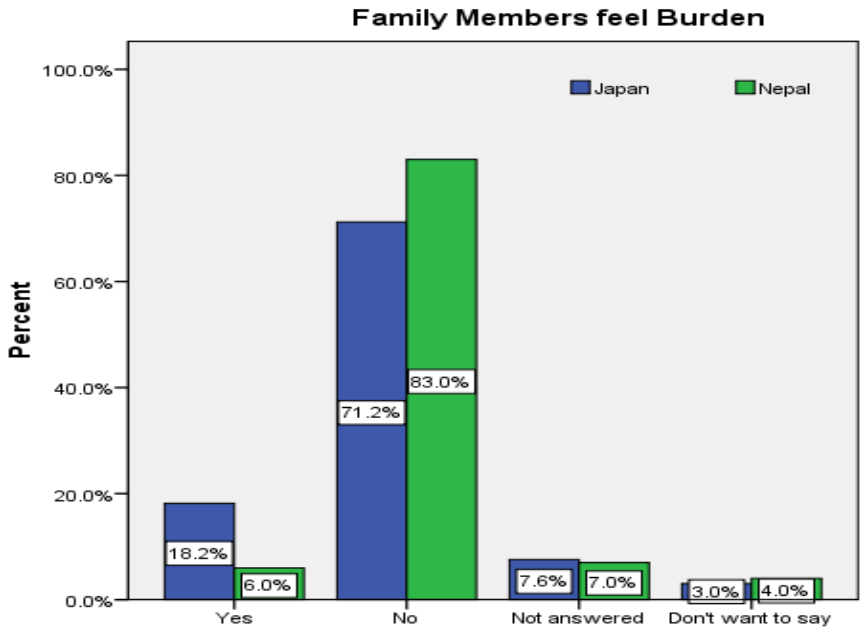


Figure 12: Family Members' Feeling of Burden

Table 55: Responsibility of Caring Elderly

Variables **1.Sex**	Family	Society/ community	Government-local/prefecture /central -	Public and private sector	Total	X^{2} Value	P value
Kyoto	5(7.6)	5(7.6)	14(21.2)	42(63.6)	66(100.0)		
Kathmandu	23(23.0)	4(4.0)	41(41.0)	32(32.0)	100(100.0)		
Total	**28(16.9)**	**9(5.4)**	**55(33.1)**	**74(44.6)**	**166(100)**	20.171[a]	p<0.001

Table 55 presents the institute responsible for caring elderly. Accordingly, majority of respondents think that public and private sector should be responsible for caring elderly (44.6%), followed by government-local/prefectural/central (33.1%) and family (16.9%). By country, about double proportion of Japanese opined government (63.65) and Nepalese (32.0%) respectively.

6. Living Arrangements of the Elderly

The living arrangements of the elderly are a major determinant of the level of support of the elderly. In particular, the availability of care from a spouse or a child may be essential to the well being of the very old and the frail elderly. In the long run however, the importance of the family as a source of support for the elderly will decrease. This is inevitable because the share of the frail elderly population will increase and the capability of families to care for older parents will decrease. The decline in the ability of families to provide in-home care will decrease not only because of industrialization and urbanization but also because of the aging of the caregivers (Maeda, 1983). Social, economic and demographic developments have all caused changes at the individual, family and societal levels, all of which influence the lives of elderly people. The living arrangements for the aged persons are often considered as the basic indicator of the care and support provided by the family (Martin, 1989). However, it must be noted that this practice is more culturally based rather than development dependent. The living arrangements of elderly persons are shown in this section.

Table 56: Living Alone or with other Family Members

Variables	Living with			X^{2} Value	P value
1.City	Alone	With family	Total		
Kyoto	23(34.8)	43(65.2)	66(100.0)		
Kathmandu	9(9.0)	91(91.0)	100(100.0)	17.683	p<0.001
Total	**32(19.3)**	**134(80.7)**	**166(100)**		
2.Marital status					
Married	0(.0)	57(100.0)	57(100.0)		
Unmarried	4(100.0)	0(.0)	4(100.0)		
Widowed	11(19.3)	46(80.7)	57(100.0)		
Widower	13(38.2)	21(61.7)	34(100.0)		
Divorced/ separated	4(26.7)	10(66.7)	15(100.0)		
Total	**32(19.3)**	**134(80.7)**	**166(100)**	50.27	p<0.001
3.Family Type					
Nuclear	32(29.6)	76(70.4)	108(100.0)		
Joints	0(.0)	58(100.0)	58(100.0)	29.071	p<0.001
Total	**32(19.3)**	**134(80.7)**	**166(100)**		

Table 56 shows that the significant size of respondents live with family (80.7%). This is found to be significantly higher in Nepalese (91.0%) than in Japanese (65.2%). On the other side, the Nepalese living alone (9.0%) were three times less than the Japanese (34.8%). This result shows that Nepalese were likely to be living with family.

Table 57: Living Arrangement of the Elderly People

1.City	Single	Husband	Spouse	Son/Daughter in Law	Daughter	Relatives	Total	X^{2}Value	P value
Kyoto	23(34.8)	5(7.6)	17(25.8)	12(18.2)	7(10.6)	2(3.0)	66(100.0)		
Kathmandu	9(9.0)	0(.0)	14(14.0)	55(55.0)	16(16.0)	6(6.0)	100(100.0)		
Total	**32(19.3)**	**5(3.0)**	**31(18.7)**	**67(40.4)**	**23(13.9)**	**8(4.8)**	**166(100)**	42.154	p<0.001
2.Marital status									
Married	1(1.8)	5(8.8)	28(49.1)	2(38.6)	0(.0)	1(1.8)	57(100.0)		
Unmarried	4(100.0)	0(.0)	0(.0)	0(.0)	0(.0)	0(.0)	4(100.0)		
Widowed	11(19.3)	0(.0)	2(3.5)	28(49.1)	16(28.1)	0(.0)	57(100.0)		
Widower	12(36.4)	0(.0)	1(3.0)	13(39.4)	4(12.1)	3(9.1)	33(100.0)		
Divorced/ separated	4(26.7)	0(.0)	0(.0)	4(26.7)	3(20.0)	4(26.7)	15(100.0)		
Total	**32(19.3)**	**5(3.0)**	**31(18.7)**	**67(40.4)**	**23(13.9)**	**8(4.8)**	**166(100)**		

Table 57 reveals that majority of respondents lived with son/ daughter- in--laws (40.4%) and daughter (13.9%). Living with a spouse, Japanese were more than Nepalese (25.8%) and (14.0%) respectively. The majority of older persons in all countries continue to live in their own homes and communities, a phenomenon that is sometimes referred to as "ageing in place". In the developing world, the large majority of older persons continue to live in multigenerational households, most of them with their children and grandchildren, and some also with other adults. In the developed world, by contrast, the largest proportion of older people lives with a spouse in a single-generation household (43 per cent) and another 25 per cent live alone. Older persons in developed countries are more likely to live in non-familial residential settings, but overall only a small proportion of older people in all countries live in centres of institutional care (United Nations, 2007).

Table 58 Numbers of Living Children and Call on for Help with any Problems

Variables	Numbers of Living Children					
City	One	Two	Three	More than three	None/Childless	Total
Kyoto	13(19.7)	21(31.8)	15(22.7)	5(7.6)	12(18.2)	66(100.0)
Kathmandu	47(47.0)	39(39.0)	6(6.0)	2(2.0)	6(6.0)	100(100.0)
Total	60(36.2)	60(36.2)	21(12.6)	7(4.2)	18(10.8)	166(100.0)

Number of Children Living within an Hour's Driving

City	One	Two	Three or More	Total
Kyoto	24(64.86)	11(29.7)	2(5.4)	37(100.0)
Kathmandu	37(84.1)	6(13.6)	1(2.3)	44(100.0)
Total	61(75.3)	17(20.1)	3(3.7)	81(100.0)

Call on Children for help with any problems

City	Yes	No	Total
Kyoto	22(59.4)	15(40.6)	37(100.0)
Kathmandu	37(84.1)	7(15.9)	44(100.0)
Total	59(72.8)	22(27.2)	81(100.0)

As shown in Tables 58 above, more than one third elderly had similar proportion of children (36.2%). However, 10.8% elderly had no any children or childless. Japanese were found to be single children (19.7%), also the respondents living in nuclear family have likely to be without any children (18.2). Likewise, more (47.0%) Nepalese elderly had single living children than the Japanese elderly. When consider the number of children living within an hour's driving, the proportion was descending from one to three children, from 75.3% to 20.1% to 3.7% respectively. These results point out that excluding the single parents, the others were living nearest by their children. Likewise, more than two third elderly called on their children for help with any problems. However this trend was seen lesser proportion among the Japanese elderly. Field note indicate that most of Japanese elderly doesn't want to disturb and interference their children's daily life.

Table 59: Parents' Expectation from Children

Variables	Parents' Expectation of Help from Children			
1.City	**Yes**	**No**	**Not Answered (Childless)**	**Total**
Kyoto	44(66.7)	10(15.1)	12(18.2)	66(100.0)
Kathmandu	83(83.0)	11(11.0)	6(6.0)	100(100.0)
Total	**127(76.5)**	**21(12.6)**	**18(10.8)**	**166(100)**

Table 59 shows overwhelming proportion of respondents expected help from their children as needed (76.5%), this tendency was significantly higher in Nepalese parents (83.0%) as compared to Japanese parents (66.7%) respectively. Likewise, 18.2% Japanese and 6.0% Nepalese elderly didn't answer about expectation from children.

6. Housing

Housing is an important aspect of the quality of life of older people and can enhance (or constrain) some of the social, physical or financial aspects of aging. Indeed for most of the population their house is their largest financial asset and their largest single financial transaction. Safe and adequate housing are essential to the well being of young and old. For older people, location, including proximity to family members, services and transportation can mean the difference between positive social interaction and isolation. Building codes need to take the health and safety needs of older people into account. Household hazards that increase the risk of falling need to be remedied or removed (WHO, 2002). This section examines the housing conditions of the elderly people of Kyoto and Kathmandu.

Table 60: Availability of Safety Alarms at Home

City	Fire alarm	Burglar alarm	Fire and burglar	No alarm	Total
Kyoto	14(21.2)	2(3.0)	30(45.5)	20(30.3)	66(100.0)
Kathmandu	0(.0)	0(.0)	0(.0)	100(100.0)	100(100.0)
Total	**14(8.4)**	**2(1.2)**	**30(18.1)**	**120(72.3)**	**166(100)**

Need of Repairs Inside and Outside of Home

City	Yes	No	Total
Kyoto	16(24.2)	50(75.8)	66(100.0)
Kathmandu	28(28.0)	72(72.0)	100(100.0)
Total	**44(26.5)**	**122(73.5)**	**166(100)**

Table 60 shows that there was no availability of safety alarm in considerable proportion of respondents' home (72.3%). Some tiny proportion had fire and burglar alarm (18.1%). More noticeably, none of Nepalese home had such safety alarms. Similarly, overwhelming proportion of respondents didn't feel needs of repair inside and outside of their home (73.5%). However, a little more than a quarter of the respondents (26.5) felt need to repair them.

Table 61: Satisfaction with overall structure of present living home

Variables	Satisfaction to present home			
1.City	Very satisfied	Somewhat satisfied	Not satisfied	Total
Kyoto	16(24.2)	40(60.6)	10(15.2)	66(100.0)
Kathmandu	14(14.0)	58(58.0)	28(28.0)	100(100.0)
Total	**30(18.1)**	**98(59.0)**	**38(22.9)**	**166(100)**

Table 61 clearly shows the expressed satisfaction level of the respondents. Accordingly, a significant proportion of respondents were somewhat satisfied with the overall structure of presently living home (59.0%). Likewise, 24.2% Japanese respondents was very satisfied with overall structure of their houses, while 28.0% Nepalese respondents were not satisfied with the present structure of house.

Table 62 below depicts housing of the sampled elders from Kyoto (Japan) and Kathmandu (Nepal).

Table 62: Number of rooms and other facilities available at home

Variables	Number of Rooms at Home					X^2 Value	P value
1.City	One	Two	Three	More than	Total		
Kyoto	9(13.6)	20(30.3)	21(31.8)	16(24.2)	66(100)		p<0.001
Kathmandu	0(.0)	2(2.0)	16(16.0)	82(82.0)	100(100)	67.761	
Total	**9(5.4)**	**22(13.3)**	**37(22.3)**	**98(69.0)**	**166(100)**		
	Shared or Private Kitchen						
	Private	**Shared**		**Total**			
Kyoto	63(95.5)	3(4.5)		66(100)			
Kathmandu	92(92.0)	8(8.0)		100(100)			
Total	**155(93.4)**	**11(6.6)**		**166(100)**		0.767	n.s.
	Private or Shared Bathrooms						
Kyoto	**62(**93.9**)**	4**(**6.1**)**		66**(**100**)**			
Kathmandu	88**(**88.0**)**	12**(**12.0**)**		100**(**100**)**		1.61	n.s.
Total	**150(90.4)**	**16(9.6)**		**166(100)**			
2.Marital Status							
Married	55(96.5)	2(3.5)		57(100)			
Unmarried	3(75.0)	1(25.0)		4(100)			
Widowed	51(89.5)	6(10.5)		57(100)		5.61	n.s.
Widower	29(87.9)	4(12.1)		33(100)			
Divorced	12(80.0)	3(20.0)		15(100)			
Total	**150(90.4)**	**16(9.6)**		**166(100)**			

With regards to number of room at home, more than two third of the respondents had more than three rooms at home (69.0%). More interestingly, there was a significant gap in the proportion among Japanese (24.2) and Nepalese (82.0%) elders that Nepalese elders were living in a home with sufficient rooms. Like this, almost all the respondents from both countries had private kitchen and bathroom at home (93.4%) and (90.4%) respectively. However, in shared kitchen, Nepalese occupied about double proportion (8.0%) whereas Japanese had made up only (4.5%). By marital status, unmarried were found to have less access less having private bathrooms (75.0%) at home.

Table 63: Possession of Home Currently Living

City	Own	Rent	Total	X^2 Value	P value
Kyoto	50(75.8)	16(24.2)	66(100.0)		
Kathmandu	86(86.0)	14(14.0)	100(100.0)		
Total	**136(81.9)**	**30(18.1)**	**166(100.0)**	2.817[a]	n.s.
Age(years)					
61-70	23(71.9)	9(28.1)	32(100.0)		
71-80	70(82.4)	15(17.6)	85(100.0)		
81-90	35(87.5)	5(12.5)	40(100.0)		
91-100	8(88.9)	1(11.1)	9(100.0)		
Total	136(81.9)	30(18.1)	166(100.0)	3.328	n.s.
Family Type					
Nuclear	83(77.6)	24(22.4)	107(100.0)		
Joint	53(89.8)	6(10.2)	59(100.0)		
Total	136(81.9)	30(18.1)	166(100.0)	3.861	p<0.05

Table 63 denotes the possession of home currently living by elder people. There were more than three quarters of respondent living in own home (81.9) whereas only 18.1% had rented home. Comparing to Nepalese elder (86.0%) Japanese were a bit less living in the own home (75.8%). This proportion was about similar among all the age group. Mostly, joint family had own home (89.8%).

Table 64: Place at Home

Age(years)	Too large	Too Small	Just about	Total	X^{2} Value	P value
61-70	13(40.6)	6(18.8)	13(40.6)	32(100.0)	5.071	n.s.
71-80	39(45.9)	19(22.4)	27(31.8)	85(100.0)		
81-90	23(57.5)	8(20.0)	9(22.5)	40(100.0)		
91-100	6(66.7)	2(22.2)	1(11.1)	9(100.0)		
Family Type						
Nuclear	38(35.5)	26(24.3)	43(40.2)	107(100.0)	22.486	p<0.001
Joint	43(72.9)	9(15.3)	7(11.9)	59(100.0)		
City						
Kyoto	11(16.7)	17(25.8)	38(57.6)	66(100.0)		
Kathmandu	70(70.0)	18(18.0)	12(12.0)	100(100.0)		
Total	**81(48.8)**	**35(21.1)**	**50(30.1)**	**166(100.0)**	51.73	P<0.001

As described in Table 64, nearly half proportion of elders felt that the home they were currently living was too large (48.8%). This was reported by remarkable proportion of them living in joint family (72.9%). However, slightly more than one fifth considered the place too small (21.1%). By country, interestingly there was a huge gap between the proportions of Nepalese elder and Japanese elders who feel the place they currently living was too large (70.0% and 16.7% respectively (X^2=51.730, P<0.001).

Table 65: Need any repairs inside or outside of Building

	Need of Repairs			X^{2} Value	P value
1.City	**Yes**	**No**	**Total**		
Kyoto	16(24.2)	50(75.8)	66(100.0)	0.288	n.s.
Kathmandu	28(28.0)	72(72.0)	100(100.0)		
Total	**44(26.5)**	**122(73.5)**	**166(100.0)**		

Regarding the need of repairs, significant proportion of elder didn't feel any need of repair inside or outside of their home(73.5%)($^{x2=.288,Pvalue=.591,df=1).}$ For Japan only 24.2 % considered their residence required maintenance while for Nepal it was 28%.

7. Employment Status

Employment opportunities play a pivotal role in the life chances of elderly people. The employment status of the elderly is shown of the following tables;

Table 66 Elderly People Engaged in any Job/Works

1.City		Yes	No	Total
Kyoto (Japan)		11(16.7)	55(83.3)	66(100.0)
Kathmandu(Nepal)		5(5.0)	95(95.0)	100(100.0)
Total		16(9.6)	150(90.4)	166(100.0)
2.Sex				
Male	Kyoto	5(7.6)	28(42.4)	33(100.0)
	KTM	5(5.0)	45(45.0)	50(100.0)
Female	Kyoto	6(9.1)	27(40.9)	33(100.0)
	KTM	0(0.0)	50(50.0)	50(100.0)
Total		16(11.4)	150(90.4)	166(100.0)

As shown in Table 66 most of elderly i.e. 90.4% were not engaged in any part/full time jobs. This proportion was to be found even higher (95.0%) among the Nepalese elderly than their Japanese counterparts (83.3%). More than three times (16.7%) Japanese elderly were engaged in any part time jobs than the Nepalese elderly (5.0%). Likewise, Japanese female elderly were more involved in jobs while males in Nepal. Surprisingly, females were not engaged in any jobs in Nepal.

Table 67 Elderly Done Jobs/Work in their Life

Variables City	Government	Private	Company	Housewife	Never Employe	Total
Kyoto	11(16.7)	23(34.8)	17(25.7)	13(19.7)	2(3.1)	66(100.0)
KTM	19(19.0)	4 (4.0)	0 (0.0)	38(38.0)	39(39.0)	100(100.0)
Total	30(18.1)	27(16.3)	17(10.2)	51(30.7)	41(24.7)	166(100.0)

As shown in Table 67, most of Japanese elderly have passed their life in public and private jobs, whereas less than a quarter proportions of Nepalese elderly have done so. Great bulks of the Nepalese elderly were either never employed or just a house wife in their life. These data clearly show that there were less job opportunities in Nepal even before.

8. Activity and Entertainment

The respondents were asked about the following ADL limitations: taking a bath (bathing); dressing or undressing yourself (dressing); eating (eating); getting out of bed or up from or sitting down in a chair (transferring); going outside; going to the lavatory (toileting). The IADL limitations include: going out shopping for personal items, medicine, etc. (shopping); preparing meals, using a telephone (telephone); going out alone, riding a bus, or subway (transportation); dusting furniture, taking out the garbage, and light housework. The respondent is identified as being disabled for the given activity if they report any degree of difficulty. This section investigates the activity and entertainment status of the elderly.

Table 68: Doing ADLs and IADLs

Variables	**ALDs**			**X^{2Value}**	**P value**
1.City	**Yes**	**No**	**Total**		
Kyoto	42(63.6)	24(36.4)	66(100.0)		
Kathmandu	60(60.0)	40(40.0)	100(100.0)	0.222	n.s.
Total	102(61.4)	64(38.6)	166(100.0)		
2. Sex					
Male	63(75.0)	21(25.0)	84(100.0)		
Female	39(47.6)	43(52.4)	82(100.0)		
Total	102(61.4)	64(38.6)	166(100.0)	13.187	p<0.001
3.Age					
61-70	22(68.8)	10(31.2)	32(100.0)		
71-80	43(50.6)	42(49.4)	85(100.0)		
81-90	26(65.0)	14(35.0)	40(100.0)		
91-100	4(44.4)	5(55.6)	9(100.0)		
Total	95(57.2)	71(42.8)	166(100.0)		

As shown in Table 68 above, higher proportion of elders from Japan (63.6%) than from Nepal (60.0%) were able to do ADLs and IADLS. It means that they didn't need assistance in such things. However, rest of elderly needs assistance in their daily life. By gender, males were more active than the females i.e. 75.0 % against 47.6% ($\mathbf{X^2}$ =13.187, P=0.000, DF=1). The age wise data shows that the mostly, the elders aged ranged 61-70 and 81-90 do ADLs and IADLs (68.8%) and (65.0%).

Participation in Leisure time and Religious Activities

Watching TV was a common activity for leisure among the respondents of both countries (41.5%) as shown in Table 69. Next to TV, respondents met friends (18.1%), followed by readings newspapers (16.8%). However, some of them were being engaged in house chores and caring grand children (12.0%).

Table 69: Activities of Leisure

	Variables			$\mathbf{X^{2Value}}$	**P value**
1.Activities of	**Kyoto**	**Kathmandu**	**Total**		
House chores	1(1.5)	0(.0)	**1(.6)**		
Reading newspapers	24(36.4)	4(4.0)	**28(16.8)**		n.s.
Watching TV	26(39.4)	43(43.0)	**69(41.5)**	60.029	p<0.001
Caring grand-children	5(7.6)	13(13.0)	**18(10.8)**		
Meeting with friends	10(15.2)	20(20.0)	**30(18.1)**		
House chores and caring children	0(.0)	20(20.0)	**20(12.0)**		
Total	**66(100.0)**	**100(100.0)**	**166(100.0)**		

Frequency of Trips for Shopping, Visiting and Business in a Week

Table 70 shows significant proportion of respondents never made trips for shopping or business in a week (43.4%). Unlikely, nearly a quarter proportions made three or four times trips in weeks (23.5%). The overall observation by country, Nepalese had less mobility in each category. Like this, male were found to be more active for making such a trip.

Table 70: Frequency of trips for shopping, visiting and business in a Week

	Frequency of Trips						
1.City	Once	Twice	Three to four	Never	Total	X^{2Value}	P value
Kyoto	3(4.5)	16(24.2)	24(36.4)	23(34.8)	66(100.0)		
Kathmandu	14(14.0)	22(22.0)	15(15.0)	49(49.0)	100(100.0)	60.029	p<0.001
Total	**17(10.2)**	**38(22.9)**	**39(23.5)**	**72(43.4)**	**166(100)**		
2.Age							
61-70	9(28.1)	13(40.6)	6(18.8)	4(12.5)	32(100.0)		
71-80	7(8.2)	18(21.2)	23(27.1)	37(43.5)	85(100.0)		
81-90	1(2.5)	5(12.5)	9(22.5)	25(62.5)	40(100.0)		
91-100	0(.0)	2(22.2)	1(11.1)	6(66.7)	9(100.0)		
Total	**17(10.2)**	**38(22.9)**	**39(23.5)**	**72(43.4)**	**166(100)**	30.261	p<0.001
3.Sex							
Male	7(8.3)	27(32.1)	25(29.8)	25(29.8)	84(100.0)		
Female	10(12.2)	11(13.4)	14(17.1)	47(57.3)	82(100.0)		p<0.001
Total	**17(10.2)**	**38(22.9)**	**39(23.5)**	**72(43.4)**	**166(100)**	17.095	

Table 71: Trouble of Getting Around

Variables	**Trouble**					
1.City	**Yes**	**No**	**Not answered**	**Total**	X^{2Value}	P value
Kyoto	12(18.1)	53(80.3)	1(1.5)	66(100.0)		
Kathmandu	36(36.0)	64(64.0)	0(.0)	100(100.0)		
Total	**48(28.9)**	**117(70.5)**	**1(.6)**	**166(100)**	3.882	n.s

Regarding the question about trouble due to lack of transportation, 70.5% of respondents answered no and rest of the respondents told that they were facing trouble due to lack of proper transportation. Only 18.1% respondents from Japan and 36% respondents from Nepal were found to be facing problem due to lack of proper transportation.

