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Better Solutions: A Comparative Analysis of Long-Term Care Home Policies in Canada, China and Japan

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Abstract

Failures of long-term care (LTC) policies caused undesirable negative outcomes for Canadian long term care residents during the COVID-19 pandemic. The purpose of this study was to explore similarities and differences in LTC policies between Ontario (Canada, Ontario), China, and Japan and identify potentially beneficial ideas for policy improvement in all countries. An adapted framework for comparing health care systems guided data collection. Information about four major policy areas: regulation, service provision, PSW workforce and financial policies was extracted from LTC policy documents, government reports and research articles. Data was described and compared for similarities and differences. Findings show that LTC policies reflect distinct cultural contexts and core principles of policy making. Ontario focuses on patient-centered care, China aims to ensure the basic LTC services, and Japan aspires to keep older adults living independently. Knowledge gained from this comparative analysis may contribute to improvement of LTC home systems everywhere.

Keywords

Older adults, long-term care, long-term care home, nursing home, health policy, service provision, personal support worker, workforce, financial policy, financial support, funding, comparative analysis, comparison, descriptive, Canada, Ontario, China, Japan.

Summary for Lay Audience

Weaknesses in long-term care policies and poor response to unexpected events may cause serious negative consequences for older people living in long-term care homes. Problems COVID-19 caused in Canadian long-term care homes provide a good example. However, other countries, such as China and Japan had different, more positive, experiences during the pandemic. The purpose of this study was to describe long-term care policies in Ontario (Canada), China, and Japan, compare the similarities and differences in regulations, how service is provided, rules that govern personal support workers, and financial policies. The goal was to identify ideas and lessons worth learning from each other to improve quality of long-term care provision. To guide data collection, the author used an adapted version of a framework for comparing health care systems. Data from LTC policy documents, government reports and research articles were extracted in a table and compared for similarities and differences. Results show that all three countries have numerous policies that govern provision of services, have similar challenges with regulating and educating personal supported workers, and provide subsidies to both residents and long-term care homes. The study also revealed differences in details of the long-term care policies related to cultural contexts and core principles guiding each country's philosophy of care. The Ontario (Canada) policies aim to provide patient-centered care, the Chinese policies are guided by the need to develop as many long-term care homes as possible for rapidly growing population of older adults, and the Japanese policies are trying to keep older adults living independently for as long as possible. The study revealed valuable lessons worth learning from each country.

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List of Abbreviations

CAD	Canadian Dollar
CIHI	Canadian Institute for Health Information
HQO	Health Quality Ontario
LTC	Long-Term Care
LTCHA	Long-Term Care Home Act
MHLW	Ministry of Health Labour and Welfare of Japan
MOHLTC	Ministry of Health and Long-Term Care
NBS	National Bereau of Statistic of China
OCHU	Ontario Council of Hospital Union
OLTCA	Ontario Long-Term Care Association
OPSWA	Ontario Personal Support Worker Association
PSW	Personal Support Worker
RNAO	Registered Nurses' Accociation of Ontario
RSC	Royal Society of Canada
UN	United Nation
WHO	World Health Organization

1 Introduction and Literature Review

People around the world are living longer (United Nations, 2015) and require more support and care as they approach the end of life. In 2019, the Department of Economic and Social Affairs of the United Nation reported in the *2019 Revision of World Population Prospects* that there were 703 million people over the age of 65 worldwide and this number is expected to double to 1.5 billion by 2050. This means that the proportion of older adults in the world population will reach 22%, increasing from 12% in 2015. Depending on the income level of the country, between 5% and 50% of older adults require assistance with activities of daily living and some of them need to move into long-term care (LTC) homes (UN, 2015).

In this study, we focus on three examples of provision of LTC from around the world, namely the Canadian province of Ontario, China and Japan. Canada's total population is 38 million, and 0.7% or around 254,000 residents live in LTC homes (Statistic Canada, 2017). Whereas in Ontario, at the time of writing this thesis, 77,536 individuals were living in LTC homes, and there were 35,308 on the waiting list (Ontario Long-Term Care Association [OLTCA], 2021). In China, 0.2% or 2.8 million of the total 1.4 billion population live in LTC homes (Ministry of Civil Affairs, 2019), while in Japan, the total population is 126 million and 0.8% or 970,000 were expected to live in LTC homes in 2019 (Ministry of Health, Labor and Welfare of Japan, 2019; Statistics Bureau of Japan, 2020). In all three countries, these numbers are rising at an unprecedented pace. The Conference Board of Canada reported in 2016 that Canadian LTC homes had 263,000 beds, but Canada will need another 239,000 beds by 2035 (Conference Board of Canada, 2017). At the highest end of this spectrum, the Ministry of Civil Affair (2019) in China estimated will need 35.2 million LTC beds in 2030. The Ministry of Health, Labor and Welfare in Japan (2019) reported the number of residents in LTC homes increased from 0.94 million in 2017 to 1.05 million in 2020 and is expected to increase to 1.21 million in 2025.

Before we start to discuss LTC, it is necessary to explain the major differences in types of residence facilities available to older adults in the three countries. In Ontario

(Canada), there are two types of residential facilities that provide care: long-term care homes, retirement homes (Government of Ontario, 2021b). Both provide general services, such as assistance with activities of daily living and meal service, but the major difference is the level of care required needed by the resident and the source of funding. All LTC homes in Ontario are recieving funding for personal and nursing care from the provincial government, which requires elaborate eligibility assessment before admission. Only people with very high care needs are admitted into a LTC home. On the other hand, provincial government does not provide any funding for retirement homes, and all charges are paid by the resident or their family (Government of Ontario, 2021c). China has a different system where the most cases that all charges for the long-term care are paid individually by the resident or family members (Ma, 2019). Japan, on the other hand, offers multiple types of residence facilities for older adults such as LTC homes, retirement homes, and short-stay rehabilitation facilities (介護老人保健施設). Similar to Canada, the difference between LTC homes and other types of residence facilities is the level of care needed by the resident. Only those with higher level of care are permitted to live in the Japanese LTC homes and use the long-term care insurance to pay for their care service (Ministry of Health, Labour and Welfare of Japan [MHLW], 2016).

On January 30, 2020 the World Health Organization declared the outbreak of the pandemic of COVID-19. At the time of writing this thesis (December 13, 2021), the Canadian province of Ontario had 527 outbreaks, 23,119 confirmed cases of COVID-19 and 3,829 COVID-19 related deaths in 627 LTC homes with 78,247 beds (Government of Ontario, 2021a). About 38.1% of all COVID-19 death cases in Ontario occurred in the LTC home (Public Health Ontario, 2021). In April 2020, as a result of the multiple outbreaks, the Ministry of Health and Long-Term Care has published an interim guidance to prevent COVID-19 infections in LTC homes in April 2020, and the document was further revised in July of 2021. The guidance standardized infection control measures in resident care, outbreak management, visitor control, and process of the visit. In the first wave of COVID-19 (spring 2020), these measures produced some improvement. The number of confirmed cases showed a downtrend from 296 new confirmed cases on April 11th 2020, to 92 new confirmed cases on May 16th 2020 (Public Health Ontario, 2021). Nevertheless, many scholars were sounding the alarm to long standing issues plaguing

LTC provision and calling for substantial policy change for the LTC sector (Gardner et al., 2020; Béland & Marier, 2020; Feder, 2020).

The report *Pandemic Experience in the Long-Term Care Sector How Does Canada Compare With Other Countries?* published by the Canadian Institute for Health Information (CIHI) (2020) described the severity of situation in Canadian LTC homes. The report indicated that Organisation for Economic Co-operation and Development (OECD) countries that swiftly implemented mandatory policies for LTC homes had significantly less infections and deaths (e.g., Australia). Unfortunately, Canada's LTC industry did not respond to the pandemic quickly enough, which in early months of pandemic resulted in over 80% of the total COVID-19 deaths in Canada being in LTC homes. Another policy brief published by the Royal Society of Canada (2020) agreed with the CIHI findings, and pointed out several risk factors that caused outbreaks of COVID-19 in the LTC homes. The Royal Society of Canada pointed out the lack of an adequate level of workforce in LTC homes as one of the risk factors (Royal Society of Canada, 2020). Authors report that more than 30% of PSWs and other staff, such as part-time nurses, had more than one job and worked in several locations, which increased the spread of the disease (Royal Society of Canada, 2020). Also, lack of staff and management education and training on how to prevent and control the pandemic contributed to the situation (Royal Society of Canada, 2020). Besides, the Royal Society of Canada believed that low job autonomy of an unregulated workforce (e.g., PSW) that provides nearly 90% of care could be a risk factor (Royal Society of Canada, 2020). additionaly, the RSC pointed out that the physical design of LTC homes in Canada was not a good fit for infection control (Royal Society of Canada, 2020). The society proposed seven recommendations to better manage COVID-19 in LTC homes: a) have LTC home prepare pre-arranged plan for pandemic like COVID-19; b) perform regular in-person inspection to ensure the plans are being ready; c) the government must assure protective equipment is available in case of a pandemic; d) give LTC workers stable and full-time working contract with benefits; e) implement working on one site policy, to prevent workers from working on multiple sites and spreading the disease; f) encourage LTC homes to develop capability of isolation; and g) prepare alternative ways of connection for residents and their families (Royal Society of Canada, 2020). Lastly, the

society pointed out “A high-quality, resilient and supported workforce is, without doubt, the major component of quality.” (Royal Society of Canada, 2020, p.28). Collectively, these reports indicate the necessity for a major policy overhaul in Ontario’s (Canada) LTC sector.

As the ground zero of the pandemic, China reported only one confirmed LTC home outbreak outside the province of Wuhan (Government of Baotou, 2020). The author failed to locate government published COVID-19 related data for LTC homes in Wuhan. However, Liu and colleagues (2021) reported that during January to May of 2020, the mortality rate of pneumonia (“mostly related to COVID-19” [Liu et al., 2021, p.7]) in the population aged over 70 was 6,450 per 100,000 population in Wuhan, which was higher than other regions and previous years. On the other hand, researchers concluded that during the pandemic, there was no major change regarding mortality rate caused by pneumonia outside of Wuhan (Liu et al., 2021). Even though reports on the Chinese government websites are uncommon, one arcticle published on the *Clinical Infectious Disease* on April 8th of 2021 by Zhang et al. (2021) chronicled 3,729 COVID-19 deaths in people over the age of 60, among which 1,016 cases were in people over the age of 80. At a press conference held on November 20th of 2021, the state council of China concluded that the current epidemic prevention work is progressing in an orderly manner, and the epidemic is under control (State Council of China, 2021). Chinese government declared this success that can be attributed to the swift national lock-down of all LTC homes in late January 2020, and early effective implementation of new COVID-19 prevention policies. These prevention measures included: visitor restrictions, arranging for staff to live in the LTC home, two weeks quarantine for all staff returning after travel for Chinese New Year, and complete home disinfection. An example from Qingdao city is provided here to help explain how the spread of COVID-19 was controlled in China. After six new cases were confirmed in Qingdao on October 12 in 2020, the Qingdao government completed COVID-19 testing of every single person in the city of 11 million within five days (testing was finished on Oct. 16) (Xinhua News Agency, 2020).

Though the government of Japan did not report the number of COVID-19 related deaths in LTC homes, (Abe & Ide, 2021, February), on October 5th of 2021, they reported

16,677 COVID-19 related deaths in people over the age 60, among which 10,251 were people over the age of 80 (MHLW, 2021). Interestingly, while Ontario government first announced outbreak guidance for LTC homes in mid-April of 2020, Japanese Ministry of Health, Labor and Welfare published their first COVID-19 guidance for social welfare facilities two months earlier (February 14, 2020) and added another 120 resources (such as standardized measures for disinfection and residents screening) in next six months (MHLW, 2020).