Table 72: Participation in Vigorous Activities

Variable	Participation					
1.City	**Yes**	**No**	**Not answered**	**Total**	**X^{2}Value**	**P value**
Kyoto	19(28.8)	45(68.2)	2(3.0)	66(100.0)	2.902	n.s.
Kathmandu	26(26.0)	74(74.0)	0(.0)	100(100.0)		
Total	**45(27.1)**	**119(71.7)**	**2(1.2)**	**166(100)**		
2.Age						
61-70	15(46.9)	17(53.1)	0(.0)	32(100.0)		
71-80	21(24.7)	63(74.1)	1(1.2)	85(100.0)		
81-90	9(22.5)	30(75.0)	1(2.5)	40(100.0)	11.274	n.s.
91-100	0(.0)	9(100.0)	0(.0)	9(100)		
Total	**45(27.1)**	**119(71.7)**	**2(1.2)**	**166(100.0)**		
3.Sex						
Male	34(40.5)	49(58.3)	1(1.2)	84(100.0)		
Female	11(13.4)	70(85.4)	1(1.2)	82(100.0)	15.956	p<0.001
Total	**45(27.1)**	**119(71.7)**	**2(1.2)**	**166(100)**		

Only 27.1% had regularly participated in vigorous activity, and this participation rate was quite low in Nepal with (74% not participating in any vigorous activity) in comparison to Japan. In comparison to female with (13.4% participation rate) most of male (40.5%) had participated in vigorous activity.

Table 73: TV Watching Hours

Variables		TV Watching Hours					X^{2}Value	P value
1.City		**1-2 hr**	**3-4 hr**	**5-6 hr**	**Never**	**Total**		
Kyoto		10(15.2)	24(36.4)	31(47.0)	1(1.5)	66(100.0)	5.018	n.s.
Kathmandu		7(7.0)	35(35.0)	58(58.0)	0(.0)	100(100.0)		
				Age				
2.Country and Hours		**61-70**	**71-80**	**81-90**	**91-100**	**Total**		
	Kyoto	1(10.0)	5(50.0)	2(20.0)	2(20.0)	10(100.0)		
1-2 hr	KTM	0(.0)	3(42.9)	4(57.1)	0(.0)	7(100.0)		
3-4 hr	Kyoto	5(20.8)	10(41.7)	6(25.0)	3(12.5)	24(100.0)		
	KTM	14(40.0)	19(54.3)	2(5.7)	0(.0)	35(100.0)		
5-6 hr	Kyoto	5(16.1)	12(38.7)	11(35.5)	3(9.7)	31(100.0)		
	KTM	7(12.1)	36(62.1)	14(24.1)	1(1.7)	58(100.0)		
Never	Kyoto	0(.0)	0(.0)	1(100.0)	0(.0)	1(100.0)		
	KTM	0(.0)	0(.0)	0(.0)	0(.0)	0(.0)		

Almost 58% participants from Nepal told that they spend 5 to 6 hours each day watching T.V while only 47% Japanese spent 5 to 6 hours per day. According age group, majority of Nepalese elders aged 71-80 watch TV more hours (62.1%) than Japanese elders (38.7%) while on the aged 81-90, Japanese ware ahead than Nepalese (35.5%) and (24.1%).

Table 74: Frequency of Reading Newspapers, Magazines and Book

Variables	Daily	Saturday and Sunday	Sometimes	Never	Not answered	Total	X^{2}Value	P value
1.City								
Kyoto	49(74.2)	7(10.6)	2(3.0)	8(12.1)	0(.0)	66(100.0)		
KTM	30(30.0)	0(.0)	4(4.0)	64(64.0)	2(2.0)	100(100.0)		
Total	**79(47.6)**	**7(4.2)**	**6(3.6)**	**72(43.4)**	**2(1.2)**	**166(100)**	53.054	p<0.001
Male	53(63.1)	3(3.6)	4(4.8)	22(26.2)	2(2.4)	84(100.0)		
Female	26(31.7)	4(4.9)	2(2.4)	50(61.0)	0(.0)	82(100.0)		
Total	**79(47.6)**	**7(4.2)**	**6(3.6)**	**72(43.4)**	**2(1.2)**	**166(100)**	22.781	p<0.001

About three quarters of the participants (74.2 %) from Kyoto read the newspaper, magazine or any other books daily. This rate was very low in Nepalese respondents with only 30% of them read magazine daily. Out of the total, 63.1% male and 31.7% female told that they read newspaper daily.

Participation in any Religious Programs

The Hindu and Shinto/Buddhist temples and shrines, the Church, Mosque has the potential to be one of the most important sources of health promoting programs of elderly in the community. These religious institutions are often called on to provide a wide array of educational, counseling, and social support services to elderly people.

Table 75: Participation in any Religious Programs

	Participation				X^{2} value	P value
Variables	**Yes**	**No**	**Don't know**	**Total**		
1.City						
Kyoto	35(53.0)	28(42.4)	3(4.5)	66(100.0)		
Kathmandu	45(45.0)	47(47.0)	8(8.0)	100(100.0)	1.432	n.s.
Total	**80(48.2)**	**75(45.2)**	**11(6.6)**	**166(100)**		
2.Sex						
Male	48(57.1)	30(35.7)	6(7.1)	84(100.0)		
Female	32(39.0)	45(54.9)	5(6.1)	82(100.0)	6.268	n.s.
Total	**80(48.2)**	**75(45.2)**	**11(6.6)**	**166(100)**		

Almost 53% Japanese and 45% Nepalese attended religious programs**.** This rate was highest in male with 57.1% and 39% female attending any religious program.

Table 76: Participation in Senior Center Programs

Variables		Yes	No	Don't know	Total		X^{2Value}	P value
1.City								
Kyoto		52(78.8)	11(16.7)	3(4.5)	66(100.0)		32.638	p<0.001
Kathmandu		34(34.0)	42(42.0)	24(24.0)	100(100.0)			
Total		**86(51.8)**	**53(31.9)**	**27(16.3)**	**166(100)**			
2.Age and Participation				**Age**				
		61-70	**71-80**	**81-90**	**91-100**	**Total**		
Yes	Kyoto	10(19.2)	21(40.4)	15(28.8)	6(11.5)	52(100.0)	7.668	n.s.
	KTM	10(29.4)	19(55.9)	5(14.7)	0(.0)	34(100.0)		
No	Kyoto	0(.0)	5(45.5)	4(36.4)	2(18.2)	11(100.0)		
	KTM	4(9.5)	30(71.4)	8(19.0)	0(.0)	42(100.0)		
Don ' t know	Kyoto	1(33.3)	1(33.3)	1(33.3)	0(0.)	3(100.0)		
	KTM	7(29.2)	9(37.5)	7(29.2)	1(4.2)	24(100.0)		

Rate of participation in any senior centre programs was high in Japanese respondents (78.8%) while only 34% Nepalese respondents had attended any senior centre program($p<0.001$). By age group, Japanese elders aged 71-80(40.4%) attended senior center programs however a bit large size of proportion of this age was Nepalese (55.9%) and 81-90 (28.8%) Japanese (Kyoto) attended in senior center programs. While among Nepalese elders these proportions were only 14.7%.

CHAPTER NINE
DISCUSSIONS

PART 1: QUALITATIVE DATA

Results from in-depth interviews with the professionals, policy makers, academicians, and social workers of both cities, the researcher have made the following discussions;

Main Issues among the Elderly

Respondents from Kyoto (Japan) revealed that caring for the elderly itself is a major issue among the Japanese elderly. They ranked psychological and emotional care as an issue, followed by financial support for the elderly. Haruki (2004) also stressed that the elderly care is an urgent problem in Japan. It is not simply that Japanese society is aging. The main reason is the collapse of Japanese families' long-standing custom to take care of their old folks in the wake of an increase in the population of those imbued with the individualistic education since the end of the Second World War. Some of the respondents stressed that a very old person caring for another old person is a bigger issue. Particularly females were involved in caring their counterparts. They said that the female elderly were healthier than males. Most of the head of the elderly section of different ward offices have argued that they were worried about increasing of individualistic nature of people. They further opined that both male and females were facing similar type of problems. But when it comes to caring, the females are more vulnerable than men because they are self- cared and also were caring their husbands. In this way, the elderly female has double burden. Hotta (2003) points out that there has been an increase in the number of elderly people who are themselves caring for other elderly people, such as children over 60 years of age are taking care of their parents in Japan. According to the Ministry of Health, Labor, and Welfare (2001) the proportion of such cases now exceeds 50 percent. Of course, care-providers are predominantly female in such cases. Moreover, the percentage of the single households of the elderly was increasing. Doshisha university doctor said that the increasing of single elderly households also is a big problem. He thinks that living alone at home might be psychologically depressed to the elderly. Quantitative data of this research also show that out of 66 respondents about 35.0% elderly were living alone. The head of the elderly section of Kyoto city municipal office has argued that changing family pattern is a big issue alongside current slowdown of the national economic. He observes that the patterns of breaking of traditional family will certainly impact on the caring process. Leakhana et al., (2008) also argue that the care giving issue appears to be a challenge for families with more than one elderly person. Today's younger generation does not tend to take care of their parents when they get old; thus, the parents prepare and condition themselves to live independently when the time

comes. Interestingly, in Japan the problems and solutions are very similar in some ways. Given the problematic constellation of demographic transitions and the issues related to familial care, the establishment of a long-term care insurance (Kaigo Hoken) as a prompt policy response has welcomed–many nationwide surveys in the last decade have indicated that an overwhelming majority (more than 70%) of respondents support the move towards a new type of elderly care. More importantly, these surveys highlighted the readiness of people to receive elderly care from the community (Lai, 2006, Vuori, 2007). Matsukura et al., (2007) stressed that Japan's fertility reduction has been the greatest in magnitude among all industrialized nations. In 2005, the Japanese population became the oldest in the world and its growth rate turned negative. Declining of familial care and support for the elderly is another major issue of the Japanese super-aged society.

In Nepal, the traditional extended family system is gradually breaking down into nuclear family. In this context, family support and family care is becoming an issue due to the increasing of nuclear systems. Likewise, poverty is one of the major constraints which impact the well-being for the elderly. Females are dominated in society due to patriarchal culture of Nepalese society. Nepalese widow elderly are also neglected or have less priority and access in social activities. It seems that females are more vulnerable than males and therefore need more care attention. Some professionals have argued that the health care of the elderly is the big issue in Nepalese society.

The main challenges in gender mainstreaming are traditional cultural practices and customs which perpetuate patriarchy, discriminatory social practices, gender stereotypes, prevalence of gender-based violence, lack of concern for gender disparities in the practice of governance, women's lack of equitable access to productive resources in comparison to men, prevalence of discriminatory legal provisions, lengthy amendment processes, and a lack of gender sensitivity in legislation. A recent assessment of the major changes in women's lives in Nepal over the past decade has shown that despite higher rates of attainment of literacy, social mobility and awareness, women still remain confined to the roles prescribed by the traditions of Nepalese society.

The challenge for public policy is to assess the viability of family support systems and to devise programs that will be supportive or complementary. Several governments have adopted such policies. In Singapore, children are now legally responsible for the support of their elderly parents. Many East and Southeast Asian countries are providing adult day care and other support services aimed at helping adult children care for their elderly parents. Malaysia and Singapore have revised their public housing policies to accommodate multigenerational living arrangements, and Malaysia also provides families with tax incentives for elderly care (World Bank 1994). However, in Nepal, now the health has been written as a fundamental human right in the interim constitution 2006 is a big way forward. Similarly, the health sector has been consistently seeking more funds to address the problems of the poor and to reach the un-reached. Government health budget was 4.93 % of the total national budget in 2003/4 and later in 2006/7 increased to 6.4 %. It has further moved up to 7.14 % of the national budget in this year amounting to 12.099

million rupees. Free public health interventions have become virtually universal (e.g. Vitamin A). Health sector strategy: an agent for reform has been instrumental in pool funding as well as joint planning and ministry health programs (Nepal Population Report, 2007). Howse (2010) clarifies the three main challenges that population ageing holds for the provision of health and social care: amount of ill health; type of ill health; ability to care. Population ageing will have a large and independent effect on the total amount of ill-health and disability in the population and as a result will exert pressure to increase total health care spending. As Howse argues, in order to understand the impact of population ageing on health care systems we must understand both the relationship between population ageing and the scale of health needs, and the relationship between increasing health care needs and levels of health care spending. In summary, the main issues regarding care for the elderly, both now and in the future, are how to finance health care and social services and ensure that there are enough qualified personnel.

In general there are four types of elderly issues; **1) Sociological/Social Issues;** group dynamics-group affinity, broken home, clash of values, beginning of new life stage, role differentiation, loss of trust, loss of parental rights, social perception, social status, lack of recreation agencies, marriages of children and grand children, lack of learning opportunities, adoption of elderly **2) Psychological;** death of companion, identity crisis, psycho-sexual difficulty, psycho-motor actions cognitive decline, loss of memory, dementia, anticipation of death, alienation, emotional imbalance, insecurity. **3) Economical;** economic autonomy, work crisis, resource dependency, transportation and mobility. balance diet, food Security, shelter home, community programmes, support for below poverty line, **4) Legal;** physical abuse, property inheritance, concession in all matters i.e. travel, medical, bank accounts, income, tax etc., friendly technology, protection of rights, establishment of old age homes, provision of old age pension, provision of old age homes/ashrams, protection of property and life, care of elderly compulsory.

Society's Views towards the Elderly

Response from Japanese respondents reveals that the society’s views towards was not satisfactory in comparison of Nepalese ones. However, some have argued that despite the westernization of culture, the society has good sense of cooperation towards the elderly in Nepal. As Aratame (2007) argues that the urban characteristics of neighborly relationships and mutual assistance prerequisites for living are becoming weaker and weaker, in Japan. The urbanization and industrialization process of Japan is seen vaster like as other most developed countries. As Kosberg (1992) argues that the societal changes occurring over time such as westernization and urbanization, changes in the role and importance of the elderly and in family care of the elderly. Their view towards society is positive, but there is a trend, that these values are changing rapidly mainly in urban areas. For the social well-being perspective of the elderly, it is necessary to obtain dynamic social support from society. Nepalese society is also in the phase of

transforming from a traditional way of living into a modern one.

Intra-family care

Although there are no any confined measures for solving the intra-family care in both countries, but most of the respondents of Kyoto (Japan) emphasized that the proper use of formal care services with community-based services could solve an intra-family care for the elderly somehow. Likewise, the informal networks and community support services should be increased for caring of the elderly. The government should appoint sufficient full and part-time care-takers and volunteers for caring. Similarly, tax-free (among other) incentives also can be increased for those children who want to live with their parents. It should be noted, however, that the present policy of the government is very lenient with regard to the enforcement of the legal responsibility of children for supporting and caring for their aging parents (Maeda and Nakatami, 1992).

The Nepalese respondents have suggested that to maintain good morale relationship between elderly and other family members, easy access to formal services could be helpful in caring for the elderly. Mr. Deuja suggested that home care taker service should be employed in order to address the intra family care issue. He further suggests that the elderly should keep the property-right, concerning land, houses etc. If we put this suggestion in practice through national policies then elderly might be respected. In Nepal after 70 years, elderly persons lose their property-rights. Some academicians have argued that other family members and relatives can assist the elderly as care takers if the government provides them with a salary. Likewise, a senior staff nurse Mrs. Bimala Subedi opined that day care center for the elderly persons may reduce the problem of intra-family care for the elderly. She further emphasizes that the formal morale education of the new generation is needed to solve intra-family care problem in some extent. Likewise, government should encourage those who want to live with their parents. It means that the informal networks can work in this sector if we could manage properly. In the other words, the restructuring of the society and family policy should be revised for a better solution.

Who is Responsible of care for the Elderly: Family or Society or the State?

Most of the respondents stressed that local and central government should be more responsible but some others emphasized that the elderly themselves as well as family should be more responsible. However, the Japanese family has long been regarded as a care institution that bears the main responsibility for looking after the elderly (Wu, 2004, p.7). Brodsky et al., (2003) emphasized that many long-term care policy issues revolve around the issue of whether the individual and family, or society as a whole should be responsible for providing and caring for persons with disabilities. Some people believe that the primary responsibility for care of people with disabilities belongs with individuals and their families and that government should act only as a payer of resort for

those unable to provide for themselves (p. 10).

All sectors of society should be responsible for caring for the elderly. Elderly are living history. We can learn many things from them. Mr. Upendra (Under Secretary of Ministry of Women, Children and Welfare) stressed that the family members should be more responsible for caring for and supporting the elderly. Mr. Raju argues that family as well as all levels of the government should be responsible. Some others have stressed that everyone should be responsible but that the government more than others. If the family would be unable to care their elderly then government should have an overall responsibility to care for the elderly. People who believe that long-term care is a societal responsibility and that, while individuals and families should do their part, formal care and public support for informal caregivers should play a large role in meeting the long-term care needs of disabled people.

Many long-term care policy issues revolve around the issue of whether the individual and family, or society as a whole should be responsible for providing and caring for persons with disabilities. Some people believe that the primary responsibility for care of people with disabilities belongs with individuals and their families and that government should act only as a payer of last resort for those unable to provide for themselves. People who believe that long-term care is a societal responsibility and that, while individuals and families should do their part, formal care and public support for informal caregivers should play a large role in meeting the long-term care needs of disabled people. In this view, societally-supported services should be available to all who need them regardless of financial status; in the same way that health insurance should be universally available. According to this view, the fact that one has a disabled relative should not result in an undue financial or care burden to the family (Brodsky et al., 2003). This perspective is characteristic of the long-term care systems in Germany, Scandinavia, and recently in Japan. Indeed, the enactment of the new social insurance program in Japan was a deliberate decision to shift the burden of long-term care from the family to society as a whole (Campbell & Ikegami, 2000). So that the ‘‘socialization of care’’ for the frail elderly under the long term care insurance either in home or community (also institutions) is a major focus for the Japanese government.

The term ‘aging in place’ also used for long-term care in reference to frail and elderly people, to solving their needs for assistance with independent living in their current housing or an appropriate level of housing and preventing a costly, traumatic and often inappropriate move to a more dependent care facility (Heumann and Boldy, 1993).Under this widespread directives for “aging in place” and “community care,” older persons are encouraged to remain living in their homes for as long as possible, assisted by community support services when needs arise. Though almost all these programs rely on public funding, they are not cost-effective and specific enough to meet individual needs. Many countries wanting to rebuild family care in order to reduce the burden on institutional systems have to incorporate a more structured approach, with higher-level skills training and support for informal caregivers (Chan et al., 1992).

The following Figure 13 shows the responsibility of three main institutions in terms of caring for the elderly people.

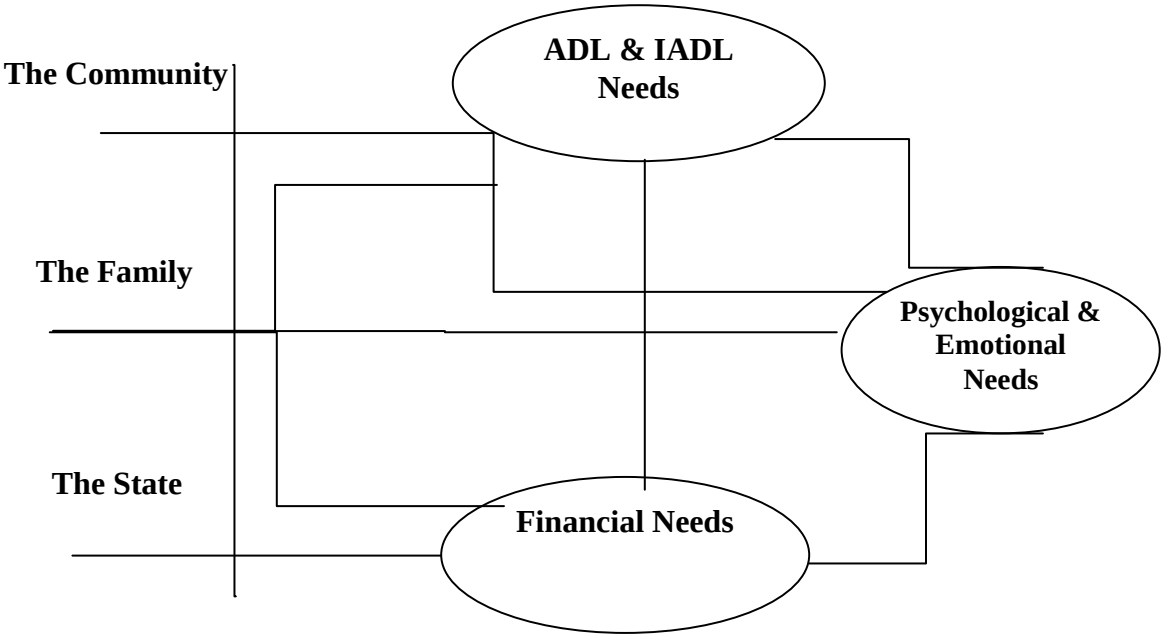


Figure 13: Major Sources of Support and Needs of the Elderly

Healthy elderly people wish to maintain an active part in society, even after retirement. It is important for the physical, mental, socio-psychological well-being of all elderly people to continue to feel themselves useful and to find a meaningful role in life. It is also important for society to gain from the wisdom and experience of the elderly. The family has long been considered the cornerstone of care and support for elderly persons who can no longer care for themselves adequately. So that the family is a major source of support for the elderly in terms of assistance in activities of daily living and fulfillment of psychological and basic financial needs. The community also can play a supportive role for caring the elderly. And the state has an overall responsibility to provide benefits and other types of social security to the elderly people so far.

In other words, we can place the community alongside the family, the state and other configurations of people, as a social institution. The community as a social institution has characteristics which distinguish it from other institutions. The kind of caring that fits best with the idea of community is perhaps one which contains an element of personally felt commitment, but is also containable within a system of balances and limitations (Wilmot 1997, p.28-30). However, three pillars such as; the family, the community and the state have a part to caring process may be helpful by all the perspectives. In this process the family members are expected to provide intermediate care, while the community and the state step into support the efforts of the family, furnish the infrastructure for financial, health and social care and lastly, provide institutional care for the poor and destitute elderly.

Options That May Provide for Better Care in the Future Or Community-Based Services for the Elderly

Most of the respondents expressed their view that community-based care practice might be a good way for caring for the elderly in infirm old age. However, most Japanese elderly people want to live in their home in later life (Wu, 2004) and their second option would be a community home which should be located close to where their home was. They emphasized that community homes should maintain 24 hour service with specialized manpower. However, some others have argued that without informal support they cannot feel well. Finally, nursing homes are also good options for caring if their fees can be affordable to poor elderly people too. Likewise, policy makers and academicians of Nepal have opined that the home care would be the better option of caring for the elderly in many respects. After that the community also would be an option in the long run. In normal conditions, the family would be an option but in severe or problematic cases old age homes or community homes might be the better option of caring for the elderly. So that professionals of both countries are in favor of community based care for the elderly.

Emphasis is now placed on keeping older people in the community for as long as possible. As an objective, this is not intended to mean that institutional care must be done away with. Instead, it conveys the ideas that were more services available to older people in the community; they might remain in their own homes for a longer period of time. Home is symbolic of security, mastery (in that the individual is in personal control), and familiarity. Ward (1979) has developed a topology of four types of community-based services that are necessary for maintaining the dignity, independence and integration of the elderly. They are: (1) Preventive services, 2) treatment services, 3) protective and support services and 4) linkage services.

Mixed Care Model

All professional respondents of Kyoto (Japan) agreed the mixed care model that includes family/home, community and state would be a better option for elderly care. According to Daly and Lewis (2000) there has been increased recognition that care is very much a 'mixed economy', involving the state, the market, the family, and the voluntary sectors. They focused on the term social care where it lies at the intersection of public and private (in the sense of both state/family and state /market provision); formal and informal; paid and unpaid; and provision in the form of cash and services (p.282). Therefore, it is important to make the connection of all the aspects of mixed economy in terms of caring for the elderly.

Health and social care for the elderly should not be considered as the sole responsibility of Government but to improve the health status a multi-sectoral development is necessary. It therefore calls for coordination and participation of public

sector, NGOs, INGOs for providing and financing a sustainable health service delivery. Most of the respondents and policy makers have named it the Partnership Model, where a public private partnership can be made in Nepalese context. The public private partnership model is popular in other sectors in Nepal. The Government of Nepal/Ministry of Health and population has initiated strengthening public private partnership for proving better, quality health care service and covering more people. The private sector should join hand with the government not only for delivery of primary health care but also caring for the elderly as well. Public-private sector partnerships are becoming important in many countries for social protection. The need for the private sector to provide pensions for workers is increasingly being discussed in many Asian countries. For example, China is increasing it's outsourcing of social security reserves to private industry and regulating private pension schemes in an attempt to achieve more adequate retirement benefits in an increasingly prosperous society (Chan et al., 2007). It should be noted that the social security issues cannot be tackled in isolation they require shared and complimentary approaches with others working in the areas of health, labour markets and family.

Participation and Empowerment of Elderly

Empowerment is closely related to participation. There are several factors that preclude the more active participation of older persons in society including poverty, poor health, low educational levels, lack of transportation and access to services, negative stereotypes about ageing, and overt or subtle age discrimination. The goals in empowering older persons are to overcome these numerous barriers, make optimal use of their potential societal contributions and enhance their life satisfaction (United Nations, 2007:46).

Elderly people are expected to participate fully in the development process and share in its benefit. This provides elderly persons with the opportunity to make a continuous contribution to society. All Japanese respondents have emphasized that providing jobs for those elderly people who are physically and/or mentally capable would also contribute to elderly people being able to fend for themselves. Similarly, the proper communication with lonely elderly people would be another way to empower them. Society should not neglect their interests, aspirations, as well as their experience. The concerned authority should think about the future of senior citizens and increase more opportunities for elderly employment.

In Nepal there is a need to support the elderly, which are one of the most vulnerable groups. Access to electronic media, provide peer group education, adult education, health education, proper communication can be empowering to the elderly people. Likewise, utilization of elderly knowledge, skills and experiences for community and national development also can empower them. Mr. Raju Joshi advised that elderly resource centers should be opened for empowering the elderly. At the same time, Mr. Dauja also advised that cultural and awareness programs should be launched in every

ward and village of the country. Mrs. Bimala opined that providing job opportunity and equal participation in social activities of male and female elderly people can empower them. International and national non-governmental organizations have been actively promoting the organization of older persons as a mechanism through which to influence the design and implementation of policies that affect them. As literacy and continuing education, including information about human rights, constitute important elements of empowerment, efforts to organize older persons should be coupled with larger programs encompassing these elements (United Nations, 2007). As elderly persons continue to constitute an ever-greater proportion of the total population, they have the potential to be more influential in society. Haber (2007) argued that peer support group also can empower to elderly. Such groups unite people with common concerns so that they can share their feelings, exchange practical information, and benefit from knowing they are not alone. In short, they attempt to help members learn to live as fully as possible, despite the limitations that accrue with age. Some peer support groups are organized around specific activities, like care giving, or life cycle events, like widowhood.

Empowerment and participation in societal activities of older people vary greatly across countries. There are countries where older people carry great social and political weight, mostly associated with the important concentration of economic resources and a tradition of political participation; in many other countries, however, older people are not organized and experience great difficulty in voicing their concerns and incorporating them in the public debate and the policy agenda. United Nations, (2007) recommends that an important element in the empowerment process is the enforcement of legislative measures to guarantee the rights of older persons that are laid out in national constitutions and international human rights conventions.

Public Long-Term Care Insurance (PLTCI) and the New Gold Plan

When asked about strong and weak points of elderly related policies and programs including the New Gold Plan, the respondents expressed positive views towards Public Long-Term Care Insurance (PLTCI) that would serve as a basic and concrete framework for implementation of elderly welfare in the community. It supports the independence of the elderly and aims at establishing the community that guarantees a secure life to all people. It is a need based care provision to a rights based universal insurance scheme that significantly expands the number of recipients. It enables an elderly individual, regardless of financial and family status, to have access to the elderly care services by means of a social insurance so that they can continue to live a self-reliant life in a community. Under this system there are two types of services, which include community care services and institutional care services. The elderly themselves decide to purchase care services with a small co-payment. Similarly, Long-Term Care Insurance makes a clear departure from earlier systems in that it promotes the community care services such as home help, day services and short stays as a primary means of elderly

care. This scheme intends to enable the elderly residents of the community to lead self-reliant lives at home as long as possible. While not denying access to more conventional institutional care service PLTCI has shifted the emphasis in elderly care from the institution to the community. The pluralism on PLTCI aims at improving the quality of care services by introducing a market mechanism while responding to the demand of an increasing number of its users with a variety of service needs.

Japan's elderly care is now moving towards market-based elderly welfare through public long-term care insurance (PLTCI). However, elderly welfare is more than care services provided through PLTCI; there are many areas that cannot be addressed effectively by PLTCI, one being to provide care and domiciliary services to the elderly whose physical conditions require care or assistance. When welfare needs of the elderly are more than or less than the care services defined by PLTCI, when the kind of service excepted is unprofitable for service providers, or when service needs are not so much physical as social and cultural, the elderly care through PLTCI is not appropriate.

In concerning the New Gold Plan there is a lack of sufficient trained manpower and adequate budget that could not fulfill the demands of the elderly. Although a one room apartment system is not sufficient for living, on the other hand it is also becoming too difficult to find apartments because the elderly population is increasing. Two respondents argued that the New Gold Plan has failed to gather money from consumer taxes. Therefore, the New Super Gold Plan is needed very soon.

For many feminist, the Gold Plans proved too inadequate and underscored the desirability of a social insurance scheme as a way to ensure individual rights to social care. With the introduction of long-term care insurance most of the services covered by the Gold Plan were transferred to the insurance program, and the means-tested care services are being left for low income elderly receiving social welfare (*seikatsu hogo*) and for disabled, who are not covered under the insurance scheme. In principle, the introduction of the insurance has meant that all elderly requiring care now have the right to receive care, regardless of income or family situation (Peng, 2002, p.430). No doubt both the Gold Plan and New Gold Plan have paved the way future reforms in the fundamental characteristics of health care in Japan, but it is evident that in order for these plans to work, more large-scale investments in long term care (LTC) infrastructure are insufficient. Apparently, such efforts have generated only limited effects. Nursing homes and health care facilities for the elderly might have increased in absolute numbers under the Gold Plan; nursing homes still cannot cope with the incessant heavy demand. However, quality LTC for the aged requires more than just expensive infrastructure, the government must likewise adopt a two-pronged approach by training more qualified caregivers and educating the public. Moreover, there are concerns that such dramatic increase funding for LTC might be just a political man-oeuvre to sweeten the effect of introducing an unpopular consumption tax in 1996 and win the support of women voters. In summary, several policy initiatives have been launched in recent years to meet the growing needs and demands among the elderly, their families.

Major policies and programs including Senior Citizen National Work Plan of Nepal

In order to promote the quality of life of the elderly in Nepal, Government of Nepal announced the Ninth National Plan (1997-2002). The development of family-based security systems to enable the elderly to lead creative and dignified lives was also initiated. Recently, the Ministry of Women, Children and Social Welfare has drafted a guideline for the implementation of a new program called the "Senior Citizen Treatment Service". The guideline envisages offering the poor and sick elders basic health care service free of cost. The Monthly Old Age Pension and the proposed Senior Citizen Treatment Service remain the two major programs that can potentially contribute to the benefits of elderly people in Nepal (Swar, 2002). To implement senior citizens policies the following working policies/programs/ activities shall be pursued in short term, medium term and long term development plans. The long term goal/objective of senior citizen functional policy is to make old age secured and easy, developing the capacity of elderly utilizing their knowledge, skills, experiences and expertise in various spheres of nation building whilst providing them social and economic security with a life in dignity. These programs/activities have been sub-divided into 7 different aspects and 52 work plans: economic aspect consisting of 6, social security-11, Health services and nutrition -9, Participation and engagement -8, Education and entertainment aspect–5, Legislation enactment -2, and miscellaneous -11 work plans.

Professionals have responded that the Nepalese policies regarding to solve the elderly issues are too ambitious. It means that the policies are good ones but their implementation has always been valued as weak due to the lack of good projects. There are no policies and provisions for care takers and also their basic formal qualification. The lack of availability of trained professionals and resources has been a key hindrance for the care of the elderly in old age homes. However, the constitutional right to health care is being translated into a policy of universal free essential health care in Nepal. In December 2006, emergency and inpatient services were declared free for the disadvantaged, destitute, underserved, the elderly, the people living with physical and psychological disability, and Female Community Health Volunteers (FCHVs), at district hospitals and primary health care centers (PHCCs). In October 2007, Government of Nepal further decided to offer essential health care services free of charge to all citizens at all health and sub-health posts from mid-January 2008. To sum up there has been a substantial positive step taken by the government of Nepal in elderly related policies, however, their effectiveness is limited because of their weak implementation.

For the elderly in Nepal, the present needs are being addressed in the following areas:

- Health insurance system for the elderly population;
- Establishment of geriatric hospitals or wards in general hospitals for the elderly with free health services for older persons;

- Establishment of day care centers free of charge for elderly people, by the government, and
- Health prevention and promotion programs for the elderly.

Regarding the current welfare policies and programs most respondents were of the opinion that current welfare programs are nearly sufficient in that they could choose according to need and earning capacity. However, some respondents emphasized that current policies and programs are not sufficient and lack of nursing homes, shortage of hospital beds and they thought it was becoming more difficult to hire a home care-taker due to increasing numbers of older people. On the other hand, when they need to enter institutions, they have to wait for a long time and there are not sufficient numbers of institutions for caring for the elderly. Some respondents stressed that the government should pay a larger amount and that elderly people's tax money should be used only for their welfare, because their generation (the baby boomers) is over ninety years old now. These respondents, due to these problems, are searching for a new reason for living.

One of the demographic trends that is most frequently discussed and debated by health service planners is the aging of the ‘baby boomer’ generation. This large group is expected to impact both the volume and type of services required. A significant amount of research exists on the effect the baby boomer generation will have on health services. Impacts include increasing health care costs, increasing demand for choice and options in health care by a population of informed consumers, increasing need for chronic disease management, and changing patterns of demand for health services by a population expected to live longer lives than the previous generations. An alternative perspective on the baby boom holds that seniors of the future will be healthier than their predecessors. Added to this, improvements in health care such as earlier, more effective intervention for chronic disease and less invasive therapies will reduce the rate of health care use, with potential for little or no net increase in health care demand as baby boomers become seniors (British Columbia, 2005).

PART 2: QUANTITATIVE DATA

Quantitative discussions were made by using both primary and secondary types of data. Primary data was collected by way of surveys of a sample of elderly respondents through face to face interview with the help of structured interview schedule.

This thesis has investigated, in a comparative perspective, the similarities and differences of elderly care practice between Kyoto and Kathmandu. The researcher compared and described the demographic characteristics, physical, mental, psychological, social, economic, housing conditions, living arrangements as well as activity and entertainment status of the elderly.

Demographic Characteristics of the Elderly

To the extent that population aging in its narrowest sense is a demographic phenomenon, which is inevitable that consideration would be given to the possibility of demographic responses that would alleviate the situation. Table 9 shows demographic characteristics of the respondents. Accordingly, the male participants were 50.5% from Japan and 50.0% from Nepal. Similarly, female were 48.5% and 50.0% respectively. By education, nearly one third of the respondents from Nepal had no schooling (30.0%) while all Japanese elderly respondents were literate. According to 2001 census, the literacy rate (those who can read and write) for aged 65+ years is found as 27.0% for males and 4.07 % for females. For both sexes, the literacy rate for aged 65+ years is found as 15.64 %. But for districts of Katmandu valley, the literacy rates for both sexes are found much higher than those observed for all Nepal. Low level of education and illiteracy are associated with increased risks for disability and death among people as they age, as well as with higher rates of unemployment. Education in early life combined with opportunities for lifelong learning can help people develop the skills and confidence they need to adapt and stay independent, as they grow older (WHO, 2002). Haber (2007) also points out that as the formal educational level of older adults continues to rise, this may well correlate with an increase in their interest in seeking out health information and engaging in health-promoting activities in their communities.

Japanese were concentrated on higher age group (50% and 88%) while in Nepal, the higher concentration was in lower age groups (65.6% and 68.2%). The mean age was found in among Japanese elderly 80yrs.while76 years of Nepalese ones. With advances in medical technology and improvements in public health and nutrition, the average life span of the Japanese people has markedly increased. Data across the family type shows, about all of the Japanese elders lived in nuclear family whereas majority of Nepalese elders lived in joint family (55.0%) **($X^{2\ value=}$**41.566, P value=.000, df=1). It means that the nuclear family living arrangements were found to be the dominant arrangement for elderly people in Japan while joint family systems in their Nepalese counterparts. As Saito (2000) argues that the rapid increase of the number of elderly people living by themselves has resulted in the decline of traditional family functions in Japan.

The Nepal average family size was found to be 4.1 persons where as in Japan just 2.43 persons. In Nepal an average family size of 4.1 in 2004 which was 5.4 in 2001. During the period 1991–2001, the annual elderly population growth rate was 3.39%, which was higher than the annual population growth rate of 2.1 percent. A survey conducted by Kathmandu Metropolitan City in 1997 shows that11.6 percent and 5.6 elderly females and males respectively stayed alone in Kathmandu.

Likewise, the number of people in each household had been approximately 5 until 1955 in Japan. However, the census in 2005 shows that it is now 2.58. As for the households with the elderly, the number is 2.73 in 2005. According to the Comprehensive Survey of Living Condition of the people on health and welfare (2005), 18.53 million households (39.4%) of the total households) contain those aged 65 and over, of whom

4.07 million (22.0%) live alone, 5.42 million (29.2%) live only with a spouse and 3.95 million (21.3%) live in three generation families.

The marital status of elderly is important for their support systems and their well-being. The elderly that are still married tend to recover more rapidly from illness, have better mental health, utilize more health services, socialize more and are generally more satisfied with their life than those elderly without a partner (Geriatric Center Nepal, 2010). By marital status widowed were found about in higher proportion in Japan (36.4%) while 33.0% in Nepalese ones. Likewise, married elderly percentages also were found more among the Japanese elderly (39.4%) compare to Nepalese (31.0%). As Horlacher (2002) argues that, because of greater female life expectancy and the fact that Japanese women generally marry older men, many elderly Japanese women are widowed. In absolute terms, there has been a significant increase in widows aged 75 and over. This tradition in Nepal is quite different that Nepalese males want to get marry with young women. The marital status of the elderly is an important indicator of their residence, their support systems, and, importantly, their individual well-being. The elderly that are still married tend to a more rapid recovery from illness, better mental health, utilize more health promoting services, socialize more, and are generally more satisfied with life than those elderly without a partner (Chalise, 2006, cited from United Nations, 1994).

One of the most important invisible sources of support for many respondents is religion. Almost all elderly respondents from Nepal and many respondents from Japan were religious followers. They believed that religion would protect them and ensure them a peaceful old age. A significant proportion of Nepalese elders were Hindu (77.0%) while Japanese were Buddhist (71.2%). Although small proportion of Japanese respondents reported that they were not belongs to any religion (13.6%).Most varied traditions have been combined in the formation of Nepalese religious culture which is unique and perhaps one of the rarest examples of ethno-religious pluralism. Majority of the people observe a complex syncretic and highly localized religiosity rather than a 'religion' in the conventional sense. In Nepal, Hinduism and Buddhism of Nepal and Shinto/Buddhism in Japan are looks similar in many respects. Shinto-Buddhist followers of Japan also have a good outlook to the Christianity. Many Japanese utilize Buddhist services on special ritual occasions; from many a heavy dose of Buddhism is no more reflective of their daily lives than is Christianity. Yet, if asked directly to name their religious preference, most contemporary Japanese respond that although their family maintains a relationship with a particular temple or shrine, they personally profess belief in no particular religion (Long and Chihara, 2000:153-54). Wu (2004) argue that the Japanese elderly people practiced their religion by doing their daily tasks, reflecting on their conduct and participating in religious activities. And most common faith was the devotion to their own family ancestors.

Religious and spiritual activities are often interchangeable terms and, when used in research, tend to be measured by way of religious beliefs or practices. When a

distinction is made, religious activity is considered to be more organizationally based and more traditional in its manifestation (Haber, 2007). Researchers have found that spirituality and religiosity are related to well being, physical health and longevity, coping behavior and mental health (Myers, 2000). Religious involvement may enhance well being by providing social support, as well as a belief system that can offer hope and a sense of meaning and purpose in life (Crowther, et al., 2003). A strong correlation has been found between wellbeing and religion, regardless of health, wealth, and social support. Correlations between wellbeing or adjustment to change and religion tend to increase over time, suggesting that as other sources of well-being decline, religion may become even more important (WHO, 2004).

Physical Health Status of the Elderly

A chronic or acute health problem such that the physiological capacity to function is significantly limited or impaired. The term shall include health impairments due to asthma, attention deficit disorder or attention deficit with hyperactivity disorder, diabetes, paralysis, a heart condition, cognitive impairment if such health impairment adversely affects an elderly people's daily living. Older people are undeniable less healthy than younger adults. Most have one or more chronic conditions. The biological decline in the functioning of organs makes older people more vulnerable to illness. This section discusses the health status of the elderly people.

Table 10 describes present health status of the respondents on the basis of gender, family, country, age and marital status. Accordingly, nearly half of the respondents feel fair health at present (51.2%), followed by good (33.1%), and poor (12.6%). However, a small proportion of them expressed excellent health (3.0%). Disaggregating data into different sex, females were significantly higher reporting fair health (63.4), than male (36.9%). This reflects, female were healthier than male. With regards to family type, majority of them living in joint family had fair health (55.9%) which was 48.6% for nuclear family. By country, excellent and fair health status was reported by 7.6% and 36.4 % respectively while for Nepal none of them had reported excellent health and 39.4% had good health, as reported. Disaggregating age group data by country, significant proportion of elders of Nepal aged 61 to 100 reported that they had fair health at present. By country, excellent and fair health status was reported by 7.6% and 36.4 % respectively while for Nepalese elderly, none of them had reported excellent health. However, About 31.5% elderly were enjoying with good health. Considering overall health condition of the respondents by country, significant proportion of elders of Japan aged 61 to 100 reported that they had good health at present. According to marital status, all the unmarried Japanese were found with fair health (100.0%),followed by Nepalese widowed (72.7%) and divorcee Nepalese (53.8%) compare to Japanese(0.0%),(50.0%) and (50.0%). According to the World Health Organization, the Japanese enjoy the world’s longest and healthiest lives. A physical

illness or impairement that interferes with one's functioning makes it difficult to continue one's normal activities and makes it difficult to maintain social ties to the society. The loss of functional capacity is also a reminder that one is approaching the end of one's life.

Table 11 presents the distribution of respondents by their vision (eyesight) and hearing status. These data show that females have fair eyesight (65.9%) and hearing (62.1%) than that of the males, i.e. (44.0%) and (32.1%) respectively. However in good eyesight, male's proportion was found to be significantly higher (50.0%) whereas female were only (22.0%). The overall results indicate the need of hearing aids and eye glasses for the elders. Hearing impairment leads to one of the most widespread disabilities, particularly in older people. It is estimated that worldwide over 50 percent of people aged 65 years and over have some degree of hearing loss. Hearing loss can cause difficulties with communication (WHO, 2002). By country, hearing status of the elderly belonging to each category was almost similar (X^2=0.681, P=0.878,df=3).

Looking at Table 12, a lion's share of respondents doesn't need any aids (75.9%). Of those who required assistive devices, the proportion from Nepal was slightly more (24.0%). However, slightly more than a quarter of female elders and those who were living in joint family reported as need of assistive device (26.8%) and (27.6%). Likewise, Table 13 shows, of those elderly people who expected assistive aids preferred hearing aids (43.5%); this is followed by spectacles (33.3%) and wheel chair (15.4%). Nepalese women prefer walker (12.5%), also half of the Nepalese found to be using hearing aid (50.0%) than by the Japanese elders (33.3%). It shows poor health status of Nepalese elders in comparison to the Japanese elders. As we grow older, our ability to hear, see and move diminishes. Therefore, the elderly need the help of hearing aids, prescription glasses, wheel chairs, walking sticks, etc., to continue to lead independent lives. Thus, these aids should be made easily available to the elderly.

Table 14 indicates the overwhelming share of respondents living with physical disabilities/ chronic illness (89.2%). The impairments were found to be slightly lower among the male respondents (88.1%) compared to females (90.2%). While compared age group across the two countries, Nepalese aged 61-70(20.9%) and 71-80(58.2%) were found to be more than Japanese (15.8% and 38.6%). While compared across the two countries, there was no significant difference between Nepal (91.0) and Japan (86.4%) (X^2 =0.868,P=0.352 at df=1).

As seen in Table 15, the differences of proportion of respondents suffering from respiratory disease across the two countries were visible. Accordingly, Nepalese elders were suffered from respiratory diseases (25.3%), gastric (16.5%) and partial paralysis (3.3%), while the tendency of heart disease, physical deformities i.e. missing or non-functional limbs and broken bones were considerably high in Japanese elders i.e. 19.3%, (15.8%) and (10.5%) respectively. In contrast, these were found in relatively fewer Nepalese elders (4.4% and (1.1% respectively). Nepalese elderly used to smoke and it may be a cause behind the respiratory diseases. In the other hand, smoke can also

have a negative effect on older people's health, especially if they suffer from asthma or other respiratory problems. According to Aiken (1995) the most common acute disorders among older adults are respiratory ailments, but these problems may also be chronic.

Table 16 presents the duration of health impairment or disability among elders. The figure significantly shows that nearly half proportion of respondents were suffering from physical disability for ten years (38.9%), followed by 15 years (33.6%). However, few of them (14.8%) were suffered from last 5 years. About 12% had severe disability (12.1%). The tendency of suffering was higher among widower (48.3%) and divorced/separated (46.7%). Unmarried elders were found less suffered (25.0%). By gender, more than one third women were suffering from last 15 years (37.8%).The majority of Nepalese respondents in the age 61-70 years had suffered for last 10 years (77.8%), followed by last 15 years (74.4%) and for last 5 years (63.6%). These proportion was found in very few among Japanese elders (22.2%, 28.6% and 36.4). Likely, the age group 71-80 follows the same trend. This shows that the chronic illness was higher in Nepalese elders than Japanese. (^{X2} =20.371, P=0.060, df=12).