Described differences in response to and consequences of COVID-19 pandemic were in part driven by differences in the LTC policies (CIHI, 2020). From Canadian perspective, it seems that there are lessons that could be learned from COVID-19 experiences in China and Japan, such as closing LTC homes at the first sign of infectious disease spread and minimizing staff exposure to the virus outside the LTC home. However, one needs to be mindful of tradeoffs between lockdowns and their side effects. For example, Paananen et al. (2021) suggested that social distancing from visitors could could have negative effects on residents' social well-being, while O'Caoimh et al. (2021) reported that visitors also experienced low psychosocial and emotional well-being. One effective way to draw on the experiences of countries that have succeeded in protecting the residents of LTC during the COVID-19 pandemic is through comparative policy analysis. As Geva-May and colleagues (2018) suggest that comparing policies can help save time and resources when challenges need to be addressed in a timely manner.

The comparative policy analysis is a branch in the field of policy analysis, which originated in the United States in the early 1960s. The comparison of public policies is done *"… to be more effective and efficient, avoid the replication of failures, to maximize our use of resources, to save time and to be inspired by those similarities that allow for a degree of lesson drawing."* (Geva-May et al., 2018, p. 23). Indeed, governments around the world do not have the time or resources to solve issues related to population aging on their own. The magnitude and urgency of the COVID-19 consequences powerfully called for new LTC policy strategies not only in Canada, but in other countries with high percentage of deaths in LTC homes, such as USA (41%), Slovenia (81%), Australia (75%) and Spain (63%) (International LTC Policy Network, 2020). The fastest way to

achieve the change may be to learn from experiences of others. However, countries have different cultures, political systems, social and economic status, and contexts of policy implementation that have to be taken into consideration. A well-functioning policy at one place may not have the same efficacy in another province or country if modifications to the regional and local context are omitted. As Geva-May advises *"context and policy transfer, policy borrowing, or lesson drawing can be compatible between social units, while transferring, borrowing or lesson drawing are determined with a view of the country's particular structure, culture and politics"* (2002, p. 251).

Based on Geva-May et al. (2018) interpretation of comparative policy analysis, there are at least four reasons to make the comparisons. The first is access, where physical distance is no more an impedance due the development of information technology and social media. Every success and failure in a policy enactment could be easily observed by others so that their failures and successes can be assessed, adopted, avoided or followed. For the LTC sector in Canada, COVID-19 offered lessons that could be learned from China and Japan to improve infectious disease prevention policy. The second reason for policy comparison is the economic path of dependence or interdependence among national actors. The budget is the fundamental factor that affects the operation and even survival of the public health system. Each LTC home policy is deeply affected by the economic status of a particular government as well as the healthcare market. Third, governments are facing similar national policy problems. A good example is that Canada, China and Japan are all trying to increase the capacity of LTC homes. Fourth, some of the policy problems are cross-national and interrelated. For instance, in order to increase LTC workforce, Japan signed multiple economic partnership agreements with southeast Asia countries, such as Indonesia and the Philippines (Fujino, 2019). Something Canada, a sought after country for immigrants from around the world, could consider.

As long as there are emerging social problems shared by governments or public services around the world, there are lessons to be learned. To date, very few scholars have done comparative policy analysis of LTC policies (Ågotnes et al., 2019; Harrington et al., 2016; Jacobsen et al., 2019), all published prior to COVID-19 era. Harrington and colleagues (2016) compared regulations and policies of LTC home staffing in the United

States, Canada, England, Germany, Norway and Sweden. They concluded that more attention to LTC home staff standards (such as minimum staffing standard) would be necessary to assure the quality of care in nursing homes. Jacobsen et al. (2019) compared job autonomy of LTC assistive personnel and found that job autonomy was interpreted differently in different countries. Ågotnes and colleagues (2019) applied Wendt et al. (2009) framework for comparing health care systems, to compare medical care policy in LTC homes between Norway, the United States, the Canadian provinces of Manitoba and British Columbia (Canada). Ågotnes and colleagues focused on three major policy areas: a) regulation and public policies used to govern LTC homes, b) financing system, and c) service provision. Authors argued that continuity of medical service in LTC homes was greatly affected by the type of service model, one based on more regulation, fee-for-service payment system and open staffing (all willing physician can provide medical care to residents), and the other model based on less regulation, salaried positions and closed staffing (only preselected physicians can provide medical care). Authors suggested that the second model could provide more accessible medical care for LTC residents.

Examples of LTC policies from Canada, China, and Japan were selected as suitable comparators for this study. These countries share commonalities, differences, and unique approaches to population aging. To elaborate on commonalities, all three countries must assure wellbeing for an increasing number of aging citizens through their publicly funded healthcare systems. Also, both private and publicly funded LTC homes play an important role in providing care to residents. As for the differences~~,~~ Canada has the second-largest landmass in the world, but only 38 million inhabitants, and 16.9% of them are seniors, (Statistic Canada, 2020) thus Canada requires health policies that can serve great diversity in urban, rural, and remote areas. Besides, Canada is the only of the three countries with the federal system, where each provincial government in the federation is responsible for creating and implementing their own health policies (including LTC policies). China is the country with the highest population concentration, and the one-child policy will further affect the demographic structure in China (Shen & Wu, 2018). Also, China has a one-party system, where the communist party oversees the country, but the local governments are responsible for creating and implementing policies, including the LTC policy. Japan is unique in its own way. Based on OECD's (2020) definitions, a

society where 15-20% of the total population are individuals over the age of 65 qualifies as an aged society, while a society where over 21% of population is over the age of 65 qualifies as a super-aged society. Japan was declared by the UN to be the first super-aged society on the planet, with 28.2% or nearly 35,500,000 Japanese over the age of 65 (UN, 2019). This compels Japanese government to formulate and deliver LTC solutions earlier than other aging societies, which can provide examples and guidance for other countries. The country's mandatory LTC insurance, established in 1997 and came into force in 2000, is one example of how Japan is coping with ever increasing needs for LTC service. Another factor guiding selection of the three countries is author's familiarity with living in each country for more than a year and good command of all three languages.

Due to differences in government systems and levels of government at which health policy is created and enacted, three regions are selected as representatives of each country. They are the province of Ontario in Canada, Hangzhou – the capital city of Zhejiang Province in China, and Tokyo - the capital city of Japan. Canada has a federalist system where healthcare policies are largely made and implemented at the provincial level (Government of Canada, 2016). Under the Canada Health Act (1985), the federal government is responsible to provide funding after the provincial government sets up health insurance that meets the conditions of portability, accessibility, universality, comprehensiveness, and public administration. Ontario is Canada's most populous province (14.8 million) and has the highest gross domestic product (GDP) of $ 851 billion CAD (Ministry of Finance of Ontario, 2021). Hence, the focus on LTC home policy in Ontario has the potential for great impact. In China, the local government is responsible for creating policies based on macro plans developed by the State Council or provincial government (Peter & Zhao, 2017). Therefore, in parallel to paying attention to overarching policies developed by the central (national) government, focusing on the county level would provide the most useful information. Hangzhou, the capital city of Zhejiang Province in China is chosen because it shares comparable population (10.4 million), and a smaller but substantial GDP (approximately 300.6 billion CAD) (Hangzhou Municipal Government, 2019). In Japan, the central government is responsible for creating health policies. However, based on the Local Autonomy Act (1947), without offending laws developed by the central government, the local

government has the right to create policies or rules that apply only to their region. Tokyo is chosen to be the representative of Japan as it is the capital city with 14 million people and a GDP of approximately 1.4 trillion CAD (Tokyo Metropolitan Government, 2019).

In summary, COVID-19 caused irreparable harm to the care-dependent residents of the LTC homes in Canadian province of Ontario. What was supposed to be a safe harbor for the most vulnerable segment of the population failed inconsolably. Much evidence has shown failures of current policies, negligence and inability of the government to quickly improve the current system. Although there is rising consensus that the system has to improve, the solutions are still unclear, and lessons from other countries unheeded. Now is the time to seize the opportunity to improve the LTC system by learning from within and from others.

The aim of this thesis is to provide a comprehensive comparative analysis of pre-COVID-19 LTC home policies in Ontario (Canada), China, and Japan. Knowledge gained from this comparative analysis may contribute to improvement of LTC home systems everywhere. The study used document analysis to comparatively analyze the policies that regulate long-term care (LTC) in three countries. More specifically, the thesis focused on three specific policy areas: service provision, personal support worker (PSW) workforce, and financial policies. The introduction and literature review describe the topic, problem and gap that support the argument that comparative policy analysis would be helpful. The second chapter describes the method of how research was completed with sufficient detal that allows repliction. The findings first describe specificts of LTC policies in each country and then comparatively summarize similarities and difference in three policy areas. The discussion chapter contextualizes the findings, reports future implications, and describes study limitations. The conclusion answers the research question and summarizes lessons learned.

1.1 Literature Review

The literature review was conducted following the framework proposed by Arksey and O'Malley (2005). Scholarly articles and grey literature published between January 2015 and March 2021 were identified in six databases, four in English (CINAHL, Scopus,

ProQuest and PubMed), one in Chinese (CNKI) and one in Japanese (CiNii), using MeSH terms for older adults, long-term care and health policy. Grey literature was searched using the search engine Google. Three common themes of challenges emerged: service provision, PSWs, and financial policies.

1.1.1 Service Provision

Service provision describes various activities that aim to "improve health outcomes in the population and to respond to people's expectation" (Adams et al., 2003). Services can include skilled nursing, personal care assistance, eating, transportation, meal service, palliative care and provision of medical equipment such as wheelchairs and oxygen. Service provision is a core policy area of LTC and was frequently discussed by scholars in all three countries. Three sub-themes emerged from the analysis of lilterature on this theme: types of LTC homes (public versus private), quality measurements and medical services.

1.1.1.1 LTC Home Type

To provide enough beds for older adults requiring high levels of care, private LTC homes were allowed and play an important role in Ontario (Canada), China and Japan. In Ontario, the OLTCA (2019) reported 627 licensed LTC homes, 58% of which were privately owned and operated. In 2019, the Ministry of Civil Affairs in China reported that there were 28,671 LTC homes, among which 14,109 were private not-for-profit, 831 were private for-profit, and rest are public funded homes. In Japan, a report published by the Ministry of Health, Welfare and Labor in 2015, estimated that there were 10,627 private and 8,974 publically funded LTC homes. In summary, privately funded LTC homes provide over 50% capacity of long-term care in each country.

However, research shows that the quality of care provided in privately owned homes is not always satisfactory (Ma et al., 2017). For example, Daly (2015) examined the private LTC home policy shift in Ontario, and suggested that private LTC homes, on average, provide lower-quality care than not-for-profit homes. A similar outcome was reported in China where the quality of private LTC also tended to be unsatisfactory as public for-profit home provide less and unstabled service. (Wang, 2015). Ma and his

colleagues (2017) investigated the differences in operations between private and public LTC homes in Beijing. They reported that the reason why publically funded homes had higher bed occupancy was access to better equipment, better service quality and lower price. The bed occupancy rate was positively associated with quality indicators such as staff-patient ratio, whether or not a home provides medical service, and completeness of equipment. Scholars in China have tried to find an explanation for such quality polarization. The overwhelming factor was the development speed of private LTC homes, and the over-focus on market-based earnings (Li, 2017; Matsuda, 2020). From the policy perspective, Zhao (2019) informed that the governments' lack of responsibility for the LTC sector, the lack of maneuverability, and allowance of maldevelopment in the private LTC industry, are some downfalls of the private LTC sector in China. Yang et al. (2021) stated that private LTC home in Japan also tended to have worse quality than the public home. In conclusion, the quality of private homes tends to be inferior to publically funded home in Ontario, China, and Japan. But in all regions, situation is changing as the policy is being modified.

1.1.1.2 Quality Measurement

The quality of care in LTC homes is measured in each country, but the systems used are different and all seem to have imperfections. For example, the Resident Assessment Instrument - Minimum Data Set version 2.0 (RAI-MDS 2.0), is a tool which collect data and allows analysis of quality indicators for LTC homes across Ontario, but it was criticized as decontextualized by Armstrong and colleagues (2016). They claim that although the RAI-MDS 2.0 is a necessary tool for assessing the residents and the quality of the care provided in LTC homes, it misses important information such as the residents' autonomy and satisfaction. The authors believed that the Canadian Institute for Health Information (CIHI) was wrong in not putting indicators on social engagement into the LTC indicators. In China, Shum et al. (2015) called for development of a new quality assurance system for LTC homes that would include outcomes for residents. Du and colleagues (2019) endorsed this opinion by developing a service quality evaluation index in which the outcome of the service (e.g., how residents experienced the service) accounted for the majority of the quality indicators.

In Japan, the Japanese National Council of Social Welfare (2019) reported that only 6.3% of all publically-funded nursing homes voluntarily accepted to be assessed. In Tokyo, only 32 private nursing homes voluntarily accepted the assessment (Ministry of Internal Affairs and Communications of Japan, 2016). The Ministry (2016) identified several reasons for such a low acceptance rate, which included: a) the high cost for limited merit, b) un-standardized process, c) not mandatory; d) questionable fairness, and e) no necessity to be assessed. Overall, it seems that Ontario and China, use resident-centered assessment tools that some scholars perceive as outdated **(**Armstrong et al., 2016; Du et al., 2019), while Japan has a voluntary system of home assessments that has limited impact on quality improvements. Scholars agree that better reporting of quality measurements has the potential to improve public confidence in trusting that thir loved ones will be well taken care of in the LTC homes. The results of quality evaluations in each country will be discussed later in the thesis.

1.1.1.3 Medical Service

The regulation of provision of medical services to residents in LTC homes vary between the three countries. The Long-Term Care Home Act (LTCHA) (2007) in Ontario requires the existence of an organized program of medical services in each home, where every resident must have access to the medical services 24 hours a day. China is the only country that does not regulate the provision of medical services to residents of LTC homes (State Council of China, 2019). In Japan, both private and public LTC homes are required to have a clinic and the necessary medical equipment on site, and have express access to the hospital in the area (MHLW, 2018a, 2018b). The analysis of literature demonstrated that access to medical services is one of the most important factors affecting people's selection of a LTC home. This subtheme was consistent across the studies from Ontario (Carter et al., 2016; Sullivan-Taylor et al., 2018), China (Shen & Bao, 2015; Ma et al., 2016; Si et al., 2019) and Japan (Sawamura et al., 2015; Gao & Nakayama, 2015). Participants in the Ontario study by Carter et al. (2016) expressed high satisfaction with nurse practitioners (NP) in their LTC homes as NPs provided urgent and accessible medical service at the lower cost than physicians. Sullivan-Taylor et al. (2018) reported poor care and treatment to be

the number one complaint received by the LTC homes. Similarly, in China, the LTC homes with higher nurse-to-resident ratio and a doctor attendance had a higher rate of bed occupancy, which shows that availability of medical service is essential for Chinese LTC home residents (Ma et al., 2016). For example, a survey conducted by Si and colleagues (2019), found that the medical services available on the site were the most desired aspect of a LTC home. Wealthy older adults preferred LTC homes with medical service and did not mind paying for it (Si et al., 2019). Another survey of 331 seniors from LTC homes in Shanghai, revealed that a large portion of residents had issues accessing medical treatment while living in LTC homes (Shen & Bao, 2015). Sawamura and his team (2015) also reported that for Japanese seniors the choice of LTC home was highly influenced by the necessity of relocation associated with medical deterioration. In summary, provision of medical services on-sight is desirable by residents of LTC homes in all included countries.

1.1.2 PSW workforce

The second theme that emerged from literature review were issues related to PSW workforce. Scholarly work mainly discussed two formal caregiver roles in LTC: registered nurses (RN) and PSWs. While nursing staff and provision of nursing care are higly regulated in all three countries, there are many issues plaguing unregulated and frequently underappreciated PSW workforce which is, in fact, dominant hands-on front line of provision of direct daily care to residents of LTC homes. Hence, in this study, the focus is on policies related to the PSW workforce. Three sub-themes emerged form the analysis of lilterature on this theme: systematic challenge (e.g., staff shortage), education and regulation challenges, and occupational challenge.

1.1.2.1 Systematic Challenge

Caregiver staff shortage have become a major challenge in all three countries. The UniFor (the largest private general union in Canada) (2019) reported that “in virtually every long-term care home, on virtually every shift, long-term care homes are working short-staffed” (UniFor, 2019, p.2). LTC homes in Ontario experience staff shortage of five to ten PSWs in a twenty-four-hour shift due to the low wage and heavy workload (UniFor, 2019). Staff shortages have been linked to the lower quality of care and

increased stress for care providers (UniFor, 2019). In 2019, the Ontario Long Term Care Association (OLTCA) 2019 budget stated that the LTC homes in Ontario do not have enough staff to provide sufficient care to the residents. The report also indicated that 80% of LTC homes reported having difficulty filling the shifts with staff. Shortage of nurses is also an issue that cannot be ignored. The Registered Nurses' Association of Ontario (RNAO, 2015) called for an increase in nursing workforce in the LTC sector in rural Ontario. Furthermore, a joint report published by the RNAO, and the Ontario Nurse Associations (2018) indicated that Ontario's registered nurse-patient ratio has become lower since 2009, and Ontario's ratio is much lower than the rest of Canada. By 2016, there were only 703 registered nurses per 100,000 people. Similarly, China is also facing LTC homes staff shortages. China Philanthropy Research Institute (2017) suggested that only half-a-million caregivers were working in the LTC field, while they estimated that China would need 13 million caregivers to fulfil the needs of frail elders. Situation in Japan is much better, nonetheless Japan's Ministry of Health, Labor and Welfare (2015) reported the needed for additional 0.38 million formal caregivers to fulfil their estimates for demand for formal caregivers to be 2.53 million.

Many systemic factors have contributed to staff shortages. One of them was difficulty recruiting new LTC staff members. According to the OLTCA report (2019) 90% of Ontario LTC homes had challenges hiring new staff. Sources from China indicated that the average age of caregivers, most of them PSWs, was between 50 and 60 years old (Jiang et al., 2019). To deal with this problem, Japan had to recruit immigrant workers from South Asia, such as Vietnam and Indonesia, to work as caregivers in LTC sector (Fujino, 2019). The RNAO in Ontario reported barriers impacting the high turnover rate and poor recruitment of new nurses. They included: working environment, heavy workload, poor career advancement opportunities, nursing leadership, and spousal employment. Some of these barriers were echoed in research from China and Japan. They were further discussed in the occupational challenges sub-theme below. Other systemic challenges that contribute to the staff shortage include over-marketization of LTC homes and unprecedented increase in number of care-dependent older adults (OLTCA, 2019; Matsuda, 2020).

Besides the recruitment, inadequate funding for LTC homes and insufficient support for caregivers were identified as reasons for staff shortages. Several reports from multiple associations in Ontario have called for increase in funding for the LTC homes to solve the staff shortages even before COVID pandemic (OLTCA, 2019; RNAO, 2015). A year after the LTC system failed in first months of the pandemic, the RNAO (2020) compiled 35 pre-pandemic reports, inquiries and inquests published between 1999 and 2019 that related the staffing to the funding model. Recommendations for increases in funding and calls to create alternative funding models were prominent in each report. The RNAO criticized the Ontario government for a failure to take meaningful action regarding the recommendations provided over the past 20 years. On the other hand, the policy brief by Dr. Janet Beed (2018) to the Ontario Ministry of Health and Long Term Care, suggested that the government has not provided enough support to the caregivers in Ontario. She indicated that the government did not provide caregivers enough information about accessing help, and there were gaps between LHIN and caregiver services. She also believed that there were not enough education and awareness programs established by the government. Similarly, but for different reasons, the Chinese government was criticized for creating support policies for formal caregivers focused only on improving their skills, such as free training programs, while neglecting caregivers' economic rights (Peng et al., 2017). Peng and colleagues argued that the government should implement incentive policies to ensure the retention of the caregiver workforce and hire of new caregivers.

1.1.2.2 Education and Regulation Challenge

Education and regulation challenges was another sub-theme that was frequently explored by researchers from the three countries. In Ontario (Canada), under the *Regulated Health Professions Act* (1991), each regulated health profession is required to have their own health regulatory colleges – agencies that are responsible for regulating the practice of professions and governing their members. Unlike nurses and physicians that are self-regulated or regulated by the government in all three countries, PSWs are not fully regulated (Ministry of Civil Affairs, 2009; MHLW, 2018a, 2018b; LTCHA, 2007).

In Ontario (Canada), the self-regulation of PSW workforce was considered in 2006, but it was denied because of the unclear scope of practice, non-standardized knowledge, lack of consensus among key stakeholders, and cost for retraining and administration (Kelly & Bourgeault, 2015). Though the PSW registry system was established in 2015, it only collected basic information on education, background, and employment history. It was critiqued for only being beneficial for the employer rather than for the PSWs (Kelly & Bourgeault, 2015). The lack of education and regulation standards also caused an absence of recognition and a lack of authority for PSWs in the process of care decision-making, especially in cases when PSWs were required to perform activities previously performed by regulated professionals, such as providing support with hearing aids or perform visual assistance (Afzal et al., 2018). Nonetheless, as an unregulated profession, becoming a caregiver had its advantages. As reported by Kelly (2017), people pursuing a PSW career wanted it because it was a short time commitment and the demand for the job was growing. The Ontario Personal Support Workers Association (OPSWA, 2019) report outlined benefits that the PSWs can gain from being self-regulated, which included: a) increasing the recognition of PSW as a career as well as the knowledge and skills, b) PSWs can investigate any complaints from the public as an association and use their own disciplinary actions to solve the issues, c) PSWs can internalize their values and standards, d) self-regulation is also a favourable factor to the province's financial infrastructure, and e) self-regulation will strengthen the credibility of PSWs. However, the OPSWA admitted barriers to being self-regulated, which included the willingness to be regulated and a need that PSWs advocate for legislative changes.

In contrast to Ontario, where the PSWs are trying to be self-regulated, the Chinese government chose a different pathway. PSWs in China tend to be older, lower educated, and less paid. A study by Jiang et al. (2019) suggested the PSWs were in a critical situation in China, where the average age for PSWs was 55 years, and only 11.3 % had high school or post-high school education. This suggests that regulating the PSWs in China is highly unlikely under the current circumstances (Wu, 2019). Although China did not have a standardized education and regulation system, historically PSWs tended to be certified and divided into five levels, from primary

level to senior level (Ministry of Civil Affairs, 2009). However, this certification system was canceled in 2017 to lower the education requirements and encourage employment in the LTC sector (Ministry of Human Resources and Social Security, 2017). Wu (2019) added that this new policy encouraged the caregivers to put more attention on caring, it stimulated marketization and lowered the administrative cost. Wu also suggested that canceling caregiver certification could cause an unstable workforce and a decrease in professionalism. An earlier study by Wu et al. (2017) argued that caregivers in China did not have a sufficient education and the government had already implemented incentive policies, such as financial aid to support caregivers.