The frequency of visiting doctors during the past six months is presented in Table 17. Accordingly, majority of respondents visited a doctor three to four times during the past six months (48.5%); a slightly more than a quarter respondents had visited twice (26.7%) while only 15.2 % had seen five to six times. Male respondents who visited 3-4 times was about two third (59.0) but only 37.8% females had visited doctor seeking health care. It indicates that females have low access to health services. According to age category, huge proportion of respondents aged 81-90 from Japan had seen a doctor frequently (44.0%). Similarly, this proportion was higher in Nepalese age group 71-80 (X^2=25.886,P=0.011,df=12).

Table 18 describes respondents' overnight hospital stay. Surprisingly, a large share of respondents never stayed in a hospital overnight (66.3%). The remaining stayed for one week (15.1%), two weeks (9.0%) and three weeks (6.6%) and more than one month (1.8%). One remarkable finding is that unmarried (50.0%) and divorcee respondents (40.0%) were most likely to be admitted in hospital. In terms of gender, there were significant differences between male and female i.e. 23.2% and 7.1% respectively (X^2 =18.6, P=0.002,df=5). More interestingly, none of the respondents age 91-100 lived in hospital for one week, they were lesser in number even for staying two and three weeks(11.1%). According to the Survey on the Actual Status of People with Physical Disorders in 2001, nearly 95% of Japanese people with physical disabilities live at home, while the number of people with other disabilities who live at home is comparatively small. People with mental disorders, in particular, are often forced into hospitalization and denied their independence, even when they could be discharged from institutions.

This suggests that there is considerable need for further measures to ensure that these people are accepted into their local communities. In 2003, average length of hospitalization was 36.4 days in Japan, whereas it was just 4.1 days in Mexico, 6.2 days in Sweden, 6.5 days in the United States, 7.6 days in Italy, 10.9 days in Germany, and

13.4 days in France. There are several reasons for Japan's unusually long average length of hospitalization (Ogawa and Retherford, 1997).

With regard to rising public expenditures for medical care, old age itself is not associated with increased medical spending. Rather, it is disability and poor health- often associated with old age-that are costly. As people age in better health, medical spending may not increase as rapidly. Table 19 reveals, the results show that the significantly higher respondents who replied somewhat satisfied had higher education was from Nepal (84.6%) and Japan (83.3%). Likewise, Japanese elderly were reported very satisfied 27.3% and somewhat satisfied 59.1% while, Nepalese 26.0% elderly were somewhat satisfied and rest of the Nepalese elderly were somewhat and very dissatisfied to their medical treatment in the past. However, only Nepalese respondents with no schooling were found to be very dissatisfied (50.0%). As compared to the Japanese cohort of the elders, Nepalese elders were very dissatisfied (36.6%) with the health services they had received in their last visit.

As shown in Table 20, through the country wise data, half of Nepalese respondents expressed poor health care system in Nepal (50.0%) while no Japanese reported this category (0.0%). More interestingly, the proportion of respondents from Japan categorized as good (68.2%) whereas only fewer Nepalese ranked this category (7.0%). Japan's health care systems have been highly commended by the WHO. However, because the pace and extent of population ageing in the country has been so rapid (the highest in the world), keeping up with the current situation and continuing to give the best services to the nation remains a challenge (Ito, 2008).

Likewise, as countries' populations age, refitting the system of health services to meet the major conditions of the population will assist in containing rising costs of health care that accompany an aging population. Refocusing health services and providing community based home care will be less expensive than providing nursing home or other institutional care for debilitated elderly (Micklin 1994, Cowart and Serow, 1998). Japan has a ten-year plan to limit institutional care and instead to provide home care and geriatric rehabilitation (Martin 1991). Countries will need to recognize that paying for the health services required of an aging population will be higher than the costs of care for a younger population (Cowart and Serow, 1998). Nepal has developed various policies and programs to expand the health care services to its population. It is stated in the Constitution to provide essential health care services free of cost to ultra poor, vulnerable, poor, senior citizens, people living with physical and psychological disabilities, and women. However, none of the programs are designed targeting on the health needs of the older population in Nepal (Geriatric Center Nepal, 2010).

The Table 21 describes the measures that can be adopted in young age to maintain health. Interestingly, 41.6%, of respondents reported no any fixed habits; about one third of them adopted balance diet (30.7%), while a little less than a quarter did exercise (24.1). Remarkably, Nepalese elder were higher for not adapting any fixed habits (48.0%) to Japanese (31.8%) whereas Japanese were ahead for doing exercise (30.3%)

and having balance diet (36.4%). It was fair to say that Japanese elder's health condition reported as good than their Nepalese counterparts. WHO (2002) also stressed that participation in regular, moderate physical activity can delay functional declines. It can reduce the onset of chronic diseases in both healthy and chronically ill older people. British Columbia (2005) emphasized that the physical activity is important for seniors because it helps them maintain muscle strength, coordination, joint function and flexibility. Regular physical activity also contributes to functional and cognitive capacity, and by facilitating daily life activities contributes to increased autonomy and well-being. Also, physical activity plays a critical role for healthy aging as it acts as a core element to other positive health-promoting behaviors. For example, the lowest use of tobacco products is found among the most active population. Finally, increased levels of physical activity can also contribute to the prevention of injuries.

Psychological Status of the elderly

As populations age, one of the greatest challenges in health policy is to strike a balance among informal support (care from family members and friends) and formal care (health and social services). Formal care includes both primary health care (delivered mostly at the community level) and institutional care (either in hospitals or nursing homes). While it is clear that most of the care individuals need is provided by themselves or their informal caregivers, most countries allot their financial resources inversely, i.e., the greatest share of expenditure is on institutional care.

Data from Table 22 shows daughter (33.3%) and home helper (16.6%) as the main care givers in Kyoto while for Nepalese elderly daughter in law (45.0%) and daughters (20.0%) were reported as the prime care givers(significant X^{2}**=21.029,P= 0.004 at 7 df)**. Husband and wife were equally engaged in caring process in Japan. It is because, Japanese elderly both men and women were enjoying with good health. Daughter-in laws were reported also as care givers. However, the increasing involvement of women in workforce is being difficult to care their parents as well. Hotta (2003) argued that it was customary for Japanese families to take care of their elderly relatives, and the state intervened only in exceptional cases when families were unable to provide such support. However, today the ability of families to care for elderly members is declining.

Interestingly in Kathmandu (Nepal), husband (none) and spouse (5.0%) were not mentioned as the main care providers but it they were mentioned by 12.5% each in Kyoto (Japan). In both cities, families are the primary care givers for elderly persons with disabilities. However, Japanese family care givers can enlist more formal services as they want. Eckerman and Sarah (2007) point out that the children are traditionally responsible for the care of the elderly in Nepal, so more children mean more potential care givers.
Home helper and servants also are the care givers in both countries respectively. In both countries women provide the overwhelming majority of care giving mainly informal care. However, professional care gives role as seen an important part in Japan. In summary, there are similarities, both in Japan and Nepal that women have had most of the

responsibilities for the day-to day activities of family care-giving. If family could afford a basic remuneration to home servants same as in Nepal, that should be an option of care giving to reduce intra-family care problem in Japan. The majority of elderly in Nepal are living in rural areas (85 %+). They are usually active and productive in their advancing years doing things such as taking responsibilities for child care, cattle herding, handicrafts and many more (Geriatric Center Nepal, 2010).

Table 23 shows that significantly, Japanese elderly liked their care givers' attitude very good (58.3%) while only a little more than a quarter Nepalese elder liked that much (30.0%). It is because they were their daughters at the most whereas daughter-in-laws were main care givers among Nepalese elders. Forty five percent Nepalese and 16.7% Japanese elders felt that their care givers attitude was normal. It may be due to lack of elderly care training, poverty and awareness in Nepal. **(X^2 Value** 7.839 **P value** 0.049, df=3). However, Wu (2004) found that attitudes towards Japanese elderly persons living with children and the norms of filial piety have also been changing. Some studies indicate that the rejection of co-residence has been growing over time and that the younger generation; the greater the percentage of respondents who think it is better for aged women than men who prefer living separately from their old parents. Wu further says that the middle aged persons have been seen as dependable family caretakers for older parents. However, their attitude towards elderly care has changed.

Table 24 indicates different services taking by elderly people. Cross-tabulation of data by gender and country shows double proportion of participants, both male and female of Japan, got home help services (8.8%) and (18.8%), this was only 4.0% and 6.0% among Nepalese male and female participants. Out of 66 Japanese elderly 80.3% were receiving different kind of services. Among them, the great bulks i.e. 57.6% were receiving day and day care services. Surprisingly, just 6.0% Nepalese elderly were taking home help and day services. It indicates Nepalese were isolated from these sorts of services. (**X^2 Value** 1.008 **P value** 0.000,df=3). There are few institutions in Kathmandu such as; one day centre organized by the government and 29 centers developed by Non-Government Organizations (NGOs) were opened in Kathmandu, the central city of Nepal (Swar, 2002). Likewise, there are about 70 organizations registered with the government spread all over Nepal. These organizations vary in their organizational status (government, private, NGO, Community Based Organizations (CBOs), personal charity), capacity, facilities, and the services they provide. Most of them are charity organizations. About 1,500 elders are living in these old-age homes at present. These private organizations are providing services to elderly out of the individual's initiatives. The services are determined with the consent of the individual generosity. The services and care, virtually, do not include aspects that are essential to cater elderly in these Homes (Geriatric Center Nepal, 2010).

Wu, (2004) argue that in 1980s, in order to relieve the enormous burden that medical and other welfare expenditure put on the economy, the Japanese government suggested a 'Japanese-style Welfare System' and promulgated that both the family and

local community should shoulder the responsibility for caring for the elderly at home. For that two main goals of developing 'community in home services' and strengthening 'institutional services' established in the two Gold Plans have become the future orientation of social welfare and security programs. The long-term care insurance system has further enhanced this trend.

According to Fuller et al., (2003) the long term care (LTC) refers to a range of services that address the needs of aging individuals who lack some capacity for self-care. These services are based upon demonstrable needs, may be continuous or intermittent, and are delivered for various periods of time. LTC typically does not involve high-tech medical care; it can include assisted living, home health, nursing home and hospice or palliative care. Long term care is provided predominantly by the informal support network of family, friends and neighbors. Table 25 show the opinion of respondents about long term care for dependent elders, 46.4% perceive that the care should be done in home with support from the government. About one third of them opined for community setting supported by the government (29.5%). However, small proportion of them considers family member (13.9) and institutional settings such as hospital and nursing homes (10.2%). Both male and female elders who reported home care supported by government were higher from Nepalese i.e.54.0% and 56.0% respectively. In addition, because of the Confucian tradition of filial piety, the majority of Japanese families prefer placing a frail elderly family member in a hospital than in an institution for older persons. In recent years the Japanese government has taken steps to improve geriatrics care in the community and it is currently directing enormous funds to develop the system of institutional care (Brown, 1988). The long-term care insurance program encourages care for the elderly at home (community-based). The target of social welfare began to change towards service marketing. After the change, the care was no longer considered as a limited service targeted only to socially weak persons but it became a universal possibility open to all elderly persons. This created a rapidly expanding private market for elderly care services, and the sector is now a growing market also for new service innovations. Chan et al., (2007) also argued that the aging in place emphasizes the importance of strategies that make it possible to support older people in their homes and communities. At the same time, it should be a matter of choice for older people and should not be mandatory. In encouraging home-living, even with a certain degree of frailty, society must foster family-oriented care-giving, because home care is less expensive and safer than institutional nursing care.

Emotional well being encompasses the affective and cognitive aspects of a person's overall summation of life experiences (Crowther et al., 2003). Table 26 shows present emotional health of the elderly people. It was found to be fair on nearly two third of the respondents (65.5%). By marital status, significantly higher Nepalese divorcee (92.3%) had fair health at present compared to Japanese divorcee (50.0%).Like this; the elders from Nepal aged 61-70 (17.1%) and 71-80 (63.2%) also perceived that they had fair emotional health at the moment. C. Ryff (1995) describes the following six

components of well being: positive evaluation of the self and self acceptance, positive relationships with others, autonomy or self determination, environmental mastery, a sense of purpose in life, and a feeling of growth and development as a person. An older adult's sense of well being may be challenged by the need for care and their loss of independence. A lack of well being has also been associated with a host of psychological problems. There are several tasks that geriatric care managers employ to assist older adults with aspects of their spiritual and emotional well being (Crowther et al., 2003).

Social Status and Networks of the Elderly

The social status of the elderly is another factor that is playing a role in the demand for care. Though the elderly are very often willing to work longer and to make themselves useful for society, they are forced to leave the workforce at an age of 65 or earlier. However, when there are no opportunities for meaningful activities (study, leisure, voluntary work), this disengagement may result in feelings of superfluousness, abandonment and loneliness. It can be expected that the difference between the aspirations of the elderly on the one hand and the lack of willingness of society to respond to these aspirations will result in lower responsibility for health status (Malcolm, 2005, p. 657-58). For social well-being of the elderly, social support and networks are also important things. According to Haber (2007), social support can be defined as the perceived caring, esteem, and assistance that people receive from others. Support can come from spouses, family members, friends, colleagues, health professionals, or pets. Likewise, social support, opportunities for education and lifelong learning, peace, and protection from violence and abuse are key factors in the social environment that enhance health, participation and security as people age. Loneliness, social isolation, illiteracy and a lack of education, abuse and exposure to conflict situations greatly increase older people's risks for disabilities and early death (WHO, 2002). Social networks, unlike social support, are defined in terms of structural characteristics: the number of social linkages, the frequency of contacts and so on.

As mentioned in Table 27 significantly high proportion of elder knew three or more people well enough who visited at home(62.2%), about half of this figure knew one or two people (33.7%). Surprisingly, the gap between Nepalese elder and Japanese elder who knew three or more people was notably visible (76.0%) and (40.9%) respectively. Crossing this data by gender, male were higher (65.5%) to female (58.5%). Social networks are connected with the mesh of relationships within which an older person is located. The concept of social network analysis has extended the approach used to the empirical and theoretical analysis of older people's social relationships because it is left up to the older person to determine who is (and is not) part of their network. Older people can include or exclude kin, friends and neighbors as appropriate (Victor, 2005).

Table 28 Indicates the frequency of times talking with friends, relatives and neighbors through telephone. Accordingly, majority of elder talked two to six times in the past (40.4%), followed by once (33.7%), 16.3% of them never talked. Japanese elder

talked more on telephone (51.5%) than Nepalese elder (33.0%). This data reflects that Nepalese elders had less telephone talked in the past. It might be a cause behind the rate of less telephone talking among the Nepalese elderly due to their hearing impairment. Likewise, Nepalese elderly used to talk to another by face to face meeting.

Table 29 indicates that the significant proportion of respondents have a nearest one to believe in (86.1%). A large proportion of age 81-90 years have someone to trust (95.0%), next to this group, the age 61-70 years occupy the second position(87.5%) followed by the age 71-80 years (84.7%). Similarly, Japanese have fewer trustworthy people (77.3%) as the Nepalese elders have (92.0%). In my opinion this is an influence of westernization of Japanese culture.

As seen in Table 30, huge proportion of respondents meet their relatives and friends as often as they want (71.1%) and the rest like to see more (27.1%). By country wise data, Nepalese elders visit friends and relatives more often (77.0%). Like this, divorcee/separated (93.3%), widower (69.7%) and married (77.2%) also see their friends more often. Friends can be a source of emotional support as well as information and entertainment and hence can contribute to the older person's sense of belonging, meaningfulness and social status. Friends provide support in crises and they do errands and perform other services for each other. But they are not expected to perform intimate tasks or provide long-term support to the same extent as family members (Aiken, 1995 cited from Aizenberg & Treas, 1985; Birkel & Jones, 1989).

Table 31 shows the elderly attachment with the neighborhood. A light majority proportion of respondents feel that they are as part of the neighborhood (51.2%). However, considerable share of female think the neighborhood just a place to live (65.9%). The Nepalese respondent's attachment with their community/neighbors was found to be greater (58.0%) than their Japanese counterparts (40.9%). According to WHO(2002) in Japan, for example, older people who reported a lack of social contact were 1.5 times more likely to die than were those with higher social support (Sugiswawa et al., 1994).

Table 32, almost all respondents have husband/wife, family members or friends (98.0%) as the care providers, if they are sick. Most commonly daughter- in- law was reported as a care giver for the elders (34.3%). This proportion is even higher in Nepal (52.0%). However, in Japan; daughters constitute this share less (22.7%).Interestingly; husbands (7.6%) and spouses (27.3%) were more reluctant to help their counterparts in Japan. With regards to need of a person to look after elders, more than a half of them didn't need anyone to look after them (56.6%) (Table 33). This proportion even higher in Nepalese elders (68.0%) comparing to Japanese (39.4%). Surprisingly, there was a significant gap between Japanese elders and Nepalese elders aged 91-100 who reported need of someone to look after (85.7) and (14.6%), $\mathbf{X^{2Value=}}$.5.576, $\mathbf{P^{value=}}$.134,df=3) However, the proportion was not that much variant among the Nepalese respondents who doesn't feel of someone to look after them all time. It is because; most of the Japanese elderly people were living either in a nuclear family or alone where as the Nepalese

elderly was living in a joint family. Aratame (2007) argue that in Japan the informal support networks are wanting, it is not only difficult but dangerous for the elderly to live alone in depopulated rural areas without the help of formal community health care and welfare services. In urban areas, it is also difficult for elder persons and their families to maintain their lives without community-oriented welfare services, since the elderly are often left alone at home during the day time while the family members work outside. The rising interest in the welfare services for the elderly provided in the vicinity of the elderly stems from such situations.

Table 34 explains the duration of living in the neighborhood. A large bulk of respondents has been living in the neighborhood from more than twenty years (65.1%). This tendency is a bit higher among Nepalese (70.0%) than in Japanese (57.6%). The p value is 0.000 and the degree of freedom is 6 i.e. the data is statistically significant. Looking the same data across the type of family, there is no significant difference between nuclear family (63.0%) and joint family (69.0%) living for a long time. Likewise, the cross-country data (Table 35) indicate that the Nepalese respondents had a bit more (41.0%) friends were living in the neighborhood than the Japanese counterparts (37.9%) friends were living in the neighborhood than the Japanese counterparts. Having more good friends in neighborhood can be helpful to enjoying a daily life.

Elderly people who are frail or live alone may feel particularly vulnerable to crimes such as theft and assault. A common form of violence against older people (especially against older women) is “elder abuse” committed by family members and institutional caregivers who are well known to the victims. Elder abuse occurs in families at all economic levels. It is likely to escalate in societies experiencing economic upheaval and social disorganization when overall crime and exploitation tends to increase (WHO, 2002). The violation of fundamental rights of frail elderly people in a care setting is usually referred to as "elder abuse" (Table 36). In total, 12.7% elders, from Japan and Nepal alike, suffered from violence and crimes from others. Gender wise also similar proportion of male and female were prone to such crimes. It shows elders, both males and females become the victims of crimes. However, the cross-country data indicate that more Nepalese elderly (14.0%) were victimized than Japanese ones (10.6%). The circumstances in which elder abuse can occur are very diverse, as are the members of the risk group. Abuse may occur when an older person lives alone or with a relative; it may occur within residential or day-care settings, in hospitals, home support services and other places assumed to be safe. In recent years, elderly abuse in homes or long-term care facilities has become a social problem in Japan. It is thus very important to prevent elderly abuse in maintaining their dignity. Hence the “Elder Abuse Prevention and Caregiver Support Law” introduced by a Diet member was approved in 2005 and enforced in April 2006. After enforcement of this law, efforts are being made in municipalities for early detection/response of abuse including establishment of contact points for abuse and responding to consultations and reports. A wide range of people may abuse older people, including relatives and family members, professional staff, paid

care-workers, volunteers, other service users, neighbors or friends. The United Nations International Plan of Action on Ageing (2002) strongly recommended that more emphasis be put on preventing elder abuse through a multi-sectoral, community-based approach. It called for changes in attitudes, policies and practices at all levels and in all sectors in order to ensure that persons everywhere are able to age with security and dignity as citizens with full rights.

Table 37 shows that home burglary and smuggling were the commonly reported crimes (28.6%). Not surprisingly, females commonly encountered home burglary (36.4%), while male came across smuggling (50.0%). In terms of age composition of respondents, the group age 81-90 was likely to be suffered from home burglary (66.7%). By country, surprisingly similar proportion elders from both countries felt smuggling as a common crime they encountered (28.8%). Poorer physical strength and skill, coupled with the tendency to live alone, increase the vulnerability of the elderly to crime and their likelihood of being victimized (Aiken, 1995).

Concerning the safe neighborhood mentioned in Table 38, two third of the elderly expressed the affirmative response (70.0%). Higher proportion of male respondents made this response (84.5%) ($\mathbf{X^{2=\ 18.3,}}$ P=0.000, df=2). A comparative perspective, neighborhood of Japanese respondents was safer than Nepalese ones. At the community level, shopping outlets, recreational venues, and services, such as health and social care, should be close by and readily accessible. It is important also to ensure a safe, crime-free neighborhood.

It is also important that how society perceives elderly people. Attitudes toward old age, of course, vary considerably from person to person. Modern society harbors many misconceptions and stereotypes pertaining to older adults, including the beliefs that most old people are in poor health, senile, inflexible, unemployable, sexless, inactive, and alone (Aiken, 1995). These expressions are related to ageism. A significant proportion of respondents feel that they were never being treated unfairly due to their old age (90.4%).However, tiny proportions of the elderly i.e. 15.2% and 6.0% from Japan and Nepal respectively were being treated due to aging. Greene (2000) cited from Butler (1975, p. 12) that ageism is a process of systematic stereotyping of and discrimination against people because they are old, just as racism and sexism accomplish this with skin color and gender. Ageism allows the younger generations to see older people as different from themselves. Thus, they subtly cease to identify with their elders as human beings. Prejudice toward older adults, which can be found to some degree in all of us, is a way of pigeonholing people and not seeing them as individual belief systems. Although each society has attitudes and beliefs about ageing that are embedded in the culture, negative responses to ageing are prevalent. Ageism can subsequently affect health care providers, professional training and service deliveries, the behavior of the older people and health outcomes, as well as policy decisions (WHO, 2004).

Attitudes toward old age and the aged, as well as the status accorded to older adults, vary with the culture, subculture and individual. Agricultural societies have

traditionally held older people in higher esteem than have hunting/gathering societies or more technologically oriented societies (Aiken, 1995). According to Table 39, slightly more than half of respondents (54.8%) believe that their society had cooperative attitude towards the elderly people, followed by positive response (26.5%). The cross-country data shows that the Nepalese society (57.0%) was more cooperative than the Japanese ones (51.5%). Likewise, significantly more females experienced cooperative attitude of the neighbors (64.6%), ($X^{2=}$8.512 P $^{value=.}$037, 3).

The key observation from Table 40 about 21.2% Japanese elderly were engaged in any community volunteer works. While the Nepalese elderly were just 7.0% were engaging in such task. It means that a lion's share of the respondents was not engaged in any community volunteer work (87.3%). This proportion was even higher in Nepal (93.0%) compared to Japan (78.8%). By age group, the tendency to not joining in community volunteer work was slightly increasing up in parallel to age. It shows that the youngest group age 61-70 years was likely to be involved in such works. Moreover, those who contributed in voluntary activities worked less than five hours per week (88.9%). By country wise data shows that Japanese elderly were involving in volunteer works three times more than the Nepalese elderly people. Ito (2008) argue that, in Japan 18.3% of those aged 65–69 years who are unemployed also wish to work. In addition, 20% of retired elderly people in Japan want to contribute to society as volunteers. The activities of these healthy elderly people should be fully utilized to help cope with the approaching super-ageing of Japanese society. Japan do not have yet any good models for balancing economic costs and satisfactory health care systems.