PSWs in Japan are not required to have certification before entering the work field, however, the Japanese government requires them to have a certain amount of practice time in fieldwork before receiving full certification (Ministry of Health, Labor and Welfare, 2018a). Even though the education requirements to become a certified PSW increased from 1500 hours to 1850 hours in 2009, Aoki (2016) identified that the Japanese government needed to better clarify the role of the PSW in local municipal policies. Meanwhile, Japan dealt with a unique challenge of recruiting immigrant PSW workforce. Japan signed the Economic Partnership Agreement with countries of Southeast Asia which allows LTC homes to recruit foreign PSWs. Under this circumstance, acquiring the Japanese language skills to be able to work in LTC homes became very challenging for foreign caregivers (Fujino, 2019; Suzuki, 2017). In the study conducted by Suzuki (2017), 10 foreign caregivers participated in the focus group discussion and reported that none of them were fluent enough to communicate in Japanese and that the language training was completely missing.

1.1.2.3 Occupational Challenge

Besides systemic shortcomings in education and regulation, many scholars and associations explored challenges experienced by individuals who chose the formal caregiving as their occupation. This sub-theme summarizes five challenges identified in literature: emotional burden, low job autonomy, heavy workload, low income and unstable contract. Most were identified as reasons for staff shortage and barriers for recruiting new staff (RNAO, 2015; OLTCA 2019; UniFor, 2019; OPSWA, 2017).

This review of literature identified perceived emotional burden as a major challenge associated with formal caregiving. This finding was consistent for Ontario (Marcella & Kelley, 2015; Banerjee et al., 2015; Brassolotto et al., 2017) and Japan (Kim et al., 2018; Matsuda, 2020; Inoue, 2020; Aoki et al., 2019). A major factor that caused mental distress was the loss of residents. To understand staff's feelings of grief, bereavement, and to identify their needs, a study in Ontario (Marcella and Kelley, 2015) examined how caregivers perceived loss of residents. The results suggested that the participants' experiences were complicated and shaped by the emotional impact of each loss. The feelings of grief were cumulative and ongoing. Participants reported that death was a hidden topic in LTC culture, and the home administrations did not provide enough mental support or education on grief and bereavement. Inoue (2020) resonated with these findings while investigating reasons behind the high turnover among Japanese formal caregivers. Using a grounded theory method, he interviewed ten participants who worked as caregivers in a LTC home. He found that depression was the major reason for the participants to consider quitting their jobs. The depression was caused by the loss of residents, the gap between reality and knowledge, and by power harassment. According to the OLTCA (2019), caregivers in LTC homes in Ontario have been scrutinized by the public through the media. Furthermore, they also bear the impact of new legislation and punitive policies from the government. The OPSWA (2017) report stated that PSWs in Ontario were feeling emotionally drained and were experiencing high levels of stress which caused increased risk of injury in their daily work.

Low job autonomy was another challenge for the caregivers working in the LTC homes (Daly et al., 2015; Brassolotto et al., 2017; Jacobsen et al., 2018; Kim et al., 2018; Inoue, 2020; Yamamoto-Mitani et al., 2018; Fujino, 2019). This topic was noted in multiple research papers from Ontario and Japan. Banerjee and his colleagues' (2015) study attempted to determine the reasons behind the insufficiency of stuff in LTC homes in Ontario. Participants included frontline care workers, licensed practical nurses and registered nurses who participated in a survey. The authors reported four major themes related to caregiver's job autonomy: a) LTC homes were taking routinized, task-based approaches to care, which the caregivers termed "assembly line care"; b) insufficient

time and heavy workloads made it impossible for caregivers to provide "relational care" or "to treat people as human beings" as caregivers' worded it. This meant that it was hard to address residents' emotional, social, existential, and spiritual needs; c) accountability caused an avalanche of documentation that took time away from providing care; and d) systematic exclusion was an organizational barrier for frontline PSWs, preventing them from contributing to the care plan, which they referred to as "care workers do not have a voice" (Banerjee et al., 2015, p. 28). Jacobsen and colleagues (2018) drew similar conclusions. Their study compared job autonomy of long-term residential care assistive personnel in Canada, Germany, Norway, Sweden, England and the United States. The authors reported that care workers in Canada had considerably more limited job autonomy by being counteracted by superiors. Japanese scholars resonated with these findings. Kim and colleagues (2018) argued that the lack of job autonomy was negatively associated with caregivers' willingness to continue their careers. Low job autonomy was also linked to unclear identity and duty (Daly et al., 2015), which may lead to a conflict between well-being of the staff and well-being of the client (Yamamoto-Mitani et al., 2018).

The caregivers in LTC homes experience heavy workloads (Banerjee et al., 2015; Jiang at el., 2019; Matsuda, 2020). In Ontario, 59% of frontline caregivers expressed concern about their heavy workloads. Many caregivers reported that rather than providing care, they spent excessive amount of time completing paperwork (Banerjee et al., 2015; UniFor, 2019). Reports from both OPSWA (2017) and the UniFor (2019) reported that the PSWs' workload in LTC homes was higher than the comparable jobs, such as waiters or salesmen, which caused the PSWs to leave the job and chose to work in local restaurants or retail shops. According to a study in China, each PSWs took care of 5.6 older adults, and the number increased to 7.8 in areas with less equipment (Jiang et al., 2019). A study in Japan reported that in a LTC home that experienced staff shortages, 29.2% of caregivers left the job due to the heavy workloads (Matsuda, 2020). One interviewee from Yamamoto-Mitani study reported that their workload was so heavy that "keeping residents alive is barely possible" (Yamamoto-Mitani, 2019, p. 4).

Contrary to the heavy workload, the PSW caregivers were not receiving compensation to match their work efforts (Fujino, 2019; Jiang et al., 2019; Matsuda, 2020). The UniFor (2019) reported that the salary for PSWs in Ontario was barely higher than the minimum wage. The MOHLTC (2015, June) increased the minimum wage for PSWs who provide public funded service from $12.5 to $16.5 CAD. The OPSWA (2017) described that many PSWs rarely make more than minimum wage (about $11.4 CAD) and they often worked more than one job and did not receive any benefits such as health insurance or transportation compensations. A study in China reported $615 CAD (3,157 RMB) per month as an average salary for PSWs (Jiang et al., 2019). Matsuda (2020) reported that the average monthly salary for PSWs in Japan was around $2,575 CAD (208,162 JPY), which was much lower than the national average salary of 304,000 JPY per month (around $3,760 CAD). Foreign PSWs in Japan seem to have even lower salaries. Fujino (2019) described one case in which the salary for the foreign PSW was around $1,608 CAD (130,000 JPY).

Finally, unstable contracts were another barrier for caregivers. The OPSWA (2017) reported PSWs' work was often unreliable, hours were inconsistent, and there were many employment formats. Japanese researchers found the same situation. PSWs in Japan were experiencing limited shift hours, high rate of part-time employment and high turnover rate (Fujino, 2019; Enomoto, 2019; Matsuda, 2020). Though none of the included articles focused on PSWs' working shifts in China, unstable employment was reported by Peng et al. (2017). In contrast, a large-scale survey of 1,088 PSWs (Wu, 2019) reported an increase in education level, standardized format of employment and income in China. Wu indicated that the turnover rate was stable, and the job satisfaction rate of PSWs was on the rise. Similarly, Wang et al. (2015) concluded that the job satisfaction rate for nurses was moderate in Shanghai.

1.1.3 Financial Policies

As a power source, the funding of LTC was a popular topic in research discussions in Ontario and China. Due to the nature of the LTC home insurance system in Japan, there were no articles focusing on funding of the Japanese LTC homes that fit the inclusion and exclusion criteria of this review. However, numerous Canadian and

Chinese articles were identified. Ontario had state eligibility and payment policies for nursing homes (Harrington et al., 2016), and the most care cost in LTC homes was publicly funded (Roblin et al., 2019). The Ontario government is responsible to set up a payment rate for all public and private LTC homes. The Ontario government reimburses LTC homes on the *per diem* rate (MOHLTC, 2012). Despite the Ontario government funding of LTC homes, there were still concerns from institutions and associations on insufficient levels of funding. The RNAO (2015, 2020), RNAO & ONA (2018), and the OLTCA (2019) have been calling on the government to increase funding so that the LTC homes can hire more staff. The OLTCA (2019) called the Ministry of Health and LTC to invest and add more beds to existing homes and exempt LTC homes from paying property taxes. A report published by the Ontario government describes the government plan to increase to 15,000 beds in Ontario, and the process would cost the government $2.0 billion CAD over 25 years (Financial Accountability Office of Ontario, 2019).

The Chinese government provided reimbursements for LTC homes, but it barely subsidized individuals. Only ‘three nos’ (no income, no labour capacity, and no relatives) seniors can live in LTC homes for free (Zhao, 2019). The local government was only responsible to set up the payment rate for public LTC homes, while private LTC homes were free to decide their own payment rate (National Development and Reform Commission, 2015). The funding regime in China was critiqued by multiple scholars. One paper suggested that the government was overly-focused on establishing new LTC homes rather than caring for seniors (Ma, 2019). Other critiques include a) the central government did not have a clear direction for creating funding policy for the LTC homes (Shen, 2018); b) the government tended to have unbalanced funding policy overly funding the sectors that did not require it and failed to fund sectors that really need it. An example is sufficient and convenient funding policy for public homes vs. insufficient and complex funding policy for private homes (Ma, 2019; Shen, 2018; Jia & Health, 2016; Song, 2019; Qin, 2020); and finally, c) insufficient funding (Qin, 2020; Song, 2019). Funding is the key to solve challenges described in the service provision and the caregiver workforce sections above.

1.1.4 Summary and Current Gap

Service provision emerged as another essential part of LTC policy worthy of future exploration. Researchers from Ontario and China suggested that private LTC homes have an overall worse rating than the public LTC homes. The bed occupancy rate was positively associated with staff-residents ratio, quality of the care service and the medical service provision. According to the residents, the most important factor when choosing a LTC home is the quality of accessible medical services. Quality indicators are another way to measure the quality of the LTC home. But researchers, and even governments, believe the current quality indicators needed to be improved.

The importance of the caregivers in LTC is undeniable. Although they experienced different challenges in the three countries, they also shared many similarities. The most common issue was staff shortage in LTC homes. Both the government documents and scholarly articles repeatedly identify persistent shortage of staff. There is a common belief, that the role of a caregiver is associated with limited opportunities for career development, low job autonomy, increased chance of developing a mental health problem, low job satisfaction and heavy workloads. These challenges were most commonly reported for caregivers in Ontario and Japan, while the caregivers in China and Japan were noted for their low socioeconomic status. In terms of education and regulation, Japan is the only country that offers certification for aspiring PSWs. Caregivers in Ontario and China that do not offer the same certification for caregivers as Japan, face lower levels of job autonomy, income, and social status.

Other than human resources, funding policy was another challenge in developing a sustainable LTC home system. This literature review identified only the sources from China and Ontario focused on the LTC funding, because Japan has a unique LTC insurance that funded by both government and individuals and specifically used to support populations who require long-term care service. Information for funding LTC home in Japan, is primarily discussed in a macro level (LTC system, LTC insurance). For instance, Shirasawa (2015) pointed out that Japan was facing a shortage of funding for its LTC insurance system. The RNAO also called for solving problems in the funding and staffing of LTC sectors for two decades (RNAO, 2020).

1.1.5 Study Purpose

The literature acknowledged numerous problems in current policies that regulate delivery of LTC, such as staff shortage, lack of service and funding that impact quality of life for LTC residents in the three countries. The review also identified several reports describing what might happen if nothing is done. Failure of the LTC system in Ontario to provide protection and appropriate care in the first year of COVID pandemic is a living example. Although the situation is different in the these countries, there are many similarities in the long-term shortage of personnel, insufficient service quality, and insufficient financial supports that lead to greater personal and social costs, such as access to higher level of medical services in hospitals.

Remaining unanswered question is: What will governments around the world do improve the situation? The answer may be complicated, as creating new or revising old policies could take long time. The COVID-19 pandemic has signaled that we may not have any more time, and should learn from good examples and experiences of others as the way to improve oneself. In words of Myers & Robert (1932) “You must learn from the mistakes of others. You will never live long enough to make them all yourself.” (p. 213). This study offers information to those in power to make a difference on what works well and what does not work so well in LTC policies of the three selected countries.

The research question addressed in this thesis was: What are the similarities and differences of regulation, service provision, PSW workforce, and financial policies in LTC policies between Ontario (Canada), China and Japan? To the author's knowledge, a comparison of this nature have not been done before. Literature review identified only four articles that applied a comparative analysis of elderly residential facilities (Harrington et al., 2016; Jacobsen et al., 2018; Roblin et al., 2019; Kim et al., 2018), where two of them applied comparative policy analysis of LTC homes (Harrington et al., 2016, Roblin et al., 2019). Harrington et al. (2016) compared the government LTC home payment systems, and the LTC home financial reporting and accountability systems between California, England, Norway and Ontario. Authors concluded that all four countries need better reporting transparency on how public resources were spent

and better mechanisms for cost control. Roblin et al. (2019) compared funding and care services policies between LTC homes and retirement homes in Ontario. After analyzing the two Acts (the Long-Term Care Home Act and the Retirement Home Act) and empirical data, such as bed occupancy rate and vacancy rate, they called on the government to fund the retirement homes the same way as the LTC home.

The focus of this study is different. It offers a comparison and deeper understanding of four LTC policy areas, regulation, service provision, PSW workforce, and financial policy, in Ontario (Canada), China and Japan with a goal to identify successes and failures, common problems and potential solutions for policy improvement. To quote Swanson (1971) “Thinking without comparisons is unthinkable. And, in the absence of comparisons, so are all scientific thought and scientific research” (p.145).

2 Methods

The methods chapter, starts with the description of the conceptual framework that was used to guide data collection for the comparative analysis of LTC policies in three countries, followed by description of the search strategies, data sources, data types, and closing with a detailed description of data analysis.

2.1 Conceptual Framework

Five policy analysis frameworks were considered for this study: a) Stages Heuristic Framework (Laswell, 1956), b) Institutional Analysis and Development Framework (Ostrom, 2011), c) Multiple Stream Framework (Kingdon, 1984), d) Punctuated Equilibrium Framework (Baumgartner, 2009), and e) Advocacy Coalition Framework (Sabatier, 1988). These frameworks were used in literature to explain processes of policy making, or changing, under different circumstances. However, in this study, the goal was to compare the content of the LTC home policies, rather than comparing the policy making process. Thus, the framework designed for comparing health care systems, proposed by Wendt and colleagues in 2009, was selected as more suitable. This framework guides comparison and evaluation of different healthcare systems using three distinct policy areas: (a) financing, (b) service provision, and (c) regulation. In this study Wendt et al. (2009) framework was used to guide selection of sources, and extraction of information in systematic and replicable way. Wendt et al. (2009) believed this framework can facilitate the process of identifying individual cases, but can also help scholars to pursue cross-national, and cross-temporal comparisons.

Multiple researchers had adopted Wendt et al. (2009) framework to compare healthcare systems around the world (Ågotnes et al., 2018; Pender et al., 2017). For example, de Carvalho et al. (2020) completed a literature review to examine if the current typologies reflect the particularities of the Global South. The authors identified that most articles that compared the health care systems addressed at least one or more policy areas described in Wendt et al. (2009) framework. de Carvalho et al. (2020) literature review included 42 articles, where 29 focused on the service provision, 29 focused on financing and 28 focused on the regulation. Most authors focused on two or

all of these policy areas (de Carvalhol et al., 2020). The review concluded that the current health care system typologies might not correctly reflect the health care systems in the Global South, but authors admitted that Wendt et al. (2009) framework is an influential example of typologies used in the Global North. Another example is a study by Pender et al. (2017) that compared out-of-pocket payments for health care needs of older adults in their last year of life in 13 European countries. They also used Wendt et al. (2009) framework to identify and categorize financing schemes in health care systems of selected countries. Authors identified differences in the payment systems, and concluded that European countries are facing challenges to make health care affordable for all people in the last year of life.

Closer to the topic of this study, Ågotnes et al. (2018) found that Wendt's et al. framework allows researchers to develop a typology to compare medical care services in selected countries. Their study compared the medical care in LTC homes in Germany, Norway, Manitoba (Canada), British Columbia(Canada) and the United States. The authors adapted Wendt's et al. policy areas of financing, service provision and regulation, into: a) regulation and type of governing, b) financing system, and c) medical practice patterns and models. By modifying policy areas, they successfully compared levels of governance, types of regulations, coverage of regulations, types of medical care providers, and staffing models, among other policy areas. The Wendt et al. framework provides the first step in distinguishing the key features of healthcare system (e.g., financing, regulation, and health service provision) and was successfully used to systematically guide data collection in comparative policy analysis studies. In this thesis, data related to regulation, service provision and financing were collected according to the framework, and data on the PSW workforce was added due to major policy failures specific for this particular LTC policy area during COVID-19 pandemic.

2.2 Data Collection

Data were collected from official government documents, laws, acts, regulations, policy statements, annual reports of stakeholders, and other publications, such as academic publications, statistical reports, and guidance documents for implementation of standards. The documents were collected from websites of respective government

ministries and relevant agencies in English, Chinese and Japanese. These agencies are responsible for creation, publication, implementation, evaluation, and provision of resources for LTC policies. In Ontario, the Ministry of Health and Long Term Care is responsible for the policymaking and implementation. In China, multiple ministries are in charge of LTC related policies. They include, the Ministry of Civil Affairs, the Ministry of Finance, the Ministry of State Administration for Market Regulation and the National Health Commission. In Japan, the Ministry of Health, Labor, and Welfare is responsible for implementing health policies, and the Ministry of Internal Affairs and Communications is responsible for calculating statistics. Data collection started at February 2021 and ended June 2021. Documents guiding the regulation of LTC, LTC home service provision, PSW workforce, and LTC home financial policy of three regions were gathered. Documents of special topic, such as regulations of veteran and first nation LTC homes in Canada, or special directives implemented during the COVID-19, were not included as they were beyond the scope of this study. Other sources, such as government press releases, conference reports, government responses to funding issues, or descriptions of specific funding application processes, were not included.

For Canada, government documents were mainly collected from the Ministry of Health and Long-Term Care website (https://www.health.gov.on.ca/en/), Government of Ontario website (https://www.ontario.ca/), E-laws of Ontario (https://www.ontario.ca/laws), Candian Institute of Health Information (https://www.cihi.ca/en), and Health Quality Ontario (https://www.hqontario.ca/). The term “long-term care home” was adapted by the government, hence it was used as a key word during the searches. Other key words included: service provision, quality, assessment, admission, personal support worker, education, certificate, financial policy, standard, payment, funding. Publications by the Ontario Personal Support Worker Association (https://ontariopswassociation.com/) were also screened. Government of Canada (https://www.canada.ca/en.html) was accessed to search data related to regulations and political structure. Reference lists of identified documents were screened and additional sources were identified.

For China, four government websites were screened to collect government documents: the State Council of the People's Republic of China website (http://www.gov.cn/), the Ministry of Civil Affairs of the People's Republic of China website (http://www.mca.gov.cn/), the Government of Zhejiang website (http://www.zj.gov.cn/), and the Hangzhou Municipal Government website (http://www.hangzhou.gov.cn/). Chinese key words were long-term care (养老), long-term care home (养老院、养老机构、养老设施), personal support worker (养老护理员, 养老从业人员,护工), certificate (认证), education (教育标准), service provision (服务), quality (质量), standard (标准,规范), assessment (评估), medical service (医养结合, 医疗卫生), payment (收费标准, 收费项目), and funding (资金支持,资金补助,资金扶持,建设补助,运营补助,资金奖励). China National Knowledge Infrastructure website (https://www.cnki.net/), and Google scholar (https://scholar.google.com/) were used to find data that explain regulations and political system in China.

For Japan, three government website and one government policy data bank were used to collect government data: the Ministry of Health, Labour and Welfare of Japan website (https://www.mhlw.go.jp/index.html), the Ministry of Internal Affairs and Communications (MHLW) of Japan webiste (https://www.soumu.go.jp/), the Government of Tokyo Metropolitan City website (https://www.metro.tokyo.lg.jp/index.html), and e-gov of Japan (https://elaws.e-gov.go.jp/). One physical book (介護保険六法 [Six Act of Long-Cerm Care Insurance]) that contains all policy documents related to the Long-Term Care Insurance Act in Japan, published by the MHLW, was purchased and used as a reference. Japanese language key words were: political system (政策制度), long-term care (介護), long-term care home (介護施設,特養,老人ホーム), personal support worker (介護士,介護福祉士), education (教育), service provision (サービス), quality (品質), standard (標準, 基準), assessment (評価, 认定), medical service (医療), payment (費用,単価), and funding (補助費). The Japan National Council of Social Welfare websitse (http://shakyo-hyouka.net/) and the Tokyo Metropolitan Foundation of Social Welfare

and Public Health website (https://www.fukunavi.or.jp/fukunavi/hyoka/hyokatop.htm) were used to search data related to quality assurance.

2.3 Data analysis

Data extraction and analysis were completed in Microsoft Excel. Relevant information from selected policies were extracted into three summary tables according to the language. A template was created to guide data collection and interpretation regardless of the country. Extracted information included: country, title, related documents mentioned, effective date, final amendment date, document type, policy area (e.g., regulation, service provision, PSW workforce, financial policy), addressed issue (e.g., PSW education, LTC home funding), quote from the policy text, key information (e.g., goals, measures or numbers), future implications of policy implementation (e.g., next step of policy implementation), and author's notes. Following Lacey & Luff's (2001) instructions for qualitative data analysis, four colours were used to code the information related to four policy areas (e.g., regulation, service provision, PSW workforce and financial policy). As most documents included multiple policy areas, the policy details were also colour-coded. The author then consolidated colour-coded information for each policy area. Multiple sub-policy areas were identified in each policy area except in regulation. For service provision, five sub-areas were examined: (1) government role, (2) policies governing services in LTC homes, (3) medical service, (4) LTC home quality assurance, and (5) admission and assessment. For PSW workforce, three sub-areas were examined: (1) PSW regulations, (2) PSW education and certification, and (3) employment and government support. For financial policies, three sub-areas were examined: (1) financial support for residents, (2) public vs. private home payments, and (3) financial support for LTC homes. The colour-coded data sets were collated for each sub-policy area and summarized at the bottom of the column in Excel. After all information was organized, coded, and summarized, the way of presenting findings used in Ågotnes et al. (2019) study was followed. The author first described findings for each country and then created comparison grids between countries for each policy area (see tables provided in comparison section of the Results).

To ensure rigor, a draft of the findings was prepared and shared with a LTC policy informant, possessing relevant knowledge or experience working in the field, in each country with a request for review, check of correctness and confirmation that all relevant policies have been included. One informant was an accountant from a LTC home in Ontario, one was a manager of a Chinese LTC home in Hangzhou, and the last one was a graduate student from Yokohama city University in Japan with major in social welfare. The author met with each informant on Zoom and communicated through email to validate the completeness, truthfulness and accuracy of the findings. Analysis was completed when similarities and differences of LTC policies in the three countries were established and ratified.