Researchers believe that the potential for increasing volunteerism among retired older adults is significant and that “in the period immediately after retirement there is a heightened receptivity to volunteerism” (Haber, 2007 cited from Caro & Morris, 2001, p. 349). If the potential tidal wave of community volunteering could be unleashed, there would likely be greater fulfillment in, and purpose to, the latter part of the life cycle. Crowther, et al., (2003) also argued that the religious organizations comprise the largest single network and the largest untapped source of volunteers to serve the needs of older people. Many of these organizations serve their own membership as well as seniors in the community. Services vary between religious organizations. Religious institutions are broadening their traditional spiritual support and material services, and offer fellowship, recreation, clothing, food and financial assistance.

As described in Table 41, a large proportion of respondents were not associated with any organization or clubs that works for neighborhood activities (77.0%). There were a bit more Japanese elderly (24.2%) were associated with any organization than their Nepalese ones (22.0). These data shows that elderly related organizations are less in numbers in Nepal than Japan. Aiken (1995) also argue that elderly people obtain a great deal of personal satisfaction and sense of identify and status from belonging to formal social organizations. Business clubs, trade unions and other occupation-related organizations are of particular importance to young and middle-aged adults. Of all the

organizations to which older adults belong, memberships in churches, synagogues, or temples are by far the most common.

Mental Health Status

Mental health/status may include such ideas and terms as life satisfaction, the statistically normal, the ability to cope, positive functioning, finding meaning and purpose in life, self-actualization, and so forth (Haber, 2007:365). Table 42 the results reveal that about fifty percent respondents were somewhat worried about old age life. The proportion extremely worried and not at all was similar (9.0%) and (9.6%) respectively. By country, the extremely worried Nepalese were 8.0% while Japanese 4.5%. More than fifty percent elderly from Nepal were worried about life in old age than their Japanese counterparts (45.5%). Table 43 reveals respondents ratings of their lives. A bit more than a half respondent felt they had pretty routine life (51.2%). However, by education, considerable proportion of respondents with no schooling felt having a dull life (80.0%). It means that illiterate and poor income elderly felt having dull life as well as worried about things.

The Japanese elderly felt their life had pretty routine (65.2%) while Nepalese just 42.0%. As mention in Figure 8, high propitiation of respondents worried hardly ever (59.1) Japanese and 36.0% Nepalese. It means that the Nepalese elderly were needier than their Japanese counterparts. Table 44 presents the elders' feeling of loneliness, the figures shows that the lion share of proportion didn't feel lonely most of the time (83.1%). This proportion even higher in Nepalese elderly (89.0%) to Japanese (74.2%). Most of the Nepalese elderly were living in a joint family. So that it can be helpful to remove loneliness in some extent. Across the data on age group, this is raising on lower range of age (71.9%) to higher range of age (88.9%). Obliviously, a feeling of loneliness among the elderly people can be seen even much in their later life.

As shown in Table 45, significant proportion of respondents was fairly satisfied with their lives (57.8%). However, nearly a quarter of them were not satisfied (22.9%) at all. Poorly satisfied Nepalese were higher (34.0%) in comparison to the Japanese respondents (6.1%). More than two third i.e. 77.3% Japanese elderly were fairly satisfied with their life. It is because they were enjoying with good health and better income as well as other formal supports.

The following figure shows the life satisfaction of the elderly with relation to other factors.

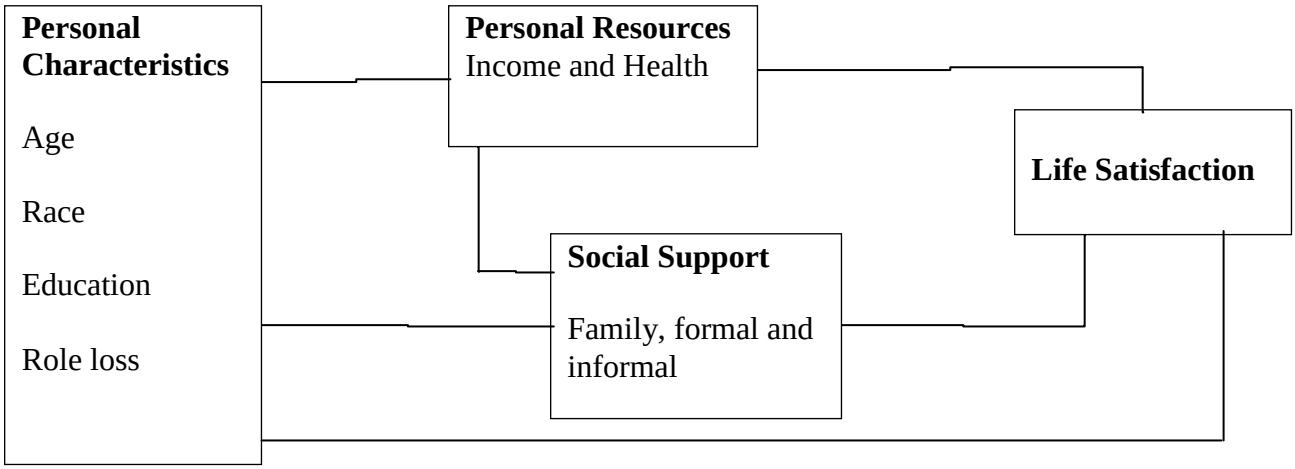


Figure14: Life Satisfactions of the Elderly

Source: Greene (2000:86)

Aging is accompanied by a number of losses, some of which are inherent to the aging process, others of which are disease-related. There are also a number of social losses, for example, the death of spouse, loss of job, income or status that people experience as they grow old. These losses can be devastating to older people experiencing them (Beaver, 1983). The life satisfaction process of the elderly people is shown in Figure 14. There are three major factors such as social support (family, formal and informal), personal resources (income and health), personal characteristics (age, race, education, role loss etc.). As Greene (2000:82) noted that at each stage of life, as people perform new roles, adjust to changing roles and relinquish old ones, they are, in effect, attempting to master new social situations. New circumstances that may occur in later life and require major role changes include becoming a grandparent, entering retirement and becoming widowed. Loss of roles can affect person's self-esteem and life satisfaction. A sense of personal loss also reflected in mental depression. The role of the family, the state, geriatric social worker is to provide support services necessary to help elderly continue to live as independently as possible.

Economic Status

The economic status has a particularly significant effect on well-being of the elderly people. Table 46 indicate that the allowance/pension was the major source of income (34.3%), followed by children (33.1%) and saving (13.3%). However, some other source of income such as house rent, business/investment, agriculture and relatives were also reported by some tiny proportion of respondents. Crossing the data on two countries, Nepalese elders had children as main source of income (55.0%) while Japanese had Pension (80.3%). The pension/ allowance as source of income were found among

nominal Nepalese elders (4.0%). As Horlacher (2002) argue that the majority of the income of the elderly is derived from pension income. The bulk of this income is derived from the public pension program. In 1977 wage and salary earnings was the largest single source of income for the elderly. Over the next quarter century, public pensions became the main source of income for the population over the age of 60. In 1996, public pensions accounted for about 57% of income. Asset income and private pension income together accounted for only about 10% of elder income. Japan is similar to the United States and Germany in that public pensions are the main source of income for those over age 60. A rapidly declining proportion of the Japanese elderly co-resides with their children. The three major sources of support for the elderly living independently are earned income, drawing down assets and pensions, both private and public.

As seen in above Table 47 elders had fairly and poorly managed their need (51.8%) and (41.0%) respectively. The majority of elders' age ranged 81-90 fairly handles their need through current income (62.5%). This proportion is even more in Japanese elders (66.7%) than Nepalese (42.0%).

Figure 9 and Table 48 shows the level of monthly income of elderly people in US dollar in Japan and Nepal. The mean monthly income of Japan is US $ 1773.37 while for the Nepalese elders it is US $ 82.1 only. The income level in Nepal is highly scattered but among the Japanese elders it is clustered more around US $ 2000.Almost all Nepalese elderly person's income lies below US$ 200 per month. The Table 40 shows that the t-test is 10.252, which is significant at df=164, and P value 0.000. The per capita GDP of Nepalese was 30361 rupee (US Dollar 470) for the year 2008. The economic growth of Nepal measured by GDP was 5.56 percent per year in the year 2007/08. Nearly one third of the population (30.8) live below poverty line as per the Nepal Living Standards Survey 2003/04 and the Ginni Coefficient, which indicates inequality between the poor and rich is 41.4 (Nepal in Figures, 2008). Likewise, the data shown in Table 49 indicates that nearly half proportion of respondents had somehow enough to buy little extras that are small luxuries (47.6%). However, more than one third of them had not (37.3); this was reported by majority of Nepalese elders (43.0%). These data shows that the economic condition of Nepalese elderly is poor. As Hurd and Yashiro (1997) argued that the Japanese elderly have more income earnings because their labor force participation rate is considerably higher. They have considerably less income because they hold a much greater fraction of their wealth in the form of housing.

According to the Figure 10, there was a visible gap between Japanese (28.8%) and Nepalese (7.0%) elders who were satisfied with pension amount. About a similar proportion of respondents from both countries somewhat satisfied Nepalese (46.0%) and Japanese (50.0%).However, nearly a double of Nepalese elders were found to be unsatisfied with pension (41.0%) in comparing to Japanese (21.2). It is because most of the Nepalese elderly were getting few amounts of money in terms of an old age allowance.

Table 50 shows the feeling of elders having enough money to met needs. Nearly

half proportion of elders reported that they didn't have that much money (47.6%), this is followed by somehow (42.6%). However, 47.0% Japanese elderly felt that they will have somehow enough money for the future. Looking the data across age group, the affirmative answer for enough money was reported by big proportion of participants aged 61-70 from both countries (23.4% Japan) and 13.3% Nepal. However, this proportion was lower in the remained age group. Likewise, the biggest financial problem experienced by elderly, medical expenses/treatment was realized by majority of proportion (43.8%); this is followed by buying foods (37.5%). However, some others expenses such as housing rent (6.9%) and social expenses(9.0%) also considered as a financial burden by some elders. Looking at the crosswise data, Nepalese elders felt medical expenses as problems whereas buying a food as a problem was realized by Japanese elderly (65.5%). It is envisaged that the data from Kyoto city, 26.1% consumer spending is buying food followed by cultural activities and recreation (10.8%) and housing 7.4% (Kyoto city data, 2009). A Table 52 show, the gap of proportion of saving between Japanese (87.9%) and Nepalese (25.0%) was notably visible. The p value is significant at 2 degree of freedom. This proportion across the age groups is decreasing from older age group to younger age groups, from 88.9%, to 60.0%, 45.9% and 37.5%.This results reflect the older were money saver than the younger. Similarly, this is found to be higher on married elders (63.2%), followed by widower (54.5%) and widowed (40.4%) respectively. Living on fixed incomes makes it difficult to juggle unexpected expenses. So that saving for future or emergencies is important. Savings strongly influence the well-being of the elderly and the rate of a country's economic growth. But decisions about saving are complex, involving consideration of current circumstances and predictions of future conditions. These decisions reflect the personal situation of the individual making choices between saving and spending, and the regulatory, insurance, and pension environment. In Germany, for example, the very old have had the highest savings rates of any group, and they still accumulate wealth as they age. Savings rates differ a great deal from country to country. The elderly saving rate throughout the world was 20% in 2004. The aggregate savings rates of the elderly in the United States 13%, UK 15%, Germany 21%, Malaysia 35%, India 23%, China 42%, and Japan 27% (34% in 1990) of national income in 2004 (Butz , 2007).

Table 53 presents the preferred place to live and expected source of income in old age. The significant proportion of participants preferred to live in own family (54.2%), followed by community home (35.5%). The remaining liked hospital (7.2%). Crossing the data into country, significant proportion of Nepalese preferred home (74.0%) while this is only 24.2% in Japanese. Likewise, the majority Japanese of elderly persons (57.6%) want to live in their own community homes in later life. It is a conditional response from Japanese respondents. If they were healthy enough then they would prefer their current home. I think this is also an increasing concern to move community living patterns of Japanese elderly. One reason behind it that more than one-third Japanese elderly respondents were living alone, preferred to live in any

community settings such as group homes in their infirm old age. It could be also helpful to remove loneliness in some extant. Wu (2004) argued that, even though most older people prefer living in their own homes, community-based services to assist the elderly and their families with home care are usually inadequate. Or family caretakers are unavailable because of the death of the spouse, childlessness, working adult daughters and daughters-in-law, and the separate living arrangements of the children. In other instances, the elderly have chosen to enter an institution to avoid becoming a burden to their families.

Social and health care policies in many Western countries and also in Japan is aim to enhance the possibility of elderly citizens living as long as possible in their own homes, thus minimizing permanent institutionalization (Valvanne, 2007). Fukuma (2005) argue that the Japanese elderly patients would prefer to spend their last days at home, but out of consideration for the strain on their families they also consider hospitalization. The preference to remain at home is considered almost universal, shared by older people around the world. But under particular conditions, such as when it is no longer safe for them to live in their homes due to physical frailty or cognitive disorders, older people may be forced to move out involuntarily, for example to an institution or group living setting (Larsson et al., 2005).

Concerning sources of income, pension was the major expected source (59.6%) for the future; however, some others expected help from children as well. By country, pension as a main source of income was for nearly all the Japanese whereas only 34.0% Nepalese elderly reported so. About 6% Nepalese respondents did not getting a pension due to age limitation of age. The elderly in Japan are much more dependent on public pensions. A good benchmark is the fraction of the elderly that gets 80 percent or more their income from public pensions. In Japan about half of elderly couples who live independently and about three-fourths of nonworking elderly couples who receive more than 80 percent from public pensions (Hurd and Yashiro, 1997). The majority of Nepalese elderly expected income from children in old age. In similar study, Bisht (2006) also found that the children as a main source of income in old age of Nepalese elderly people. In Nepal, elderly aged 70 and above are eligible of old age allowance. The most vulnerable are older women and men who have no assets, little or no savings, no pensions or social security payments or who are part of families with low or uncertain incomes. Particularly, those without children or family members often face an uncertain future and are at high risk for homelessness and destitution.

The Figure 11, show that near about fifty percent Japanese elderly were receiving retirement pension while this figure was just 17.0% for the Nepalese elderly. Large bulks i.e. 83.0% of Nepalese elderly respondents were not receiving the retirement pension. The major cause in this fact was illiteracy and less access of job in the past. As Jacobs (1998) argued that the social security in Japan is very complex because of its institutional fragmentation, especially in the health care and old age pensions sectors, which is the product of a long history of incremental development. There is not one

health or old age insurance scheme, but different systems existing in parallel, the boundaries of which correspond to broad occupational groups (e.g., civil servants, private sector employees, the self-employed, seamen, teachers and so on). Moreover, there are numerous insurance schemes within each system, managed by a large number of quasi-public institutions that are all regulated by the Ministry of Health and Welfare. The level of both contributions and benefits may vary considerably across systems. Likewise, the government subsidies all insurance schemes in quite different proportions. Some genuinely national schemes have been added on top of this already complex structure, in an attempt to limit social stratification. The main examples are the National Pension, which provides uniform benefits for all, on top of which the occupational pensions are added (two-tier system), and the Health Services System for the Aged, covering the health care costs of all people over 70 years old. Just like health insurance, old age insurance is fragmented into several occupational-based systems. The Employees Pension Insurance (EPI) covers private sector employees and the Mutual Aid Associations (MAA) cover government officers. The National Pension (NP) offers an Old Age Basic Pension Benefit to everyone. This pension is not related to income but only to the length of contribution. By contrast, EPI and MAA pensions are proportional to lifetime earnings.

According to Table 54, almost all the respondents received pension or elderly allowance from government (96.4%). This shows that the elder people had some sort of allowance or pensions to support financial problems in their lives. However, 6.0% Nepalese elderly respondents were not getting an elderly allowance due to age restrictions. In Nepal aged 70 and over are eligible to get such allowance. Chalise (2006) argue that the Nepalese government provides pensions for government employees. It is provided to civil servants, military personnel, police officers and teachers. The retirement age is currently 58 for civil servants. However, in universities, the age of retirement for teachers and administrator is 63 and for the lower ranks of military and police officers, it is 46 to 48. The government of Nepal has pension scheme for retired public servants and their widows and children. The government also adds 10% in the total pension amount to the pensioners who are aged 75years and above. However, only less than 7% of elders in Nepal benefit from this pension system. Majority of the population receive no pension and must depend on family support and personal savings (Geriatric Center Nepal, 2010). Hugo (1997) argued that as countries age the dependency ratio increases, resulting in fewer workers to support the Pension fund and concern over financing the pension coverage will increase. Without adequate pensions, the economic status of the elderly lowers to poverty levels. Poor data about the health and disability status of the aged is an added concern for the long term viability of these nations in the Pacific Rim. Clearly, the countries examined here fall into two distinct groups in terms of the immediacy of concerns with pension funding. Those such as Japan, Hong Kong, and Singapore, with low fertility and rapidly rising numbers of elders (relative to the working age population) will need to address this issue sooner than the other nations (Cowart and Serow, 1998).

Figure 12 reveals that the significant proportion of respondents doesn't think their family members' feel support them as a burden, to both in Nepal (83.0%) and Japan (71.2%). It seems that to support to the elderly people in Nepal was better than the Japanese ones. Jacobs (1998) cited from Sumitaka (1996) that as far as Japan is concerned, reports anecdotal evidence on overburdened Japanese housewives neglecting their parents-in-law. The Japanese government has long recognized the challenge of family welfare. Since it is a burden mainly for women, three intertwined trends must be addressed: the sharp decline in fertility, the increase in women's employment and the nuclearisation of the family. On the other hand, in Nepal the trends show that the family is a strong source of financial and emotional support to the elderly. Among 65+ years aged persons, 47.12% are found economically active with sex differential of 59.7% for males and 34.3% for females. This could be because women's contributions are generally not accounted for in market values (Geriatric Center Nepal, 2010).

In concerning the caring responsibility, 44.6% of respondents think that public and private sector should be responsible for caring elderly followed by government-local/prefectural/central (33.1%) and family (16.9%). Public-private sector partnerships are clearly becoming important in many countries in many areas of social protection (OECD, 2005). By country, about double proportion of Japanese elderly (63.65) and Nepalese (32.0%) have opined that the public and private sector should be responsible for caring for the elderly. Likewise, 41.0% and 23% Nepalese elderly have opined that the government and family should be responsible for caring their elderly respectively (Table 55). These results clearly suggest that Japanese elderly were stressed public private mix services than their Nepalese counterparts. The Nepalese elderly opined that to caring for the elderly should be government responsibility as well as familial. Obviously, due to poverty the Nepalese elderly were more hopeful to government supports. Wu (2004; 8) cited from Somucho (1992) that the expectations of formal services have risen during the past years in Japan. In the other hand, the consciousness of family responsibility has weakened over time in Japan. In addition, women's participation in the labor market has constrained the capability of the family to care for the aging parents.

Living Arrangements

The living arrangements of older people, as with other groups, are influenced by a number of factors including key demographic indicators and the health, financial and social resources available to the older person as well as cultural norms and values. However, it is not always easy to disentangle which are the most important factors as many of these aspects of later life are highly interrelated. The type of household in which an older person lives varies with key demographic factors, the most important of which are age, gender and marital status. The percentage living alone increases with age and is more common among women and the divorced/widowed/never married. Living arrangements in later life are not the result of a simple linear relationship with age or

gender. Clearly the three variables of age, gender and social status are strongly interrelated and it is not always clear as to whether age, gender or marital status is the key influence (Victor, 2005: 203). Table 56 shows that the significant size of respondents live with family (80.7%). This is found to be significantly higher in Nepalese (91.0%) than in Japanese (65.2%). On the other side, the Nepalese living alone (9.0%) were three times less than the Japanese (34.8%). This result shows that Nepalese were likely to be living with family. Improvements in the social security and welfare systems have also contributed to the increased incidence of the elderly living alone and have allowed for other, diversified living arrangements. Instead of the traditional type of extended family in which household members' incomes are pooled, the elderly can live economically independent from their children while sharing the house or housing space, or they can live alone in either the same neighborhood or the same town as their children (Yashiro, 1997:92-94).

Table 57 reveals that majority of respondents lived with son/ daughter- in--laws (40.4%) and daughter (13.9%). Living with a spouse, Japanese were more than Nepalese (25.9%) and (14.0%). The living arrangements of the elderly in Nepal are contingent on their level of support. In particular, the availability of care from a spouse or child or other family members may be essential to the well-being of the very old or frail elderly. Wu (2004) argue that housing for employees in big cities is usually not spacious enough for two generations to live together. These conditions have exerted a profound impact on the living arrangements of the Japanese elderly and made it difficult for them to live their adult children.

As shown in Tables 58 more than one third elderly had similar proportion of children (36.2%). However, 10.8% elderly had no any children or childless. It was even higher among the Japanese elderly. Japanese were found to be single children (19.7%), also the respondents living in nuclear family have likely to be without any children (18.2). Likewise, more (47.0%) Nepalese elderly had single living children than the Japanese elderly. When consider the number of children living within an hour's driving, the proportion was descending from one to three children, from 75.3% to 20.1% to 3.7% respectively. These results point out that excluding the single parents, the others were living nearest by their children. Likewise, more than two third elderly called on their children for help with any problems. However this trend was seen lesser proportion among the Japanese elderly. It is because, most elderly people of Japan are active, independent and self-reliant.

Table 59 shows overwhelming proportion of respondents expected help from their children as needed (76.5%), this tendency was significantly higher in Nepalese parents (83.0%) as compared to Japanese parents (66.7%) respectively. Likewise, 18.2% Japanese and 6.0% Nepalese elderly didn't answer because they were childless. Despite that tradition, family support for the elderly is on the decline due to urbanization, the emergence of the nuclear family, and the increasing likelihood that women will become educated and join the labor force in Japan. The result indicates that the tendency of

visiting offspring is higher among Nepalese elderly than Japanese elderly person; this might be due to that Nepalese likely to be lived in joints family. Living with family members or relatives may be better in many respects for the emotional and psychological well-being of the elderly. However, several studies in Nepal show that the long established culture and traditions of respecting elders are eroding day by day. Younger generations move away from their birthplace for employment opportunities elsewhere (Geriatric Center Nepal, 2010) In Japan, living arrangements of the elderly will be influenced considerably by the changes in demography and socio-economic factors, and the proportion of those elderly who need long-term care services increases rapidly with the age increase. Japanese rapid population ageing threatens the sustainability of social security systems, and a great many of policy efforts are devoted towards making social security systems more affordable.

Living arrangements are a major determinant of the level of support of the elderly. In particular, the availability of care from a spouse or a child may be essential to the well being of the very old and the frail elderly. In the long run however, the importance of the family as a source of support for the elderly will decrease. This is inevitable because the share of the frail elderly population will increase and the capability of families to care for older parents will decrease (Horlacher, 2002). Likewise, Maeda and Nakatani (1992:196-99) argues that the traditional family care of the elderly in Japan has been declining due to the industrialization and urbanization accompanied by the rapid economic growth. Therefore, the role of public social services should be expanded and much more responsibility will be placed on local and national governments in order to supplement and strengthen the family care. They further emphasizes that mainly four factors should be considered as causes of the decline of family care in the context of the Japanese social situation, such as: change in socioeconomic structure as a result of rapid economic development and urbanization, demographic changes, decrease in capability of family to care for their aging parents and development of formal support and care services. Long (2000) also highlight that the family care giving is seen as a burden in Japan by both givers and receivers of care and the government has accepted responsibility for creating a new system to fund alternatives to family care.

Housing

Housing is quite an essential matter for elderly people. The type of house and housing condition are influenced by local environment or availability of construction materials locally and the level of development. The term housing means the household or family accommodation in dwelling units, its structure type and facilities such as electricity, drinking water, cooking fuel, toilet etc. So it is the main indictor of human well-being and level of development (Kayastha and Shrestha, 2003). Table 60 shows that there was no availability of safety alarm in considerable proportion of respondents' home (72.3%). Some tiny proportion had fire and burglar alarm (18.1%). More noticeably, none of Nepalese home had such safety alarms. Similarly, overwhelming proportion of

respondents didn't feel needs of repair inside and outside of their home (73.5%). However, a little more than a quarter of the respondents (26.5) felt need to repair them. Japanese houses are found well-equipped and elderly friendly in comparison of Nepalese. In principle, the total environment should become more elder friendly, with barrier-free housing provided for those with handicaps and suitable appliances and adaptations placed in the home.

Table 61 clearly shows the expressed satisfaction level of the respondents. Accordingly, a significant proportion of respondents were somewhat satisfied with the overall structure of presently living home (59.0%). Likewise, 24.2% Japanese respondents was very satisfied with overall structure of their houses, while 28.0% Nepalese respondents were not satisfied with the present structure of house. In Japan, the state's intervention in housing is comparatively much less important, and focuses on the provision of houses for sale for the middle-class, with some cheap rental flats available for the poor (Jacobs, 1998).

Table 62 indicates the housing condition in terms of number of rooms and other facilities at home. More than two third of the respondents had more than three rooms at home (69.0%). More interestingly, there was a significant gap in the proportion among Japanese (24.2) and Nepalese (82.0%) elders that Nepalese elders were living in a home with sufficient rooms. Like this, almost all the respondents from both countries had private kitchen and bathroom at home (93.4%) and (90.4%) respectively. However, in shared kitchen, Nepalese occupied about double proportion (8.0%) whereas Japanese had made up only (4.5%). By marital status, unmarried were found to have less access less having private bathrooms (75.0%) at home. The overall condition of rooms as well as kitchen and bath rooms of Japanese elderly was found to be better than the Nepalese ones.

Table 63 denotes the possession of home currently living by elder people. There were more than three quarters of respondent living in own home (81.9) whereas only 18.1% had rented home. Comparing to Nepalese elder (86.0%) Japanese were a bit less living in the own home (75.8%). This proportion was about similar among all the age group. Mostly, joint family had own home (89.8%). As described in Table 64, nearly half proportion of elders felt that the home they were currently living was too large (48.8%). This was reported by remarkable proportion of them living in joint family (72.9%). However, slightly more than one fifth considered the place too small (21.1%). By country, interestingly there was a huge gap between the proportions of Nepalese elder and Japanese elders who feel the place they currently living was too large (70.0% and 16.7% respectively($X2=51.730,^{Pvalue}=0.000,df=2$). Lee et al., (2000) argued that in Japan housing is often small and too crowded. So that Japanese style housing is being difficult to live together for two generations.

Regarding the need of repairs, significant proportion of elder didn't feel any need of repair inside or outside of their home(73.5%)($^{x2=.288,Pvalue=.591,df=1)}$. For Japan only 24.2 % considered their residence required maintenance while for Nepal it was 28%. By

observation, most of Japanese houses were found elderly friendly than the Nepalese ones. In Japan, formal policies for suitable housing for the elderly were not instituted until 1986. Now, public programs provide rental housing for the poor, rental or purchase programs for the middle income population and purchase options through lone programs for more affluent persons. Housing for the elderly may be in two generation units, or elderly households in the same neighborhood as the adult child. Housing for elders provides special accommodations for safety and mobility of the elderly. Newer initiatives include "silver housing" for elders, life care communities, revising existing housing, and "aging in place," all with support services (Kose, 1997). In case of Nepal, there are no organized programs of housing for the elderly. Cowart and Serow (1998) argued that there is some evidence that the traditional patterns of multigenerational family living in the Asian countries are changing. Whether the elderly reside in rural or urban areas, the traditional practice of living with their children has declined. Contributing to this practice are the expense and small size of urban housing, housing designed for nuclear families, adult children migrating away from parents to seek employment, the education and employment of women, and preferences of the elderly for living independently.

Employment Status

Most of the elderly people i.e. 90.4% were not engaged in any part/full time jobs. This proportion was to be found even higher (95.0%) among the Nepalese elderly than their Japanese counterparts (83.3%). More than three times (16.7%) Japanese elderly were engaged in any part time jobs than the Nepalese elderly (5.0%). Likewise, Japanese female elderly were more involved in jobs while males in Nepal. Surprisingly, females were not engaged in any jobs in Nepal. In Nepal, it is difficult to find any jobs for elderly and females were less access in every sectors of national development, on the other. Women are often disadvantaged due to a lack of education and their dependency on men for land and income. This puts them at great financial risk when their husbands pass away. Japanese elderly responded that it was additional source of income. But for Nepalese it was prime source of income.

Most of Japanese elderly have passed their life in public and private jobs, whereas less than a quarter proportions of Nepalese elderly have done so. Great bulks of the Nepalese elderly were either never employed or just a house wife in their life (Table 67). These data clearly show that there were less job opportunities in Nepal even before. The Silver Human Resource Center (SHRC) is an initiative by the Japan government to offer opportunities for people, generally aged 60 or over, who desire to participate in society through work that suits them. SHRC contracts work from corporations, households, public organizations and others and then it allots the work to its registered members based on the work content, frequency, and volume. SHRC provides easy, temporary, and short term jobs for the elderly. On the other hand, there are no any job initiative institutions for the elderly in Nepal. As Eldemire (1993:238) argue that in developing countries where jobs are hard to come by in the first place, interesting philosophical, sociological and perhaps moral questions will arise with respect to whether

the youth or the elderly should have priority to jobs which are such scarce and precious commodities and there will be challenges to design and implement strategies and programs. It is emphasized that productive ageing will become a future employment trend, for example, older professionals may maintain their skills through working or volunteering.

Activity and Entertainment

Activity and entertainment status of the elderly are the most important aspects for the well being of elderly. As shown in Table 68, higher proportion of elders from Japan (63.6%) than from Nepal (60.0%) were able to do activity of daily living (ADLs) like bathing, dressing, toileting, difficulty with walking and instrumental activity of daily living (IADLs) like shopping, preparing meals, transportation, light house work, and getting around the community. It means that 36.4% Japanese and 40.0% Nepalese elderly people need care or assistance in their daily life. By gender, males were more active than the females i.e. 75.0 % against 47.6% ($X2^{=13.187, P=0.000, DF=1}$). The age wise data shows that the mostly, the elders aged ranged 61-70 and 81-90 do ADLs and IADLs (68.8%) and (65.0%). Bisht (2006) also found, the majority of elderly people aged 60 and over of Kathmandu Metropolitan City are active and do not need help to perform their activities of daily living (ADL). A cross-sectional analysis of the Japanese and Korean frail elderly using the 1998 survey data indicates that the proportions of those who are able to do ADLs and IADLs are much greater among the Japanese elderly than the Korean elderly (Kim & Maeda, 2001).

Watching TV was a common activity for leisure among the respondents of both countries (41.5%) as shown in Table 69. Next to TV, respondents met friends (18.1%), followed by readings newspapers (16.8%). However, some of them were being engaged in house chores and caring grand children (12.0%). Likewise, a significant proportion of respondents never made trips for shopping or business in a week (43.4%). Unlikely, nearly a quarter proportions made three or four times trips in weeks (23.5%). Table 70 shows the overall observation by country; Nepalese had less mobility in each category. Like this, male were found to be more active for making such a trip.

Elderly people who are impaired by disease or disability have special difficulties in getting from place to place, particularly when they do not drive and public transportation is scarce and costly. Even when public buses and trains are available, the high steps, sudden stops, and starts and rapidly closing doors are often nerve-rattling and unsafe. Having to depend on other people to take them from place to place restricts the life space and lifestyle of many elderly individuals. This is particularly true in the case of the poor, who, because of lack of money for transportation or the unavailability of public transportation in their area, may become isolated and lonely (Aiken, 1995:323). Regarding the question about trouble due to lack of transportation, 70.5% of respondents answered no and rest of the respondents told that they were facing trouble due to lack of transportation. Only 18.1% respondents from Japan and 36% respondents from Nepal were found to be facing problem due to lack of transportation. More than eight percent

Japanese elderly felt that they could easy access for public transportation (Table 71). However, the elderly people of Kyoto can call the taxi by telephone but public transportation like buses etc. are not available inside all streets. In case of Kathmandu metropolitan city, public transportation is not available most of the inner streets.

Only 27.1% had regularly participated in vigorous activity, and this participation rate was quite low in Nepal with (74% not participating in any vigorous activity) in comparison to Japan. In comparison to female with (13.4% participation rate) most of male (40.5%) had participated in vigorous activity (Table 72). According to WHO (2002) in all countries, skilled and experienced older people act as volunteers in schools, communities, religious institutions, businesses and health and political organizations. Voluntary work benefits older people by increasing social contacts and psychological well being while making a significant contribution to their communities and nations.

Watching television is seen as a common tool of entertainments for the elderly in both countries. Almost 58% participants from Nepal told that they spend 5 to 6 hours each day watching T.V while only 47% Japanese spent 5 to 6 hours per day. According age group, majority of Nepalese elders aged 71-80 watch TV more hours (62.1%) than Japanese elders (38.7%) while on the aged 81-90, Japanese were ahead than Nepalese (35.5%) and (24.1%) (Table 73).

About three quarters of the participants (74.2 %) from Japan read the newspaper, magazine or any other books daily. This rate was very low in Nepalese respondents with only 30% of them read magazine daily. Out of the total, 63.1% male and 31.7% female told that they read newspaper daily (Table 74). These data clearly revels that Japanese were far ahead in any intellectual tasks such as reading news papers, books etc. One of the major causes behind it is illiteracy (30.0%) among Nepalese elderly.

Religious organizations might provide critical, local assistance and support to the aging parents who lives a long distance from his/her parent. These primary tasks are: conduct spiritual/ religious and well being assessments, assist older adults in reminiscence and life review, identify religious programs that focus on older adults and establish reliable contact with religious person/organization that is a part of the older adult's network, and finally discuss end of life issues (Crowther et al., 2003*)*. Almost 53% Japanese and 45% Nepalese attended religious programs**.** This rate was highest in male with 57.1% and 39% female attending any religious program (Table 75). In recent years, the activities of groups which claim to be religious organizations have increased the public's distrust of the sincerity of religious motivation and action. Haber (2007) argued that religious or spiritual people not only live longer, they also have stronger immune systems, are physically healthier and are less depressed than those who are not. Explanations for the positive relationship between religion and health range from the impact of religion on healthy lifestyles, positive and supportive social relationships, positive ideologies and prayers, which lower harmful stress hormones; and more stable marriages (Harber, 2007, cited from Idler, 1994, Strawbridge et al., 1997).

The rate of participation in any senior centre programs was high in Japanese respondents (78.8%). While only 34% Nepalese respondents had attended any senior

centre program. On the one hand, senior centre programs are not sufficient in Nepal and the lack of proper awareness among Nepalese elderly to hindering easy access to such type of programs on the other. Senior centers can provide a broad spectrum of health education offerings, seminars, exercise and nutrition classes, self-care programs or referrals to appropriate health services.

CHAPTER TEN
CONCLUSIONS AND RECOMMENDATIONS

10.1 CONCLUSIONS

This dissertation has dealt with a comparison of elderly care practices in two dissimilar cities, Kyoto and Kathmandu, with the aim of examining the family, community and the state based elderly care practice. This thesis briefly concludes the following ways;

The main issues regarding care for the elderly, both now and in the future, are how to finance health care and social services and ensure that there are enough qualified personnel. This is somewhat of a welfare paradox, i.e. due to improved general living conditions in Japan, people are living longer and reaching an age when they require a significant amount of service and care.

A social practice of elderly care is present in any country, because sick and infirm people are taken care of everywhere. How people give or receive care varies, is contextual and has to be empirically investigated. The great advantage of using Tronto's concepts of care is that the results become comparable and lead to insights into care needs and care provisions as universal issues.

Although both countries have bilateral kinship system, the typical images about Japanese and Nepalese families and elderly-care arrangements are contrasting. In Kyoto (Japan) the nuclear family is supposed to be predominant, among whom respect and care for the elderly persons is somehow lacking, because most elderly persons are cared for either in a home or in any community based homes and also institutions such as Hospitals, Nursing homes etc. The image about elderly care in Nepal is that joint family is predominant, strong families ties and respect for parents exist and elderly persons are supported within the family.

With advances in medical technology and improvements in public health and nutrition, the average life span of the Japanese people has markedly increased. Aggravating society’s care problem is the fact that the average family’s ability to provide such care is decreasing, partly because of the ongoing transition from extended to nuclear family patterns. In response to these circumstances, the government is reorganizing the welfare system for the elderly together with medical services for those elderly requiring care. As part of this reorganization, in 2000 a long-term care insurance system was inaugurated as a new social insurance system. In fact, it is an epoch- making event for the history of the Japanese public health policy, in which Japan has moved toward socialization of care in modifying its tradition of family care for the elderly.

As one ages, muscles lose tone, organs become less efficient, energy level declines and the risk of developing the chronic conditions of the later years of life increases exponentially. Many elderly individuals suffer from several health conditions, such as hypertension, diabetes, respiratory diseases, and arthritis, simultaneously. We can safely assume that the accumulation of conditions magnifies their impact on functioning and on the individual's emotional state and it is also likely that this process can lead to a cycle of increased physical illness, decreased functioning, and poorer mental health.

In Japan, the traditional family support system is under pressure from demographic, social, and economic change. The fertility has been low for decades, the elderly have few adult children to provide support, and many of these children have moved away from their family homes. Marriage rates have dropped sharply and women are entering the work force in increasing numbers. Middle-aged women, the traditional caregivers, are likely to have less time than they did in the past to care for elderly family members. Increasing exposure to the West may also be introducing new ideas about marriage, family and individualism ideas that clash with the traditional sense of responsibility for the elderly.

Although the government of Japan has been implemented a series of programs and policy measures in hopes of boosting fertility since the early 1990s, their impact on fertility has been insignificant so far. To cope with the formidable difficulties arising from its rapid population aging, Japan should explore the feasibility of alternative policy options.

The Japanese welfare state's policy responses to gender and demographic pressures, though clearly significant, have yet to show signs of success, that of reversing or even slowing the decline of fertility. It seems that the policy reforms have been largely focused on relieving women of undue care burdens by putting most of the effort on expanding social care.

Japan is the world's healthiest nation; the typical Japanese person lives free from disability until age 75. This fact is often overlooked in dire predictions of Japan's future. Older people are a vital resource to society, as volunteers, care givers, grandparents (providers of child care), and consumers. Considering future advancements in health and medical technology, longer lives will not necessarily aggravate old age dependency. It is more likely that increasingly healthy older persons will raise the social and economic output of the society.

Japanese people will tend toward "active aging" not just because they enjoy good health, but because they do not view leisure-based retirement as an entitlement. That is, they do not expect to completely take it easy at the end of a long career, partly

because Japan's public pension programs are relatively new and partly because continuing as a productive member of society is seen as virtuous.

The aging of the population in general and the rapidly increasing numbers of the elderly in particular, represent major social challenge and present the biggest test yet to concepts of community care in all countries. However, in most of the countries including the Asian countries informal care mainly by the family members (also friends and relatives) is still a main source of care for the elderly. The changing pattern of family structure due to impacts of modernization and urbanization care by informally is being difficult. At the same time the provision of formal economic care for the elderly persons also may, to some extent, replace functions performed by the family.

A rapidly increasing population of elderly people and also frail elderly people, public policy concern with increased costs of providing care now encompasses care in, by and for the community system. In this context, an emerging new type of care model, the community care model seems a way out for caring the elderly people. The community care model is a combination of community service and home care. Elderly people could live in their own homes while enjoying certain level of community care. This is a modern way of caring for the elderly, extending one's family to the community or taking the community as one's home.' The encouragement of true community care involves a broad approach and genuine joint strategies in social policy. A key aspect of social policy towards the care for the elderly must therefore be a positive partnership between family, the state, the market and other voluntary sectors as well.

With increased life expectancy, however, long-term care for frail elders has begun to emerge as one of the most important familial, social and financial issues. Long-term care essentially involves diverse sets of health, personal care and social services for elderly people who need assistance with their daily life because of chronic health impairments. The settings of long-term care are usually divided into two types: institution based (primarily nursing homes) and home and community based (home care, visiting nurse services, nutrition programs, senior center programs and other formal and informal services). Long-term care services may also be divided into two types: unpaid informal services that are chiefly provided by family members and formal services that encompass institutional services and home and community based services supported by public and private funds.

The professional respondents of Kyoto and Kathmandu have emphasized to adopt a mixed care model that includes family/home, community and state would be a better option for elderly care.

The mixed economy of care/welfare is a top-down intervention of policy makers

intended to prescribe what they believe should take place rather than a description of existing reality in which care comes primarily from the informal sector. The encouragement of true community care involves a broad approach and genuine joint strategies in social policy. A key aspect of social policy towards the care for the elderly must therefore be a positive partnership between family, community, the state, the market and other voluntary sectors as well.

Japan's initial overall success with Long-Term Care Insurance (LTCI) is encouraging to other countries that are considering the introduction of similar programs. Within a short period, LTCI has been widely accepted in Japanese society.

As Eckerman and Sarah (2007) point out that the rapid and dramatic social change that has swept through Nepal and in many other Countries, over the past 50 years have brought about many changes in the family. Historical systems of care, living arrangements, and familial responsibilities that once centered around or within the family network are changing to look more like Western, individualistic systems.

Nepal is a developing country where agriculture remains the major industry. The family structure is tending towards nuclear families in urban areas. In the Nepalese context the fact is that elderly care mainly takes place within the family (i.e. informal care), and therefore the result of restrictions by social policies or lack of effective and substantial policies and programs, which build barriers to access of formal care. Traditional forms of care for older people in Nepal are fast disappearing like in other countries due to modernization and the nuclear family system.

In recent years, a number of NGOs and elderly homes for the elderly have been established in Kathmandu valley and other areas of Nepal. Despite some efforts to help elderly persons and use their knowledge and experience for the development of society, there is still much to do in these areas in the Nepalese context. Although there have been increases in the population of elderly persons, there have not been proportionate increases in the resources and budget for their welfare. Inadequate resources; sub-standard and inadequate old-age home facilities; lack of relevant institutions, human resources, and community arrangements to look after the need and health of elderly persons; and a lack of long-term plans, regulations, and coordination mechanisms among the related agencies are the present challenges. In particular, poverty and the rise in nuclear families taking the place of joint families present special challenges to this sector.

More importantly, Nepal is going to be federal states, which also needs broader understandings regarding the social welfare policy and programs of care for the elderly. So that, we can take enormous experiences from Japan in terms elderly related policies and programs into the Nepalese context. Nepal should develop its own policies and

programs based on its own cultural traditions, economic capacity and social transitions in the society.

Formal, professional care is something that is available to elderly persons in Kyoto, not to elderly persons same as in Kathmandu. These differences make it difficult to compare the two cities.

It was customary for Japanese families to take care of their elderly relatives, and the state intervened only in exceptional cases when families were unable to provide such support. However, today the ability of families to care for elderly members is declining. As people are living longer and fewer babies are being born, the factors behind the rapid aging of the population, the ability of families to take care of their elderly members has weakened. Another significant factor is the change in the role of women who have been chiefly responsible for household duties such as housework, child care, and care of the elderly. It has become economically difficult for women to live simply as a “housewife” even if they desire such a lifestyle, and a double-income family has become the social norm by necessity. Consequently, less time and energy can be directed to the care of elderly people, and, proportionately, the burden of nursing care is becoming heavier.

Elderly people living at home may need special support to enable them to cope with their families and to prevent their isolation from society. As their capabilities diminish, they will more often require such services as home help, laundry services, meals cooked ready for eating, and chiropody. Loss of mobility brings the need for friendly visiting, transport to social clubs and occupation centres, and arrangements for holidays. When illness is added to other infirmities, they need more home nursing, night care, and help generally in the home. In terminal illness, an elderly person may for a limited period need considerable help from many of the domiciliary services.

There were more than three quarters of respondent living in own home whereas only had rented home. Comparing to Nepalese elderly, Japanese were a bit less living in the own home.

In Japan, one of the demographic trends that is most frequently discussed and debated by health service planners is the aging of the ‘baby boomer’ generation. This large group is expected to impact both the volume and type of services required.

The results show that the health and medical care of Japanese elderly is better than the one of their Nepalese counterparts. However, the increase in the elderly population, especially old elderly has raised many serious social and medical issues in Japan.

It is found that the daughters-in law or daughters as the main care givers in both countries. Japanese care givers attitude towards elderly is found more positive than Nepalese. It is because they were their daughters at the most. In Nepal there is a tradition to keep a home servant who assists in caring for elderly as well as household's chores.

The social status of the Nepalese elderly was found to be better than the Japanese one. The majority of Nepalese respondents believed that their neighbors have a cooperative attitude towards the elderly people.

The overall mental health status of the Japanese respondents was found better than the Nepalese elderly. The life satisfaction and rating of life was seen good than their Nepalese counterparts. Japanese respondents worried hardly ever about things they need in their daily life while Nepalese worried more.

Most elderly people of Kyoto (Japan) are active, independent and self-reliant, whereas Nepalese elderly are less active and dependent on their children. On the other side, relative health among the Nepalese elderly has improved considerably in the past years, presumably because those factors, largely environmental, which increase life expectancy, also tend to reduce morbidity.

Qualitative and quantitative results show that the most of Japanese respondents expressed their view that community-based care practice might be a good way for caring for the elderly in an infirm old age. In other instances, the elderly have chosen to enter an institution to avoid becoming a burden to their families. On the other hand, Nepalese professionals and respondents have showed their opinion primarily in favor of home care and secondarily in community-based care practice as well.

Professionals have responded that the Nepalese policies regarding to solve the elderly issues are too ambitious. It means that the policies are somehow good but their implementation has always been valued as weak due to the lack of good projects. There are no policies and provisions for care takers and also their basic formal qualification. The lack of availability of trained professionals and resources has been a key hindrance for the care of the elderly in old age homes.

Even if governments major emphasis of caring for their super aged society in Japan, the public financing still remains insufficient to cover the whole costs. This situation is more vulnerable for elderly people of Nepal.

Looking at the crosswise data, Nepalese elders felt medical expenses as problems whereas buying a food as a biggest financial problem was realized by Japanese elderly.

Pension as a main source of income was for nearly all the Japanese. The majority of Nepalese elderly expected income from children in old age. However, both Japanese and Nepalese elderly have expressed a common concern to increase monthly old age basic pension/old age allowance.

While the number of elderly people is growing, fewer people are available close at hand to care for them when the need arises. Elderly people are frequently single or live alone, but, even if not, their partners too are likely to be old and to need care. Moreover, the current and future generations of elderly people have fewer children than their predecessors and it can no longer be taken for granted that the children will always live close to their parent's home. In addition, it is increasingly common for women, once the obvious candidates to provide care, to have paid work.

Living in a joint family or with family was seen well for psychological and emotional well-being. Living with the family members can reduce loneliness. They can communicate with other family members. Effective communication is important up to end of life. Some health care professionals believe that discussing end-of-life care issues upsets their clients. However, living arrangements of the elderly will be influenced considerably by the changes in demography and socio-economic factors, and the proportion of those elderly who need long-term care services increases rapidly with the age increase. Japanese rapid population ageing threatens the sustainability of social security systems, and a great many of policy efforts are devoted towards making social security systems more affordable.