3 Findings

In the results chapter, findings are reported in four sections. The first three sections describe the specific policies for each country in the following order: Ontario (Canada), China, and Japan. Anticipating that the content of this thesis might be of interest for readers in all three countries, descriptions of policy documents might come across as too detailed. The author has made every attempt to synthesize the most important parts of the policies that fit the purpose of this thesis. The fourth section of the findings reports the differences and similarities in LTC policies between the three countries. Based on adopted Wendt et al. (2009) framework and following the example from Ågotnes et al. (2019), results are presented for four policy areas of LTC policies: regulation, service provision, workforce, and financial policies.

3.1 Ontario (Canada)

3.1.1 General Information

Among the three countries under study in this project, Canada is the only country with a federal system of government. Federalism dictates that government power is divided between federal and provincial government legislatures, and protects important areas of provincial jurisdiction, such as providing health services to the public, also known as Medicare. Although health services do not fully cover long-term care services, the provincial government is responsible for providing and regulating long-term care services. Nineteen documents published between 2007 and 2020 were included in this study. Most (n=15) were published by the Ontario Ministry of Health and Long-Term Care (MOHLTC), while others were published by the Government of Ontario (n=3), and the Ministry of Training, Colleges and Universities (n=1). According to the management authorities, these documents can be divided into three categories: ministry managed (n=11), Local Health Integration Network (LHIN) managed (n=8). The types of sources were: operational policies (n=15), acts (n=2), regulations (n=1), and education standards (n=1). It should be noted that on June 20, 2019 the Ministry of Health and Long-Term Care in Ontario was split into the Ministry of Health and the Ministry of Long-Term Care.

This change had no substantial impact on this research as all documents used to harvest the data for this study were released before this split. Hence, the name Ministry of Health and Long-Term Care name is retained throughout the thesis.

3.1.2 Regulation

In 2010, the Legislative Assembly of Ontario passed the Long-term Care Home Act (LTCHA, 2007). The LTCHA guarantees the rights of the residents, such as right to be protected from abuse, and the right not to be neglected. At the same time, the new Act imposed stricter supervision on the LTC homes compared to former Acts such as the *Charitable Homes Act* (1960), the *Homes for the Aged and Rest homes Act* (1990), and the *Nursing Homes Act* (1990). According to the LTCHA (2007)

> *"The fundamental principle to be applied in the interpretation of this Act and anything required or permitted under this Act is that a long-term care home is primarily the home of its residents and is to be operated so that it is a place where they may live with dignity and in security, safety and comfort and have their physical, psychological, social, spiritual and cultural needs adequately met."* (c. 8, s. 1).

The LTCHA has ten chapters: fundamental principle and interpretation; residents' right, care and services; admission of residents; councils; operation of homes; funding; licensing; municipal homes and first nation homes; compliance and enforcement; and administration, miscellaneous and transition. Each chapter further indicates the responsibilities of the government, the requirements for the LTC homes, and the rights of residents. Along with the release of the LTCHA, the Ontario government also implemented the corresponding Regulation - O. Reg. 79/10 that corresponds to ten chapters of the LTCHA. Unlike the Act, that only puts forward overarching ideas, the Regulation provides specific requirements for LTC home service provision, government supervisions and other aspects such as workforce and licensing. It can be said that the LTCHA and the Regulation cover all aspects of the LTC homes. Due to the scope of this research project, only content relevant to service provision, workforce, compliance and enforcement, and funding from the Act and the Regulation were explored.

3.1.3 Service Provision

3.1.3.1 Policies Governing Services in LTC homes

To qualify for federal funding, the Canada Health Act requires each provincial government to include health services into health insurance that must fit the five principles set by the Canadian government: comprehensiveness, universality, portability, public administration, and accessibility. However, the LTC is not regulated under the Canada Health Act making the operation of LTC homes across Ontario sole responsibility of provincial governments under the LTCHA. As one of the most important aspect of the LTC homes, service provision is placed in the second chapter of the LTCHA. The second chapter consists of multiple sections, including residents' bill of rights, mission statement, safe and secure home, plan of care, care and services, prevention of abuse and neglect, reporting and complaints, minimizing of restraining, office of the long-term care homes resident and family adviser, and regulations. For comparison purpose in this study, focus was only on following sections: residents' bill of right, plan of care, care and services.

In the section residents' bill of right, the LTCHA requires the home to ensure the rights of the residents are fully respected and promoted. The rights to be protected are directly to one's physical and mental health such as the right to be protected from abuse, the right to live in a safe and clean environment, and the right to freely believe in religion.

To achieve resident-centered care, the LTCHA further stipulates that LTC home needs to develop a written plan of care for each resident based on the resident's assessment. The care plan should include the planned care, the goals of care, and detailed directions for staff who directly provide care to the resident. The care plan should be reviewed at least every six months, along with the reassessment of the resident. The resident should participate into the development of the care plan. In addition to LTCHA, the Regulation requires the LTC home to develop a 24-hour admission care plan for the first 24 hours of-admission. The Regulation also puts forward more detailed requirements for the care plan. For example, LTC home must include information about the physical

conditions, drugs, and treatments the resident needs. Further, the Regulation requires the LTC home to finish the assessment and complete the care plan within 14-21 days of the admission.

The LTCHA subchapter Care and Services regulates the types of services the LTC homes must provide such as 24-hour nursing care, personal support services, restorative care, recreational and social activities, dietary and hydration services, medical service (discussed in next section), and accommodation services. While the LTCHA provides only brief information about these services, the Regulation specifies detailed requirements for each. Good examples are the nursing care and personal support services. The LTCHA requires the home to provide 24-hour nursing service and personal support service to residents in need. The personal support service was defined as a "service to assist with the activities of daily living, including personal hygiene services, and includes supervision in carrying out those activities" (c. 8, s. 8 [2], LTCHA, 2007). Under the Regulation, the nursing and personal support services are further divided into bathing, dressing, transferring, and positioning, oral care, foot care and nail care, item keeping and notification, sleep support, and end-of-life care. The Regulation also asks the LTC home to develop and implement specific programs such as a fall prevention and management program, a skin and wound care program, a continence care and a bowel management program, and a pain management program. Appendix A provides further details regarding services provided in the LTC homes in Ontario.

3.1.3.2 Medical Service

Medical service provision in LTC homes is another requirement under LTCHA and the Regulation. The LTCHA stipulates "Every licensee of a long-term care home shall ensure that there is an organized program of medical services for the home(2007, c. 8, s. 12." (LTCHA, 2007). The Regulation adds further detail that the medical services should include availability of medical services, individualized medical directives and orders, and attending physicians or registered nurses (RN) in the extended class RN(EC). According to the definition provided by the College of Nurses of Ontario (2017), the RN(EC) are the RNs with additional education and clinical experience that allows them to be nurse practitioners. Based on the definition provided by the Canadian Nurses Association,

nurse practitioners are nurse with extra education and nurse experience which enable them to do practice such as diagnose and treatment. The Regulation is clear that every LTC home is responsible for providing residents with access to medical services 24 hours a day. Unfortunately, the Regulation does not specify the extend of the medical service provision (e.g., medical examination or surgery). On the other hand, the Regulation is clear that every LTC home must have either physician or an RN(EC) in the home at all times. The physician or the RN(EC) are tasked with providing physical examinations for each resident after the admission and annually thereafter. The results of the examination have to be documented in written form. The physician or the RN(EC) is required to regularly work in the LTC home to provide services, after-hours coverage, or on-call coverage. Though the Regulation stipulates the LTC home must have a written agreement with the physician or the RN(EC), there is neither a no requirement for the minimum number of physicians or RN(EC)s that must be hired, nor a requirement for the type of employment, such as full time or part time. Furthermore, the Regulation does not include a requirement for the total number of nurses, or the patient to nurse ratio, with the exception that "at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times" (O. Reg. 79/18, s. 45, 2010). In addition, the Regulation does not require a specific number of PSWs which causes a significant impact on the working environment of the PSWs (as will be discussed later). In summary, although the LTCHA and the Regulation put forward the requirement for the LTC homes to provide medical service to the residents, the conditions of medical service provision are not detailed enough allowing much room for improvements.

3.1.3.3 LTC Home Quality Assurance

The Ontario government mainly uses three measures to ensure the quality of services in the LTC homes. They are self-improvement (self-inspection), government inspection under the Long-term Care Quality Inspection Program (LQIP), and self-report of the Resident Assessment Instrument – Minimum Data Set 2.0 (RAI-MDS 2.0).

Self-improvement of service quality is stipulated by the LTCHA and the Regulation. In the section of continuous quality improvement of the LTCHA, each LTC

home is required to have a quality improvement and utilization review system to monitor and evaluate the services (e.g., accommodation service, care service, dietary service) to enhance the overall quality of the LTC home. Under the Regulation, each LTC home is required to have a written document on quality improvement and utilization review. The document must contain the goals, objective, policies, protocol, process of the system, any improvement made by the LTC home. At the same time, the LTC home is asked to communicate results of the self-improvement review with the residents' council, family council and staff.

Government inspection plays an important role in the quality assurance of the Ontario LCT homes and is regulated by both the LTCHA and the Regulation. The Act allows the health minister to appoint an inspector to inspect the LTC homes to ensure every requirement under the LTCHA and the Regulation is attained. All 627 LTC homes in Ontario are inspected at least once a year. No appointment or notice is given to the home prior to the inspection. The inspector has the right to conduct the following actions: meet with the residents' council and family council (with permission from the councils), enter the LTC home or any places operated closely with the home (e.g., places that provide service to the home) at any reasonable time, inspect premises of the LTC home, inspect or copy records required under the Act and the Regulation, demand production of records related to the inspection, question a person, make any form of record in a way that does not invade privacy, conduct examinations or tests, use devices in the home to make the record, request help from experts to help with the inspection, and exclude anyone from interviews with individuals in the home (e.g., staff, resident). The inspector is required to create an inspection report reporting the inspection results and provide copies to the LTC home and the residents' and family councils. Failure to meet these requirements under the LTCHA and the Regulation must be recorded in the report. A compliance order will be issued to the home if they fail to achieve the requirements under the Act and the Regulation. Failure to comply with the compliance order will result in different levels of administrative penalty (e.g., $5,000 CAD for failure to comply with requirement of 24-hour nursing care).

The MOHLTC has also launched LTC Quality Inspection Program to ensure the quality of LTC homes and protection of residents' rights. The content of the LQIP is built upon the inspection regulated by the LTCHA and the Regulation. The key features of the LQIP are interviews with residents and family members (using certified inspectors to support consistency), surveys and inspection protocols to ensure-transparency. All non-compliances to Regulations must be posted publicly in the LTC home and provided to the councils. Inspection reports for all LTC homes in Ontario are published on the MOHLTC website.

While the self-improvement and government inspection focus on regulating the LTC homes, the RAI-MDS 2.0 focuses on improving and standardization of the LTC service. RAI-MDS is an internationally acknowledged instrument used to collect information on residents lives in facility-based long-term care and continuing care (HQO, n.d.). It is collected by the government and submitted to the Canadian Institute for Health Information's (CIHI) Continuing Care Reporting System, which aims to provide comprehensive standardized data on residents in the LTC homes and patients in hospitals (Health Quality Ontario, n.d.). According to the *Policy: Resident Assessment Instrument Minimum Data Set 2.0 Funding* (The MOHLTC, 2013), the purpose of collecting RAI-MDS 2.0 data is to: produce standardized assessments and care plans, point out potential concerns and needs to raise the concerns with residents and families, help care providers to make critical decisions, support communication within the interdisciplinary health care team, provide more comprehensive information for administrator to better enhance the quality of the service, and help develop a consistent and comprehensive provincial standards and policies. Each LTC home in Ontario is required to use the RAI-MDS 2.0 tool to assess their residents on the following occasions: upon admission, every three months after the admission and if resident experiences any significant health change (e.g., diagnosed with diabetes). Based on the information from the HQO website, "the assessment includes patient-level measures of function, mental and physical health, social support and service use. It was modified by the Canadian Institute of Health Information, with permission, for Canadian use" (Health Quality Ontario, n.d.). The RAI-MDS 2.0 data from each Ontario LTC home is recorded in the CIHI database, and results are published on the HQO website for public access (Health Quality Ontario, n.d.). The items

reported on HQO are: use of antipsychotic medication in residents without diagnosis of psychosis, falls, use of physical restraints, pressure ulcers, pain, and residents with worsened symptoms of depression.