Long term care expenses may be incurred over an extended time and require the services of medical professionals, as well as social and personal care services. In Japan there are many types of long term care services and facilities, and over time these may be very expensive.

The significant size of respondents lives with family. This is found to be significantly higher in Nepalese than in Japanese elderly people.

Due to a lack of adequate financial assistance, social welfare facilities are unable to pay for the manpower necessary to provide a variety of services.

A rapidly declining proportion of the Japanese elderly co-resides with their children. This is particularly true for the younger portion of the elderly population. The three major sources of support for the elderly living independently are earned income, drawing down assets and pensions, both private and public.

The amount of care and who provides it are highly variable. However, elder care typically refers to unpaid, informal care performed by family members. Daughters and daughter-in-laws are more likely to perform elder care assistance in Japan and Nepal, respectively. In Nepal children are more likely to provide financial support to their parents in comparison of Japanese.

Community care is not just about the provision of care services to those in need of support; it is about having an adequate income and suitable housing to lead a 'normal' life in the community.

The Nepalese policy maker and academician emphasized that the mixed care model (that includes family/home, community and state) would be a better option for elderly care. They focused on the term social care where it lies at the intersection of public and private, formal and informal. They argued that Nepal's right based model is not sufficient for the elderly well-being.

About the responsibility of care, most of the respondents both elderly and policy makers stressed that government should be more responsible but some others emphasized that the elderly themselves as well as family should be more responsible. I think all individual and family and society as a whole should be responsible for providing and caring for persons with disabilities and government should act only as a payer of resort for those unable to provide for them.

In Nepal there are not sufficient and well furnished old age homes, day care center and rehabilitation centers in Kathmandu Metropolitan City. However, currently the data received from the Social Welfare Council shows that there are 138 *Bridhhashrams* (Old age homes) throughout the country. There is a lack of resources (man, money and materials) in such kind of old age homes due to governments fixed policy and monitoring systems. Most of the policy maker and professionals argued that there is a need to establish new community homes, day care centers for care of the elderly people.

These results clearly suggest that Japanese elderly were stressed public private mix services than their Nepalese counterparts. The Nepalese elderly opined that to caring for the elderly should be government responsibility as well as familial.

The provision of care is not a zero-sum activity and that neither is there a fixed quantum of care to be given nor is it divisible between public and private spheres. In Nepal there is complementarity rather than competition between formal and informal care.

In Nepal the elderly are traditionally looked after by the sons and daughters-in laws in a joint family. This way of life is getting significantly threatened by the breakup

of the joint family due to many socio economic factors. The elderly people are really in need of social, economic and health security for their protection and well-being. The state pension/allowance in Nepal for old people is also insufficient for survival.

In Nepal, younger generations moving far from their birthplace and parents for employment purposes are the principal change. Social, economic and demographic developments have all caused changes at the individual, family and societal levels, all of which influence the lives of elderly people.

More recently the government of Nepal has announced the universal health care service for all Nepalese citizens. However, the psychosocial health has not been recognized as a part of health services. There is only one mental hospital in capital city. There is no special training given to health professionals and service providers throughout the country to provide special care and support to elderly people. Older persons and disability issue is not in public debate and government programs.

In Nepal, there is less priority of issue in the development field and lack of aging management and also care giving training system. There is a lack of awareness and understanding in the family and community towards the independence, participation, self-fulfillment, dignity and care of the elderly people.

There is no special training given to health professionals and service providers throughout the country to provide special care and support to elderly people. Older persons and disability issue is not in public debate and government programs in Nepal. There has not been much attempt on the part of government to help the elderly people. This section of the population has been overshadowed in all areas of policy making level.

Housing that meets the needs of the aged as well as their adult children and their families will need to be planned. As countries mature, the spatial concentration of the aged will gradually shift from predominately rural to urban, requiring a corresponding shift in the placement of housing, social and health services, and transportation that is suited to the elderly.

Most of the houses of Japanese elderly are safety and elderly friendly than the Nepalese. However, Japanese houses are narrower than Nepalese, which being difficulty to live two or more generations in a same households.

Japan’s health care systems have been highly commended by the WHO.

However, because the pace and extent of population ageing in the country has been so rapid (the highest in the world), keeping up with the current situation and continuing to give the best services to the nation remains a challenge. The increase in the elderly population, especially the old elderly, has raised many serious social and medical issues in Japan and will surely continue to do so.

Responses from different Japanese professionals, policy makers and social workers reveal the priorities attached and actions undertaken by local and central governments to meet the challenges of aging to improve the quality of life of older persons and ensure their continued active participation and development in society. These include emphasis on building positive images of the elderly, promoting active aging, strengthening informal supports including formal community and ultimately institutional care, review of social security systems, establishing standards of care, developing an integrated or mixed care model and providing long-term care and community services. The New Super Gold Plan needs to find a sustainable solution while considering the current economic and intra-family care crisis. It should be formulated to address the crisis of the baby-boomer generation as well as intensify international mutual cooperation for the sake of elderly people.

The Government priority settings in allocating public resources are often reflected in the mindset of politicians and lawmakers, while economic and social realities put pressure on the decision-making processes of public policies including social welfare. Advocacy for the promotion of healthy aging and institutional support in meeting needs of growing numbers of elderly people is becoming an important mission for social welfare sectors.

Government welfare policies of Japan have begun to advocate the creation of a society in which everyone lives together, with an emphasis on the idea of “social inclusion” in which everyone is a society member, rather than isolation and exclusion, to ensure a healthy, social life to all citizens. In 1995, the Japanese government developed its “Action Plan for Persons with Disabilities” and began shifting policies toward increasing both the quality and quantity of services to enable the disabled to live in their local communities.

Volunteering, a personal or collective engagement, which flourishes in all nations, cultures and religions, is present across the spectrum of human development activities. What is new is the growing awareness and recognition of the contribution of volunteerism to social and economic development. Data suggest that about similar compositions of the elderly from both countries are engaged in volunteer activities. A growing trend for elderly persons is to engage in unpaid volunteer work. With the future elderly being more educated, we are likely to see an increase in the number of older

people who desire to engage in volunteer work or continue to contribute in other ways to society.

In Japan government strategies are looking at the professionalization's of care, heightened health promotion and prevention and enriched lifestyles for old people in their society.

The significant proportion of Nepalese elderly preferred to live at home in infirm old age while the majority Japanese of elderly persons wants to live in their own community homes. This is a changing concern of Japanese elderly (mainly single) to move community living patterns. It is found that Japanese traditional care system is still in the phase of transformation.

In terms of providing financial security, policy needs to set the framework of incentives within which individual and institutional decisions are made. Key consideration in the light of population ageing include the importance of integrating public and private transfers into future systems including understanding the complementary relationship between private and public intergenerational transfers, and the relationship between upward and downward transfers, and exploring frameworks to support and encourage individual responsibility. It may be argued, for example, that population ageing will necessitate a division between government responsibility to keep population out of poverty and individual responsibility to raise personal standards of living.

Multiple factors influence healthy aging, including adequate income, education, appropriate housing, satisfying relationships, and safe environments. Linked to the concept of healthy aging is the model of healthy human development which posits that ongoing human development is neither age-based nor dependent on the absence of illness or disease.

No doubt both the Gold Plan and New Gold Plan have paved the way future reforms in the fundamental characteristics of health care in Japan, but it is evident that in order for these plans to work, more large-scale investments in long term care (LTC) infrastructure are insufficient.

Most of the elderly people were not engaged in any part/full time jobs. This proportion was to be found even higher among the Nepalese elderly than their Japanese counterparts. More than three times Japanese elderly were engaged in any part time jobs than the Nepalese elderly.

In professional care settings, inappropriate practice involving poor standards of care, rigid routines, quantitatively and qualitatively inadequate staffing, and overprotective and excessively paternalistic attitudes may all lead to elder abuse. In such situations it becomes difficult to identify any specific individual as the perpetrator because it is a systemic and organizational problem of the institution rather than the result of individual professional failure, let alone deliberate malevolence. Care in the home brings with it particular strains, not least for the health, well-being and social contacts of those providing it. Families and women in particular, sometimes have to sacrifice a great deal to look after relatives. The problem is exacerbated by a lack of proper preparation for the care situation, insufficient financial and human support and lack of access to respite care during the care period.

As societies undergo development and the processes of urbanization, industrialization, increasing participation of women in the workforce, economic hardship and structural adjustment, there has been an influence of family life and composition including attitudes towards the care of the elderly. The rising cost of health care for the aged is placing an increasing burden on the family and on society.

Population aging, or the increase in the number and percentage of older persons resulting from reduced birth rates and increased life expectancy, raises a number of social issues. Aging has gone beyond the realm of welfare concern and needs to be viewed as a developmental challenge. It is essential that aging-related issues be mainstreamed into national development agendas and relevant policies. Most importantly, the existing efforts are inadequate to enhance the dignity of older persons and to eliminate all forms of neglect, abuse and violence in the family and community. The government should ensure a coordinated mechanism to increase elderly allowance and other social benefits at all levels.

In Nepal, where older people have limited access to formal mechanisms of social protection, they will need to rely on the family and the local community. However, these informal protection mechanisms have been under increasing stress recently, owing to the process of population ageing itself but also, in some contexts, to a growing participation of women in the labour force and to changing perceptions about caring for parents and older persons in general. In Japan, may need to expand the supply of formal long-term care for their advanced aging society, including institutional living, as well as to develop alternative services to allow older persons to age in their homes if they so desire.

10.2 RECOMMENDATIONS

Based on qualitative and quantitative findings of the study the researcher briefly recommended the following ways;

As the population ages, new areas of interest and concern emerge. Two of these

emerging concerns have been the care of frail or dependent elderly and the maintenance of optimum health according to the World health Organization (WHO) definition, i.e. including social, economic and spiritual well-being, of independent elderly within the community. It is an accepted fact for both economic and social reasons that community-based programs are better than institutional care.

Elders play a vital role in providing a sense of structure and cultural identity that helps keep our families and communities emotionally and mentally healthy. It is therefore essential that we develop the services to support Elders so they can remain with their families and communities. Keeping our Elders near their families also supports their own mental and emotional health, resulting in longer and happier lives. And, in an interrelated way, healthy families are able to provide a safer, more supportive environment for elder care.

Care services need to be integrated between social and health services including reorganizing the welfare systems. They should be appropriately tailored to demand and balanced across institutions and care in the community (also at home). For that, all levels of government and all sectors of society will need to work in partnership to respond to the challenges of an aging society.

The increasing number of people providing and requiring elder care calls for a new approach to elder care in the future. Elder care has traditionally been viewed as a women's issue. The norm of female care giving in turn leads to discrimination against women in the workforce since caregivers typically cannot meet the demands of traditional jobs and careers. Organizations and the government should enhance flexibility in an employee's job commitments when elder care commitments arise.

The health needs of older persons, either unmet or expressed in actual utilization of health services, are much greater than that of the rest of the population. This expected rise in demand for health care is intensified by both the increasing proportion of the elderly and by the ageing of the older population itself, that is, the growing number of older persons who are living longer. The elderly are particularly vulnerable to chronic debilitating diseases and severe disability, and are more likely to need long-term care. As all these conditions are expected to increase, it becomes necessary to plan for the appropriate levels and types of services required by older persons. Hence, there is the urgency for more innovative approaches to the organization and financing of health care against the rapidly ageing population trends.

Elderly people in their productive spans of life have made significant contributions to the development and prosperity of the world. Now it is the time when we join hands and work for the welfare of elderly and provide shelter, meet the physical, psychosocial, spiritual, recreational and medical needs of the elderly. In other words, elderly people are unique and individual and while not a homogenous group with uniform needs, they do have special needs which differ from those of the younger and middle aged population and which need to be addressed at community level.

In both countries, there is an immediate need to create a supportive environment

by the family, community and nation at large to use the knowledge, skills and experience of the elderly people in the economic and social development.

Public-private sector partnerships are becoming important in many countries for social protection. So that the public-private sector partnerships may be appropriate to adopt to cater the care issues for the elderly and their well-being.

Aging in place emphasizes the importance of strategies that make it possible to support older people in their homes and communities. At the same time, it should be a matter of choice for older people and should not be mandatory. In encouraging home-living, even with a certain degree of frailty, society must foster family-oriented care-giving, because home care is less expensive and safer than institutional nursing and hospital care.

Japanese society is now changing dynamically as it grapples with the problems introduced by a decreasing child population and rapidly aging society. Undoubtedly, the welfare reform will not come to a conclusion in its present form but will continue to develop and to be an important policy issue. Policy makers must be concerned with a variety of issues, ranging from practical political considerations to satisfying the broadest possible range of constituents. They must be concerned with financial cost and feasibility.

The most important thing for Nepal is to establish a nationwide pension system and health care insurance scheme for all citizens. At the same time, it is necessary to develop social services to meet the expanding social demands of elderly people as well.

Senior centers can provide a broad spectrum of health education offerings, seminars, exercise and nutrition classes, self-care programs or referrals to appropriate health services. So that senior centres should be established throughout the nation for well being of elderly.

On the one hand the fertility rate is going below than replacement level, late marriage and consequently late birth or no birth, increasing female labor participation; heavy child care and rearing burden and rapidly increasing of elderly population on the other are most considerable aspects of Japanese society. The arrival of the aged society of this magnitude calls for a new policy for the elderly so that they can live with peace of mind with physical, mental and financial security. For this Japan government should be more dynamic and responsible to their older citizens by reforming mainly family policies and other support programs.

For the psychological and emotional well-being for the elderly a strong safety net is needed, and the role of the informal social network becomes especially important. The family, along with other informal caring networks such as friends and neighbors, can provide essential assistance to meet the needs of older persons. It is therefore important to revitalize traditional family values in the years to come.

Health expectancy is more important to older adults than life expectancy. The well-being of elderly at a standpoint of human rights and humanitarian perspectives in all countries should have been taken into account in this issue. Healthy elderly people are resources of their families, their community and also national economy. The focus is not

only on prolonging the life of elderly people but also improving the quality of life for active and healthy aging perspective.

The community needs to be sensitized to the special needs of the elderly and motivated to be supportive and caring of the elderly. The community also needs to be helped to distinguish the physical and mental changes that accompany the normal ageing process from those that would be considered as abnormal and dispel certain myths about ageing. The community should be motivated to actively participate in taking care of the elderly and not isolate them.

Moral education of the young is a fundamental, long-term strategy to eradicate age discrimination. In addition, encouraging widespread participation by older people in social, economic, and political affairs is the ideal complement to formal education in order to promote an image of productive aging. It is to this latter emphasis on participation that we now turn.

A global solution approach needs to incorporate social development perspectives from an integrated perspective of economic, social, psychological and environmental dimensions of aging.

The mainstreaming process becomes more interesting and dynamic when the intergenerational dimension of aging is taken into account. By enhancing solidarity via mutual understanding and care between generations, it is hoped that not only will care be improved, but also ageism will be eradicated, creating a much larger and more influential mass of advocates for older persons. The mutual interest of younger generations to improve the well-being of their parents, reducing burdens on themselves, and guarantee their own future, should not be overlooked as an important force for social change.

There is an urgent need for governments, institutions and concerned organizations to focus on health care for the growing numbers of the elderly, and to develop appropriate strategies for health promotion that can educate the elderly on patterns of behavior that can lead to healthy ageing.

Networking of those concerned with care of the elderly should be encouraged and opportunities made available for the exchange of knowledge and experience in the field of care of elderly.

In the Nepalese context, long term care within the family could be promoted by using alternatives like cash payment and pension for the care-taker as already practiced by developed countries such as Japan. The sustainability of those measures also needs to be evaluated, according to other countries' experiences.

The best approach to enhance the elderly welfare is to increase their self-reliance and to provide them facilities so that they may make useful contribution to their families, communities and also to the Nation.

Health care providers need to be trained in the care of the elderly so that they can in turn help to educate and train family members to provide the care and support needed by the elderly in order for them to lead healthy lives. The family should be supported to provide home based care, instead of institutionalizing the elderly.

Provide technical and financial support to private sector for enhancing the effectiveness of awareness building programs at different levels (individual, family, community and national).

With the development of information resources and research, nationally and internationally, informed policies and plans for the care of the elderly can take place, ensuring successful coping by the elderly and their families of the ageing process, economically, mentally, emotionally and physically.

In the case of Nepal, it should be considered to designing health insurance schemes to provide long-term security for the elderly particularly from disadvantaged and marginalized population.

Promote and support private entrepreneurs engaged in providing goods and delivering services to meet needs of ageing population. The support could be in the form of a) scholarship for higher education, and short and long training; b) tax-deduction or subsidies, c) grants and so on.

Elderly people are becoming a social stratum interesting to academics in the social and health care approach because they are needy, they are a group of specific size and in general, they are as yet unexploited as objects of genuine scientific investigation.

The quality of relationships among the elderly and with their environment is a key factor in maintaining the conditions of human dignity. Preserving the autonomy of older people for as long as possible allows them to relate to others as equals and makes them less vulnerable to abuse and neglect.

Both countries should formulate and act the policies and programs on the basis of the rights, needs, preference and capacities of older people. They also need to embrace a life course perspective that recognizes the important influence of earlier life experiences on the way individual's age.

Future policy lessons in the light of population ageing will by necessity have to be holistic and focus around the development of broad, coherent and integrated multi-pillar approaches to labour markets, social security and health and social care. These should enable and promote longer working lives through life long training, education and skills updating, and the provision of appropriate working environments for older workers; ensure that private family/household transfers are integrated into old age security systems where possible; promote wellbeing and enable healthy active living to reduce chronic illness and health care costs and support active contributory life for as long as possible; and provide access to education across the life course to ensure that all individuals are prepared physically, mentally, socially and financially to cope with increasing individual responsibility for old age.

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Appendix A

Outlines of Major Health and Welfare Services for the Elderly (Gold Plan 21)[12]

Home-Visit Type Services

The home help service is regarded to be a core of the network of various community services for the elderly and their families. Home helpers visit to the families with the elderly who has difficulty in engaging in daily life activities to assist in providing personal and housework services.

Home-Visit Nursing Care

For this purpose home visit nursing care stations provide the bedridden elderly living at home with nursing services based on their doctor's instructions.

Commuting-Type Services

These services consists day service and commuting rehabilitation service. The elderly people commute by shuttle bus to day service centers, where such services as baths, meals, health check-ups and training in daily activities are provided.

Short-Term Stay Type Services

Nursing care and medical care services are provided for short stay period. A frail older person can stay at a nursing home for one week for any reason and this period can be extended when necessary.

In-Facility Type Services

The special nursing care services are provided for those elderly who need long-term care. In other words these are welfare facilities for the elderly who constantly require personal care and who have difficulty living home.

Health Care Facilities for the Elderly Requiring Long Term Care

Facilities for the elderly requiring long-term care and functional training conducted under the nursing and medical management.

Living Support Type Services

Those demented elderly people whose condition is stable and requiring long-term care can take these types of services in group homes. For example: bathing, excretion and eating and functional training.

Economical Nursing Homes (Care Houses)

There are two types of care houses. Type A offers meals and other services for daily living at low cost. Type B are institutions nearly the same expect users should be healthy enough to be able to cook their own food. The purpose of this institution is to promote independence of the elderly.

Living Support Houses

These are small scale comprehensive facilities where the elderly can live in security receive the needed care and engage in a social exchange with their peers in the community.

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Appendix B

A Comparative Study on Elderly Care Practice: Kyoto and Kathmandu
高齢者や介護の状況を比較します: 京都 とカトマンジュ
Interview Schedule for the Elderly (Set-A) 部分A
Interview Date 面接日
Respondents Address 応答者の住所

A) Demographic Characteristics）人口統計の特性
1. Sex 性別：
2. Age 年齢：
3. Educational Status: 教育程度
a. Elementary 小学校 b. Junior high school 中学校
c. Senior high school高等学校 d. Higher Education 大学以上の学歴
4. Family Type: Nuclear/Joint 家族形態：核家族・核大家族
5. Family Number: 家族の人数
6. Marital status: 結婚の状況
a. Married 結婚 b. Unmarried 独身 c. Widowed 未亡人
d. Widower 男やもめ e. Divorced 離婚

7. Number of children: 子どもの数 8. Religion: 宗教
8. Income: 所得
9. Total Time of Interview 面接の全体時間

B) Health Status 健康状態
1. How is your present health status? 現在の健康状態はいかがですか？
a) Excellent すごく良い b) Good 良いc) Fair まあまあ d) Poor 悪い
2. Do you have any physical disabilities or health impairments?
お体で悪いところがありますか？
a) Yes はい b) No いいえ
2 A. If yes what types もしはいの場合
a) Total paralysis 完全に麻痺している b) Partial paralysis 部分的に麻痺がある
c) Missing or non functional limbs 手足に障害がある
d) Broken bones 骨折 e) Heart diseases 心臓病
f) Respiratory diseases 呼吸器疾患 g) Diabetes 糖尿病
h) Diabetes and Heart diseases 糖尿病と心臓病 i) Gastric 胃の病気
j) Mental illness 精神的な病気 k) Any others その他
3. How long have you been suffering from these types of problems?
いつ頃からその問題を抱えていますか？
a) From last 5 years 5 年前から b) From last10 years 10 年前から
c) From last 15 years 15 年前から d) More than15 years 15 年前以上
4. About how many times have you seen a doctor during the past six months?
過去 6 カ月以内に何回病院に行きましたか？

a) One to two times　　1・2 回　b) Three to four 3・4 回
c) Five to Six　　5・6 回　4) More than Six　6 回以上
d) None　なし
5. How many days in the past six months were you in a hospital overnight or longer?
過去 6 カ月以内に何日入院しましたか？
Number of days.....　入院日数
a) Seven days　1 週間　b) 14 days　2 週間
c) 21 days　3 週間　d) 28 days　一か月程度　e) More than 28 days　一か月以上
6. How many days in the past six months were you in a nursing home or rehabilitation center?
過去 6 カ月以内に老人ホームやリハビリセンターに何日入所しましたか？
a) One week　一週間　b) Two weeks　2 週間　c) Three weeks 3 週間
d) Four weeks　4 週間　e) More than above　５週間以上　f) None　なし
7. How satisfied are you with the medical treatment that you have received in the past?
a) Very satisfied.....　とても満足している b) Somewhat satisfied　だいたい満足している c) Somewhat dissatisfied　あまり満足していない
d) Very dissatisfied　不満 e) Not answered　答えなし
8. How do you rate your countries health care system in general?
あなたは自分の国の医療システムについてどう思いますか？
a) Excellent　すごく良い　b) Good　良い
c) Fair まあまあ　d) Poor 悪い
9. How is your eyesight (with glasses or contacts)?
(眼鏡やコンタクトを含む)
a) Excellent　すごく良い　b) Good　良い　c) Fair　まあまあ
d) Poor　悪い e) Not answered　答えなし
10. How is your hearing?　聴力はいかがですか？
a) Excellent　すごく良い　b) Good　良い
c. Fair　まあまあ　d) Poor　悪い　e) Not answered　答えなし
11. Do you need any aids that you currently do not have?　現在の生活で救援物資が必要ですか？
a) Yes　はい　b) No　いいえ　c) Not answered答えなし
11 A. If yes what aids do you need? (Specify)
もしはいの場合、どのような助けが必要ですか？
a. Spectacles　眼鏡　b. Hearing aid　補聴器
c. Walker 歩行器 d. Wheel chair　車椅子　e. Others　その他
12. Can you think of any measures you might have adopted when you were young to maintain health?　あなたが若かった時に、健康を維持するためにやっていたことを教えて頂けますか？
a. Exercise　運動　b. Balance diet 食事制限
c. Avoidance of certain habits　ある習慣の回避
d. No any fixed habits　特定なことはなし
13. What do you think about long term care for the dependent elderly?
介護が必要な高齢者への長期的な介護についてどう思いますか？

a) It should be done mainly by family 主に家族が介護をするべき
b) Home care supported by formal care (governments)
公的に支援された家族介護が良い
c) Care should be done in community, supported by formal care (governments)
地域などにおいて公的に支援された形態の介護が良い
d) Care should be in institutional settings such as nursing home etc.
組織的な団体(老人ホームなど)において介護されるべきである
e) Don't know わからない
14. Do you need for assistance in your daily life?
あなたの日常生活で援助が必要ですか？
a) Yes はい b)No いいえ
14 A. If yes what types such as もし はい のばあい
もしはいの場合
a) Daily living and Personal care with aids
日常生活においてや個人的に、介護が必要 b) Walking with aids 歩くのに助けが必要 c) No needs on above assistance 助けは必要ではない

C) Social Status and Support Networks 社会的地位と支援
1. How many people do you know well enough that you visit them in their homes?自宅に訪問するような仲の良い人は何人いますか？
1) None いない 2) One or two1 人か 2 人
3) Three to five or more 3 人から 5 人以上 4) Not answered 答えなし
2.About how many times did you talk to someone.....friends, relatives, neighbors.....on the telephone in the past week(either you called them or they called you)?
過去 1 週間に友達や親族・近所の人などで、電話で何度話しましたか？(電話 かけたのも、かかってきたのも含めます)
1) Not at all....全くない 2) Once ..... 1 回 3) 2-6 times.....2-6 回
4) Once a day or more..... 1 日 1 回以上 5) Not answered答えなし
3. Do you have someone you can trust and confide in?
信頼している人がいますか？1) Yes はい 2) No いいえ
3) Not answered こたえなし
4. Do you see your relatives and friends as often as you want to or would you like to see them more often?
親族や友達に会いたい時に会えていますか？
1) As often as wants.....会いたい時に会えている 2) Like to see more.... もっと会いたい 3) Not answered....答えなし
5. Is there someone who would give you any help at all if you were sick or disabled, for example your husband/ wife, a member of your family, or a friend?
あなたが病気や怪我をした時に助けてくれる人はいますか？例えば夫・妻、家族の誰か、友達など。
1) Yes.....はい 2) No.... いいえ 3) Not answered.... 答えなし
5 A. If yes who is that person？ もしはいの場合誰ですか？

1) Husband/ wife.....夫や妻 2) Children.... 子ども 3) Other relatives.....
その他の親族 4) Friend/Neighbor 友達や近所の人
5) Others その他 6) Not answered 答えなし
6. How long have you been living in this neighborhood?
この地域にどれくらいの期間住んでいますか？
1) Less than one year １年以内 2) 1 yr. to less than 2yrs. １年から２年
3) 3yrs. to less than 5yrs. ３年から５年 4) 5yrs. to less than 10yrs. ５年から１０年
5) 10yrs. to less than 15 yrs. １０年から１５年 6) 20yrs. or more ２０年以上
7. How many of your friends live in this neighborhood?
この近くにどれくらい友達がいますか？
1) All 全員 2) Most ほとんど 3) Some 何人か 4) Not many あまりいない
5) None いない 6) Not answered.答えなし
8. Do you belong to any organizations or clubs that are involved with neighborhood activities?
地域のクラブや団体などの活動に参加していますか？
1) Yes はい 2) No いいえ 3) Not answered 答えなし
9. Do you feel that you are really a part of this neighborhood, or do you see it as just a place to live?
あなたはこの地域の一員だと感じていますか？それともここはただ住むための所だと思いますか？
1) Feel a part of 一員だと思う
2) Just a place to liveただの住むところだと思う 3) Not answered答えなし
10. Would you feel safe waiting alone in this neighborhood at night time?
日中や夜にこの地域でいるのは安全だと思いますか？
1) Yes はい 2) No いいえ 3) Not answered 答えなし
11. Have you ever been the victim of a crime?
犯罪にあったことがありますか？1) Yes はい 2) No いいえ
3) Not answered 答えなし
11 A. If yes what type of crime that was? もしはいの場合、どのような犯罪でしたか？
1) Home burglary 空き巣 2) Vandalism 器物破損
3) Mugging ひったくり 4) Sexual Assault 性犯罪
5) Other (Specify) その他(具体的に記述願います) 6) Not answered 答えなし
12. Do you have any other difficulties in the neighborhood?
近所付き合いで何か難しいことがありますか？
1) Yes はい 2) No いいえ 3) Not answered 答えなし
12 A. If yes what type (specify)
もしはいの場合、どのようなことですか。(具体的に記述願います)
13. All things considered do you think that this is a safe neighborhood in which to live?
住むところを考える時、安全な地域ということは重要なだと思いますか？
1) Yes はい 2) No いいえ 3) Not answered 答えなし

14. Do you feel that you have ever been treated unfairly because of your age?
年齢を理由にして、不当な扱いを受けたと感じることはありますか？
1) Yes　はい　　2) No　いいえ　　3) Don't know　わからない
4) Not answered 答えなし
15. What do you feel attitude of people towards elderly people in your area?
高齢者に対する、あなたの周りの人々の態度についてどう思われますか？
1) Positive　肯定的　2) Not so positive　そこまで肯定的ではない
3) Cooperative 協力的　4) Negative　否定的
16. Are you engaged in any community volunteer works?
何かボランティアに関わっていますか？
1) Yeはい 2) No いいえ　3) Not answered 答えなし
16 A. If yes how many hours per week?
もしはいの場合、週に何時間ですか？
Hours per week..... 週あたりの時間 1) Less than 5 hours　５時間以内
2) 5 to 10 hours 5-10 時間　3) More than 10 hours 10 時間以上
17. Do you have any savings for an emergency purpose?
緊急時に備えて、貯蓄がありますか？
a) Yes　はい b) No　いいえ

D) Mental Status　精神的状況
1. How often would you say you worry about things?
どれくらいの頻度で悩むことがありますか？
a) Very often　いつも　　b) Fairly often　よく
c) Hardly ever 一度もない　d) Not answered　答えなし
2. In general, do you find life exciting, pretty routine or dull?
日常生活は楽しいですか？まあまあですか？つまらないですか？
a) Exciting　楽しい　b) Pretty routine まあまあ
c) Dull　つまらない　e) Not answered　答えなし
3. Taking everything into consideration, how would you describe your satisfaction with life in general at the present time? 今の生活について全体的に満足していますか？
a) Good　良い　　b) Fair　まあまあ
c) Poor　良くない　d) Not answered 答えなし
4. Are you happy most of the time? いつも幸せだと思いますか？
a) Yes　はい　　b) No　いいえ
3) Dull つまらない　　4) Not answeredこたえなし
5. Even when you are with people, do you feel lonely much of the time?
人と一緒に居る時でも、寂しいと思いますか？
a) Yes　はい　　b) No　いいえ
6. How would you rate your emotional health at the present time?
現在は、感情面から捉えた時に健康だと思いますか？
a) Excellent　とても良い b) Good　良い c) Fair　まあまあ
d) Poor　良くない　e) Not answered　**答えなし**

E) Psychological Status 心理的状況

1. Who is caring to you?
誰が世話をしてくれていますか？
1) Husband 夫 2) Wife 妻 3) Daughter 娘 4) Daughter-in law息子の妻
5) Son 息子 6) Son in-law 娘婿 7) No one 8) Others その他
2. What do you found care givers attitude towards you?
介護者をどう思いますか？
a) Very good とても良い b) Not so good あまり良くない
c) Normal 普通 d) Don't want to say 言いたくない
3. Where would you like to live if you become infirm in your old age?
年をとったらどこに住みたいですか？
a) In own family/home 自分の家
b) In the community Home 地域のグループホーム
c) In the Nursing home 老人保健施設 d) Hospital 病院
e) Facility for the elderly 老人ホーム f) Others その他
4. What sources of income do you expect to support you in old age?
高齢者になったらどのような収入が見込まれますか？
a) Employment Earning 給料 b) Old-age Pension 年金
c) Help from Children 子どもの援助 d)Others その他
5. What do you think about care providing services?
介護サービスについてどう思いますか？
a) It is a responsibility of family or children
それは家族、あるいは子どもの責任だ
b) It is a responsibility of local municipality or central Government
それは地方自治体、あるいは政府の責任だ
c) Voluntary agencies ボランティアd) Private agencies **私的民営機関**
6. Are you worried about old- age life? 高齢者になってからの生活を心配していますか？a) Extremely 非常に心配 b) Somewhat ちょっと心配
c) Not very 心配しない d) Not at all 全然心配しない
e) Haven't thought about it 考えたことがない
7. What types of services are you receiving?
どのようなサービスを受けていますか？
a) Home help service ホームヘルプサービス
b) Short Stay Services ショートステイサービス
c) Day service and day care service デイサービス デイケア
d) Special Nursing Service 特別介護サービス
e) Home help and day service ホームヘルプ とデイサービス
f) Not answered 答えなし g) Any others その他h) None なし
8. Do you satisfy the above type of services?これらのサービスに満足していますか？
a) Yes はい b) No いいえ
9. Is there family members feel burden to caring you?
あなたの面倒をみることを負担に感じている家族がいますか？
a) Yes はい b) No いいえ c) Don't want to say 言いたくない

10. Do you think you need to have someone with you all the time to look after you?
いつも面倒を見てくれる人が必要だと思いますか？
a) Yes はい b) No いいえ c) Not answered答えなし
11. Who do you think should take the responsibility for providing for fulfill your needs?
誰があなたの面倒をみる責任を負うべきだと思いますか？
a) Senior children 長男・長女 b) Relatives 親戚
c) Friends or neighbors 友達、または近所のひと
d) Government- local/ Prefectural/Central 政府、あるいは自治体
e) Private agencies 個人代理人
f) Children and government 子どもと政府 g) other (specify) その他

F) Living Arrangements 居住状況
1. Are you living alone or with other family members?
ひとりで すんでいますか？ かぞくと いっしょに すんでいますか？
1 人で住んでいますか？家族と一緒に住んでいますか？
1) Alone 1 人 2) With family 家族と一緒 3) Other relatives その他の親族
2. Who lives with you? 誰があなたと一緒に住んでいますか？
1) No one 誰もいない
2) Husband 夫 3) Wife 妻 4) Husband with children 夫 と 子ども
5) Spouse with children 配偶者と子ども
6) Son 息子 7) Daughter 娘
3. Do you have any children? 子どもがいますか？
a) Yes はい b) No いいえ c) Not answered 答えなし
4. How many living children do you have? 何人の子どもと一緒に住んでいますか？
1) One 1 人 2) Two 2 人 3) Three 3 人 4) More than three 3 人以上
5) None いない
4A. How many of your children live within an hour's driving time from you?
車で一時間以内の距離に住んでいるこどもは何人いますか？
One 1 人 2) Two 2 人 3) Three 3 人
4) More than three 3 人以上 5. いない
4 B. How often do you see any of your children?
どれぐらいの頻度で子どもに会いますか？
a) Daily 毎日 b) Several times a week 週に何度か
c) Once or twice a week 週に一度あるいは二度
d) Once or twice a month 月に一度あるいは二度 e) Several times a year 年に数回
f) Never 会わない g) Not answered 無解答
4C. Do you call on them for help with any problems?
助けてもらいたい時に電話しますか？
a) Yes はい b) No いいえ c) Not answered 答えない
5. Would you like to see your children more often?
もっと頻繁に子どもに会いたいと思いますか？

a) Yes　はい　　b) No　いいえ　　c) Not answered　答えなし

G) Economic Status　経済状況

1. Who is supporting to you by economically?
誰が経済的にあなたを支援していますか？
a) Son 息子　　b) Son in-law 義理の息子 c) Daughter　娘
d) Daughter in law　義理の娘
e) The government　政府　f) Others（その他
2. Have you receiving old age pension/elderly allowance from the government?
年金を受給していますか？
a) Yes　（はい）　　b) No　（いいえ）
3. Have you receiving retirement pensions (either public or private)?
厚生年金を受給していますか？　（公的年金・私的年金）
a) Yes　　（はい）b) No （いいえ）
4. Do you satisfy the pension amount? 年金の額に満足していますか？
a) Very satisfied　とても満足している
b) Somewhat satisfied　だいたい満足している
c) Not satisfied　不満だ　d) Not answered　答えなし
5. What are your main income sources? あなたの主な収入源はなんですか？
a) Employment 仕事
b) Public or private pensions/old age allowance 年金(公的・私的)
c) Business/Investments　商売．投資
d) Agriculture 農業　e) Pension and savings　(ねんきんとちょきん
f) House Rents（やちん）　g) Children's income　子どもからの小遣い
h) Relatives (しんせき)　i) Other（その他
6. How many others in your household have an income?
あなたの家族であなた以外に収入があるのは何人ですか？
1) One 1 人 2) Two 2 人 3) Three　3 人 4) More than three 3 人以上
7. Have your financial asserts and financial resources sufficient to meet needs?
あなたの収入は、経済的に必要な額を満たしていますか？
a) Yes（はい　　b) No（いいえ c) Somehow　なんとかいける
d) Not answered（回答なし
8. How well does the amount of money you have take care of your needs?
あなたが持っているお金は、どのくらいあなたの必要を満たしていますか？
a) Very well とてもよく満たしている
b) Fairly well かなり満たしている
c) Poorly　あまり満たしていない d) Not answered 答えなし
9. Do you usually have enough to buy those little "extras" that is those small luxuries?
小さな贅沢のために何か特別なものを買う余裕はありますか？
a) Yes はい　　b) No いいえ
c) Somehow なんとかなる d) Not answered答えなし
10. Which of the following is the biggest problem to you by financially?
次の中で何が一番経済的に大きな影響を与えていますか？

a) Buying foods　食費　b) Housing　住宅費
c) Getting adequate medical care医療費　d) Social Expenses　交際費
e) Buying foods and getting adequate medical care　食費と医療費
f) No problem　問題はない　g) Others　その他
11. Do you feel that you will have enough money for your needs in the future?
将来の自分の必要を満たすだけの十分なお金を持っていると感じますか？
a) Yes はい　b) No いいえ c) Don't know わからないd)Not answered 答えなし

H) Employment Status 雇用の状況
1. Are you engaged in any work now for which you are drawing an income?
あなたは今収入を得る仕事についていますか？
a) Yesはい　b) No いいえ
1 A　If yes what type of work? (Specify)どんな仕事ですか？
2. What kind of work have you done most in your life?
これまでの人生で最も多い時間を占めたのは、どんな仕事ですか？
a) Never employed
仕事に就いたことがない b) Government　政府
c) Private Job　自営業 d) In a company 会社
e) Housewife　専業主婦 f) Not answered 答えなし g) Other その他
2 A. If "R" answers "Other" to Q. 2, ask- what is /was your specific job?
もしあなたが自営業かその他ならば、どのような仕事なのか教えて頂けますか？
3. Does your husband/wife work or did he/she ever work?
あなたの夫・妻は仕事をしていますか。していましたか。
a) Yes はい　b) Noいいえ
c) Never married 結婚していない d) Not answered 答えなし
3 A. If yes specific job in detail..... 具体的にどんな仕事ですか。
4. Do you interested to engage in any full or part time jobs?
常勤や非常勤の仕事に就くことに関心がありますか？
a) Yesはい　b) Noいいえ

I) Housing 住宅
1. Do you own your home, rent or is your rent provided free?
家は持ち家ですか。借家ですか。
a) Own 自分の持家　b) Rent 借家
c) Rent provided free　無料で借りている　d) Not answered　答えなし
2. Would you say that this place is too large, too small or just about right for your needs?
この家はあなたにとって大きすぎますか。小さすぎますか。ちょうど良い大きさですか。
a) Too large　大きすぎる。b) Too small 小さすぎる。
c) Just about right ちょうどよい d) Not answered 答えなし
3. How many rooms do you have?　部屋はいくつありますか。
Number of rooms.....部屋の数
a) One　１つ　b) Two　２つ　c) Three ３つ 4) More than three　３つ以上

4. Do you have your private kitchen or do you share a kitchen with other households?
自分の台所がありますか。それとも、他の家族と台所を一緒に使っていますか。
a) Private 自分専用 b) Shared 一緒に使っている
c) No kitchen 台所はない d) Not answered 答えなし
5. Do you (and your family) have a private bathroom, or do you share a bathroom with people in other families?
あなたとあなたの家族は、自分専用の浴室を持っていますか。それとも、他の家族と浴室を一緒に使っていますか。
a) Private 自分専用 b) Shared一緒に使っている
c) Outhouse no facilities 浴室がない d) Not answered 答えなし
6. Does your home have any safety alarms such as fire or burglary?
あなたの家には火災や防犯の警報機がついていますか？
a) Fire alarm 火災警報器 b) Burglar alarm 防犯警報機
c) Fire and burglar alarm 火災警報器と防犯警報機
d) No alarm 警報機はない e) Not answered 答えなし
7. Does this building need any repairs inside or outside?
この家の中や外に改修の必要なところがありますか。
a) Yes はい b) No いいえ c) Not answered 答えなし
If yes what kinds of repairs どんな改修が必要ですか。
8. Considering everything amount of room, structure, condition and so forth- how satisfied are you with your present home?
部屋や構造の状態からみて、今の家にどれくらい満足していますか。
a) Very satisfiedとても満足 b) Somewhat satisfied 少し満足
c) Not satisfied 満足していない d) Not answered こたえなし

J) Activity and Entertainment 日常の活動と楽しみ
1. Can you do activities of daily living (ADLs) such as eating, dressing or going to the toilet and instrumental activities of daily living (IADLs) such as shopping, preparing meals, or doing light work? 食事・着替え・トイレに行くなどの活動をしていますか。買い物・食事の支度・軽い仕事などを活動していますか？
a) Yes はい b) Noいいえ
2. How are you spending leisure time nowadays?
余暇はどのように過ごしますか
a) House chores 家事 b) Reading newspapers 新聞を読む
c) Watching TV テレビを見る d) Caring children 孫の世話
e) Meeting with friends 友達に会う
f) House chores and caring children 家事と孫の世話 g) Othersその他
3. On the average, how many round trips do you make each week for shopping, visiting, work or any other reason?
買い物、訪問、仕事、その他の理由で、週に平均してどのくらい外出しますか？
Number of trips .....外出の回数
a) Once 一度 b) Twice 二度

c) Three to four　　3-4 度　d) Never　　一度もない

4. In general, do you have any trouble getting around? That is, does lack of transportation keep you from doing things you need or would like to do?
外出したいのに、交通手段がないなどの困難がありますか。

a) Yesはい　　b) Noいいえ　　c) Not answered 答えなし

5. Do you regularly participate in any vigorous activity such as jogging, tennis, swimming, biking or hiking?
ジョギング、テニス、水泳、自転車に乗る、ハイキングなどの激しい運動を定期的にしますか。

a) Yes　はい　　b) No いいえ　　c) Not answered 答えなし

6. How many hours do spend each day to watching the TV?
一日どのくらいの時間、テレビを見て過ごしますか。

Number of hours.....時間

a) One to two hours 1・2 時間　b) Three to Four 3・４時間

c) Five to Six　５・６時間 d) Never　なし

7. How often do you read newspapers, magazines or any books?
新聞、雑誌、本はどのくらい読みますか。

a) Daily　　毎日　b) Saturday and Sunday 土曜日と日曜日

c) Never 全く読まない　　d) Not answered 答えなし

8. Do you attend religious services/programs?
宗教的な礼拝に参加しますか。

a) Yes　はい　　b) No いいえ　　c) Not answered 答えなし

9. Do you participate in any senior centre programs?
次のようなプログラムに参加していますか

a) Yes はい b) No　いいえ c) Don’t know わからない

Is there anything that we have not talked about that might help daily lives of elderly?
(Write Respondents comments below. Question is not coded here, but may be included in the analysis.)
老人の日常を助けるために出来ることで、今までに挙がっていない方法はありますか？(回答者は以下に答えを書いてください。質問はここでは限定しませんが、分析の一部として含まれる可能性があります)

Appendix C

A Comparative Study on Elderly Care Practice: Kyoto and Kathmandu
高齢者や介護の状況を比較します:　京都　とカトマンジュ
Set B (セットＢ)

Name: 名前：　　Profession:　職業：
Institution:　所属：

1. In your opinion what are the main issues and problems of the Japanese (also Nepalese) elderly?
Please mention….
日本の高齢者の最も重要な課題・問題と思われるのは何ですか。

2. What do you found the society's views toward the elderly?
高齢者に対する社会の視点はどのようなものだと思われますか？

3. In your opinion, are the current welfare policy and programs sufficient to address the elderly needs?
Please mention….
現在の年金制度は、高齢者の必要に見合っていると思われますか？理由も併せてお答えください。

4. How can the intra family care problem for the elderly be solved? Please mention some measures.....
家族内のケアのみで、どのように高齢者問題を解決することができるでしょうか？

5. In your opinion which place might be the better option for caring the elderly?
a) Family or home　　b) Community home (group home, day care centers etc.)
c) Nursing home　　d) Hospital
e) Others
Please mention some reasons…….
この選択肢のなかで、最も高齢者介護に適しているものと、その理由をお答えください。
a)家族、あるいは家庭内
b)コミュニティーホーム(グループホーム、デイケアセンターなど)
c)老人ホーム
d)病院
e)その他

6. In your opinion community based care practice (group homes, day care centers, short stay, Rogin homes etc.) is more suitable and long-lasting than other types of caring settings?

a) Yes b) No

Please give some reasons.....

地域に基づく介護(グループホーム、デイケアセンター、ショートステイ、老人ホームなど)は、他の介護方法と比べて、もっとも適した長期的な介護方法だと思われますか？

a)はい b)いいえ

理由も併せてお答えください。

7. In your opinion, who should be more responsible for caring the elderly?

a) Elderly themselves b) Family

c) Society d) Local and central government

この中で誰が最も高齢者介護に関して責任を持つべきだと思いますか？

a)高齢者自身 b)家族

c)社会 d)政府と、地域行政

8. What do you think about the long term care for the dependent elderly?

a) It should be done at home by family members (informal)

b) It should be done at home supported by the Government (formal)

c) It should be done in community (mix of formal and informal)

d) It should be done in any institutional settings such as Hospital, Nursing homes etc.

e) It should be done in home and in communities (supported by the private sectors/ NGOs/Voluntary organizations etc.)

(Please mention also your opinion)

長期的に介護しないといけない環境にある高齢者に対して、最も当てはまると思うのは次のうちどれですか。理由も併せてお答えください。

a) 家族がするべきである(私的)

b)政府がするべきである(公的)

c) 地域がするべきである(私的と公的のミックス)

d)組織や団体がするべきである(病院や、介護施設など)

e)家庭と地域でするべきである。(民間セクターやNGO、ボランティア団体のサポートも含む)

9. How to empower and activate to the elderly people in their later life? Please mention some suggestions.....

どのようにしたら、高齢者の晩年を力づけて活動的にできると思われますか？

10. Could you mention some strong and weak points of the current elderly related policies and programs of Japan? (Such as Long-Term Care Insurance System, the New Gold Plan etc.).

今現在の日本における、高齢者介護に関する政策の良い点と悪い点を述べてください(例として、長期的介護保険、ニューゴールドプランなど)

For Nepal: Could you mention some strong and weak points of the current elderly related policies and programs including Senior Citizen National Work Plan?

11. Do you feel that mixed care model (family, community and the state) might be more effective for well-being of the elderly?
あなたは、高齢者の幸福の為には、混合介護モデル(家族、地域、政府)が効果的だと思われますか？

Thank you very much for your cooperation!

ご協力頂き、ありがとうございました。