3.1.3.4 Admission and Assessment

As all the LTC homes in Ontario are receiving funding from the government of Ontario, screening seniors' eligibility for admission into a LTC home is a long and complicated process. The procedures of application and admission into LTC homes are regulated by the LTCHA and the Regulation. The admission process involves an admission application, placement coordinator designation, eligibility assessment, authorization for admission, LTC home selection, approval from the home, and check-in. Appendix B schematically describes the procedure of LTC resident admission process in Ontario. Under the LTCHA, the Minister of Health will designate agencies as the placement coordinators for the LTC homes in the specified region, which will give the agencies right to process the requirement of admissions from individuals in that region.

When an individual submits the application for LTC admission, the placement coordinator will have to determine if the individual is eligible. The assessment includes information regarding the applicant's physical and mental health, required treatment and medications, functional capability, level of care required, current behavior, and behavior for the year prior to the assessment. The eligibility assessment has to be completed by a physician or a registered nurse. Based on the Regulation, the eligible individual should be at least 18 years old, insured under the *Health Insurance Act (1990)* (OHIP), require nursing care 24 hours a day, 24-hour on-site monitoring, on-site supervision to ensure safety, and assistance with activities of daily living throughout the day. After the applicant is determined eligible for admission into a LTC home, the placement coordinator helps the applicant with home selection. The applicant preferences that relate to ethnic, religious, linguistic, and other factors are taken into consideration. The placement coordinator passes the request for admission to the selected LTC home for approval. If the LTC approves the request, the applicant is placed on the waiting list. The coordinator has the right to remove the applicant from the list if the applicant refuses to accept the admission, refuses to sign the agreement for authorization of admission, or

fails to move into the home within five days. The LTC can also choose to withhold the approval of an applicant based on its capability to provide service. In that case, the LTC home must provide the coordinator and the applicant with a proper explanation. Once the applicant is successfully placed onto the waitlist, the placement coordinator categorizes and ranks the applicant based on his/her status, which adjusts applicant's position on the waiting list. There are 13 placement categories: 1, 2, 2.1, 3A, 3B, 4A, 4B, related temporary, exchange, re-admission, re-opened, replacement and veteran. Each category stands for a different crisis level and is different in terms of applicant's situation, such as physical and mental status or family situation. For example, category 1 includes applicants who occupy a bed in hospital, or in a psychiatric facility. Category 2 includes applicants whose spouse or partner are already a resident in the LTC home, and they meet the criteria of living in a LTC home. Appendix C provides further details regarding LTC home waiting list.

3.1.4 PSW Workforce

3.1.4.1 PSW Regulation

PSWs are frontline workers providing direct daily care for the residents living in a LTC home. Unlike nurses or physicians, PSWs are not self-regulated or regulated by the government. The PSWs have had a chance to self-regulate in 2006, when the Health Professions Regulatory Advisory Council in Ontario considered making the PSWs self-regulated. However, the Council gave up on this idea due to limited scope of practice, non-standardized education system, and potential costs of retraining. Though the PSWs are still not self-regulated (in 2021), the MOHLTC developed a voluntary registration system for PSWs. The system collects basic information such as experience, employment history, and education level. Participation to register in the system is voluntary, except for the PSWs employed in public funded facilities for who registration is mandatory.

Compelled by devastating events during COVID-19 pandemic, the Ontario government seems to be considering a certain level of regulation of PSWs. On April 27, 2021, the Legislative Assembly of Ontario introduced a Bill 283, which aims to establish new acts in response to the situation created by COVID-19. Among four schedules listed

in the bill, the one named *Health and Supportive Care Providers Oversight Authority Act*, focused on the PSWs. Based on the information provided by the Ontario Council of Hospital Unions (OCHU, 2021), the act aims to increase the accountability of PSWs by establishing an authority named "Supportive Care Providers Oversight Authority". The oversight authority will use the public registry system to identify registrants to the public. One of the goals of the act is to "establish a new legislative framework that supports consistency in education, training and standards of practice for the province's personal support workforce, regardless of work setting or employment type" (Newsroom Ontario, April 27, 2021). However, the OCHU also mentioned that only PSWs who voluntary registered in the registry system will be involved in the act. The act will not prevent PSWs who choose not to register from working as PSWs. Further, PSWs will not be allowed to use any visual symbols developed by the authority (the Health and Supportive Care Providers Oversight Authority) under the regulation of the act. The act will also give the authority the power to complete missions such as investigate, mediate, or resolve complaints related to the registrant or inquiring the registrant. Although the act has proposed several measures for PSWs, since the act is still in the legislative stage, this study will not report the content of this act. It can be anticipated that the Ontario government will pass *the Health and Supportive Care Providers Oversight Authority Act*, in the future to further improve the rights of the PSW and provide a comprehensive regulation framework.

3.1.4.2 PSW Education and Certification

The O.Reg 79/10 outlines education and certification requirements for the PSWs, even though they can be bypassed. According to the Regulation, each PSW in the LTC home must have completed a personal support worker training program recognized by the government and must provide a proof of required education to the LTC home. The program must meet the requirements published by the Ministry of Training, Colleges and Universities and provide at least 600 hours of training. Although this requirement seems formal and strict, the *Personal Support Worker Program Standard* and the *Personal Support Worker Training Standard* do not specify the content of education in detail. The Standards only put forward certain requirements for the vocational skill development of

the PSWs. For example, under the requirement of the *Personal Support Worker Training Standard*, a PSW should have ability to "work within the personal support worker role in community, retirement homes, long-term care homes and/or hospital care settings in accordance with all applicable legislation and employer's job description, policies, procedures and guidelines" (Ministry of Training, Colleges and Universities, 2014, p.7). Ontario does not currently have a unified and standardized curriculum for PSW training. In addition to the curricular inconsistencies, the Regulation also allows for several exceptions to the requirements for PSW training. The Regulation allows the following personnel to be hired as a PSW: any person working or employed as a PSW that has at least three years of full-time experience, any person enrolled in RN or RPN courses and is believed to have sufficient skills as a PSW, any person enrolled in a PSW program completing the practical experience requirement, any person who is enrolled in or have graduated from a 600-hour program and is believed to be capable of being a PSW.

3.1.4.3 PSW Employment and Government Support

This study identified limited information on employment regulations and government support for the PSWs. Under the requirements of the LTCHA and the O.Reg. 79/10, only the director of nursing and personal care, and the home administrator are regulated to work on a full-time basis. There are no requirements for employment form (e.g., full-time, part-time, casual) of PSWs. Simultaneously, probably due to the non-regulation and non-certification, there were limited policies regarding supporting PSWs prior to the COVID-19 pandemic except a minimum wage increase to $16.5 in 2015. Only after the pandemic, the Ontario government introduced several measures to support PSWs. For example, to cope with the shortage of PSWs, the Ontario government implemented the *Long-Term Care Staffing Plan*. As a measure of the plan, the Ontario government is planning to provide $86 million CAD to fund new students enrolled in government recognized PSW programs. Each student will receive maximum of $13,235 CAD as coverage of their tuition. Other than this, to mobilize enthusiasm of PSWs during COVID-19 pandemic, the Ontario government introduced a temporary salary increase plan. The government invested $141 million CAD to extend the temporary wage increase for PSWs working in facilities such as LTC homes, community care, and publicly funded

hospital. This wage increase was extended until March 2022. Each eligible PSW could get an extra hourly pay increase of maximum of $3 CAD per hour dependent on his/her workplace. The Health Force Ontario, government issued marketing and recruitment agency, also introduced a personal support worker Return of Service Plan. The plan provides a maximum of $5,000 CAD to new PSW graduates in exchange for a six-months commitment to work in an eligible LTC home. Although the Ontario government has created supportive measures and incentives for PSWs, it is not clear if they will have sustained positive effects.

3.1.5 Financial Policies

3.1.5.1 Financial Support for Residents

Since Ontario has a universal health care system, the Ontario government is responsible for providing accessible health care and LTC service to all citizens. While the LTC service is covered by the government, the residents living in LTC homes still have to pay accommodation fee, which is determined by the room type and will be discussed in the next section.

All Canadians after the age of 65 receive the Old Age Security pension (on October 2021 maximum value was $635.26 CAD per month). Low-income seniors can also apply for Guaranteed Income Supplement to pay for their living expenses. Residents of LTC homes who do not have enough income to cover the cost of the basic room, may be eligible for government support funding, also known as the *Long-Term Care Home Rate Reduction Program*. According to the Government of Ontario December 2021 rates, every eligible resident in the LTC home will get a subsidy of up to $1,891.31 CAD per month to help pay the basic accommodation fee, if the applicant's net income is low, and if they receive Old Age Security Pension, Ontario Disability Support Program, Guaranteed Income Supplement or Guaranteed Annual Income System Benefit. Only individuals already receiving supplementary funding qualify for the rate reduction program. The eligibility is assessed using the net income, which is calculated based on most recent tax assessment, payable taxes, Universal Child Care Benefit Payments, Registered Disability Saving Plan, death benefit payment, lump-sum income, non-taxable

income, income from private sources and any other government benefits the applicant is eligible for. Residents receiving *LTC Home Rate Reduction* have to re-apply for the program every year. It is worth noting that this income threshold is related to Canada's Guaranteed Income Supplement, in which the threshold for single individual is $19,284 CAD (Government of Canada, 2021). Other than the *Long-Term Care Home Rate Reduction Program*, this study has not been able to identify any other financial program specifically created to support residents of LTC homes in Ontario.

3.1.5.2 Private vs Public Payment Differences

There are both publicly and privately owned LTC homes in Ontario (including non-for profit and for-profit LTC homes), and all are receiving funding from the government. Hence, the government of Ontario has the power to regulate every LTC home in the province, regardless of the type (i.e., public or private). The accommodation costs are set by the MOHLTC and are unified across the province (Government of Ontario, 2021b). Based on the information provided on the website of Government of Ontario, the MOHLTC divides LTC accommodations into four types: long-stay basic, long-stay semi-private, long-stay private, and short stay where the daily cost ranges from $40.24 to $88.82 CAD (Table 3-1).

Table 3-1

Daily and Monthly Accommodation Rates for LTC Home in Ontario in 2019

Accommodation type	Daily rate in $CAD	Monthly rate in $CAD
Long-stay basic	62.81	1,891.31
Long-stay semi-private	74.96	2,280.04
Long-stay private	88.82	2,701.61
Short-stay	40.24	N/A

Note. Table adopted from the Government of Ontario. https://www.ontario.ca/page/get-help-paying-long-term-care#section-0. The Queen's Printer for Ontario holds copyright in Ontario statutes, regulations and judicial decisions. The Queen's Printer permits any person to reproduce the text and images contained in the statutes, regulations and judicial decisions without seeking permission and without charge. The legal

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Due to the COVID-19 pandemic, under the *COVID-19 Directive #3 for Long-Term Care Homes under the Long-Term Care Homes Act, 2007 Issued under Section 77.7 of the Health Protection and Promotion Act (HPPA), R.S.O. 1990, c. H.7* (MOHLTC, 2021), from July 16th, 2021. the government requires the LTC homes to no longer provide basic accommodation where four individuals are sharing one room. All new residents admitted into a LTC home have to be placed in a semi-private (two individuals in one room) or private room (one person per room). If the private and semi-private rooms are full, the LTC home must arrange for the new residents to be accommodated into a basic room with a maximum of two people (including the new resident). However, the directive did not provide any information regarding the change of the accommodation rate. In addition, the directive is only a temporary measure against the COVID-19 pandemic, and there is a possibility that it will not remain effective permanently.

3.1.5.3 Financial Support for LTC Homes

Although the LTCHA and the O.Reg. 79/10 regulate most aspects of LTC homes in Ontario, funding is an exception. As previously mentioned, the MOHLTC is funding-all LTC homes in Ontario. Most of the funding is transferred through the *Long-Term Care Home Service Accountability Agreement* (the L-SAA). In general, there are two types of funding, daily operations support (managed through LHIN) and construction subsidy (managed by the MOHLTC). *The Long-Term Care Home Level-of-Care Per Diem, Occupancy and Accuity Adjustment Funding Policy* was published by the MOHLTC in May 2019, and it replaced earlier types of funding from the Ontario government, such as the *LTC Home Occupancy Targets Policy* and the *LTC Home Physiotherapy Funding Policy*. The new funding model funds LTC homes through the level-of-care (LOC) per diem and is adjusted to the acuity of the residents, occupancy rate and other funding already paid to homes. This new funding policy introduced a new formula for the homes to calculate their funding (the MOHLTC, 2019):

(NPC+PSS+RF+OA) - Resident Co-Payment Revenue = LOC per diem funding rate

Note: NPC stands for nursing and personal care, which covers expenditure related to nursing staff and any other staff who provide direct care to the residents along with any supplies or equipment used by the care staff to provide care. PSS stands for the program and support service, where funding from the Ontario government can be used to cover staff salaries and equipment or supply cost related to programs provided to residents (such as a fall prevention program). RF stands for raw food which covers the expenditure related to purchasing of raw food for residents as well as the necessary supplementary substance such as condiments and therapeutic food requested by physicians or RNs. However, the cost of raw food preparation is not included in this category. OA stands for other accommodation. The Ontario government funds LTC homes to cover the expenditure related to the accommodation and service provided to residents, such as housekeeping, dietary and equipment maintenance services.

Each bed in LTC homes receives the same amount of funding for PSS, RF and OA category. Only a portion of NPC is adjusted based on residents' acuity. The exact amount of NPC for each bed in LTC home is calculated based on the Case Mix Index. The CMI is calculated based on the average acuity assessed by the Ministry. The Ministry applied Resource Utilization Groups to assign weight for each category of residents who share same symptoms and require similar support. Due to the complex categorization of the RUGs, the detail of NPC calculation will not be included here. For those who interested in the details, please refer to the original policy (MOHLTC, 2019). Periodically, the government publishes the *LTCH Level-of Care Per Diem Funding Summary* to announce the exact base amount of the funding. Table 3-2 provides an example of funding amounts in place in April 2019 and August 2019.

Table 3-2

Amount of LTCH Level-of Care Per Diem in April 2019 and August 2019

Month	Funding Categories				Total ($ CAD)
	NPC ($ CAD)	PSS ($ CAD)	RF ($ CAD)	OA ($ CAD)	
April	100.91	12.06	9.54	56.52	179.03
August	102.34	12.05	9.54	56.16	182.23

Note. Information gathered from:
https://www.health.gov.on.ca/en/public/programs/ltc/docs/level_of_care_per_diem_funding_summary_201904.pdf and https://www.health.gov.on.ca/en/public/programs/ltc/docs/level_of_care_per_diem_funding_summary_201908.pdf.

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Other than the basic LOC funding, the MOHLTC also provides *Pay Equity Funding, Attending Nurse Practitioners in Long-Term Care Homes Initiative Funding* to support LTC homes with the labor cost; and funding such as Municipal Tax Allowance Funding, High Intensity Needs Funding to help LTC homes lower the cost. Table 3-3 provides the overview of some of the LTC home funding policy. In addition to the daily operational funding, the MOHLTC also provides construction subsidies for eligible LTC home operators to develop new or renovate existing LTC homes. Under the *Long-term care Home Capital Development Funding Policy,* each operator must sign a development agreement with the MOHLTC and meet all the conditions and requirements. The LTC home development funding grant consists of construction funding subsidy per day, and a planning grant, which is not applicable to for-profit homes. The amount of CFS per diem is calculated based on the population living in the target region and the number of beds in the new LTC home. The operator would receive up to $23.78 CAD per diem if they opened a new LTC home in a large urban area, and they would receive another $1.50 CAD if the number of beds is less than 96. Each LTC home operator will receive another development grant of up to $51,376 CAD per bed. For non-profit home operators, the government provides a one-time funding of 250,000 CAD to assist with the development.

Table 3-3

Overview of Funding Policies under the Long-Term Care Home Service Accountability Agreement

Funding Policy	Date	Managing body	Overview
LTCH Reconciliation and Recovery Policy	Jul 2010	N/A	Outlines how funding for LTC home should be recorded, used, and reported. It stipulates the government to adjust funding paid to LTC homes and reconcile funding from LTC homes.
Pay Equity Funding and Equalization Adjustment Guidelines	Feb 2011	MOHLTC	The MOHLTC provides funding for LTC homes to meet obligations under the Pay Equity Act.
LTCH Cash Flow Policy	Apr 2011	N/A	Outlines information of types of LTC home funding and the calculation of funding.
Municipal Tax Allowance	May 2011	MOHLTC	The MOHLTC provides LTC home with up 85% of home's eligible municipal tax costs.
Laboratory Service Funding	May 2011	MOHLTC	The MOHLTC will help reimburse laboratory related service costs incurred byLTC home to ensure that the cost will not negatively impact LTC service.
LTCH Bad Debt Reimbursement	Apr 2016	LHIN	The MOHLT covers 50% of the eligible bad dept cost.
High Intensity Needs Fund Policy	Dec 2016	MOHLTC	The MOHLTC provides funds to LTC homes to prevent unnecessary hospital admissions, and to enable discharge of patients from hospital to LTC homes.

Eligible Expenditure for Long-Term Care Homes	Jan 2017	LHIN	Categorizes the eligible LTC home costs into four categories.
Spousal Supplement for Two-Bed Room Shared by Spouses/Partners	April 2017	LHIN	Local Health Integration Networks (LHINs) will fund LTC home a supplement where spouses/partners reside in a two-bed room in a LTCH
Attending Nurse Practitioners in LTC Homes Initiative Funding Policy	Oct 2017	LHIN	The MOHLTC provides LTC home up to $122,853 CAD per Nurse Practitioner for labor cost.
LTCH Quality Attainment Premium (QAP) Funding Policy	July 2018	LHIN	Improves and maintains quality of service in LTC (supplementary line in OA category).
Falls Prevention Equipment Funding Policy	Oct 2018	MOHLTC	The MOHLTC provides up to $100 CAD per bed to LTC homes purchasing equipment to prevent residents from falling.
Long-Term Care Minor Capital Funding Policy	April 2020	MOHLTC	To maintain LTC homes in an good situation (e.g., environment) to ensure the safety of their residents.
Long-term care Home Capital Development Funding Policy	Aug 2020	MOHLTC	Stipulates the government to fund eligible LTC home operators for developing new or redeveloping the existing LTC home beds.
Physician On-call Program	Nov 2020	MOHLTC	The MOHLTC provides LTC homes up to $103.54 CAD per bed annually for payment to physicians under the Physician On-Call program.

Note. LTCH = long-term care home, MOHLTLC = the Ministry of Health and Long-Term Care, LHIN = local health integration network. Information gathered from: https://www.health.gov.on.ca/en/public/programs/ltc/lsaa_policies.aspx.

It is worth noting that all funding provided by the government, no matter the types of funding, could be revoked and retrieved by the MOHLTC under the *LTCH Reconciliation and Recovery Policy*. Under this policy, the Ministry has the right to recover or adjust any amount of money based on the usage of the funding, or after discovering misuse of funding or corruption. Under the reconciliation policy, each LTC home is required to submit a report at the end of each term of funding, containing information about municipal tax allowance, revenue, occupancy, LTC home annual report, and any ad hoc report requested by the Ministry. The amount of funding to be paid or recovered is determined after the report is submitted.

3.1.6 Summary

In summary, Ontario government is responsible to provide accessible LTC service to the public and long-term care service is regulated by the LTCHA. Medical care in LTC homes is mandatory by the MOHLTC but requirements are not described in great detail, such as resident to RN ratio or to what extent the medical service should be (e.g., surgery). Quality assurance for LTC homes is done through self-assessment, government inspection, and RAI-MDS 2.0. The LHIN is responsible for pre-admission assessment, and the LTC home is responsible for regular RAI-MDS 2.1 assessments every three months after-admission. PSW workforce is not regulated, does not have certification system or standardized curriculum. Several support policies for PSWs were instated only after the COVID-19 pandemic, but their sustainability is uncertain. The Ontario government offers a LTC home rate reduction program for residents who cannot afford the LTC accommodation charge. There are two main types of funding for LTC homes, that could be recovered by the government in case of misuse.

3.2 China

Ever since Confucius's (551-479 BC) philosophy and teachings, Confucianism has had an indelible influence on Chinese culture (Yu, 2008). Although there are multiple interpretations of Confucianism, one of the most important idea is "for the greater good". For Chinese people, the interests of the collective are far greater and more important than the interests of the individual, and sometimes, it is completely acceptable to give up personal interest for the collective. This was well reflected through the quarantine in Wuhan (from January 23rd to April 8th of 2020) during the epidemic and the speed of construction of two new infectious disease hospital (Huoshenshan hospital: 1000 beds within nine days, Leishenshan hospital: 1600 beds within 12 days [Xinhua News Agency, 2020, April]). Therefore, China's public policies tend to focus on the society as a whole and show less interest for individual.

3.2.1 General Information

The LTC home sector in China is regulated on multiple levels of government. Unlike Ontario, where the MOHLTC is responsible for every LTC home related policy, in China multiple government agencies make different LTC home policies. Scholars have reported that the policy creation process in China follows both top-down and bottom-up approach (Heilmann, 2008; Ning, 2012). This means that the policy making is an iterative process where the central government determines the general policy direction while the local government determines details of the regulations and stipulations. In the present study, 53 policy sources were gathered and categorized into three levels: central level (n=38), provincial level (n=2), and local level (municipal and city) (n=13). The following Chinese government bodies were identified as contributors to making LTC policies in the municipal of Hangzhou – the representative of China in this study: the State Council, the Ministry of Civil Affairs, the National People's Congress Standing Committee, the State Administration for Market Regulation, the China National Standardizing Committee, the China Development Bank, the National Development and Reform Commission, the Ministry of Human Resources and Social Security, the Ministry of Education, the People's Congress Standing Committee of Zhejiang – where Hangzhou is located, the

Hangzhou Civil Affair Bureau, the General Office of Hangzhou Municipal Government, the Quality and Technical Supervision Bureau of Hangzhou, the Hangzhou Human Resources and Social Security Bureau, and the Hangzhou Financial Bureau. Documents published from 1996 to 2021 were included in this study, as the first law that focused on protecting the older adults was published in 1996. The included sources were official documents from all government levels (n=41), national standards (n=9), government evaluation report (n=1), provincial regulation (n=1) and national law (n=1).

3.2.2 Regulation

In 1996, the Chinese National People's Congress Standing Committee passed *the Law: of the People's Republic of China on Protection of the Rights and Interests of the Elderly* (老年人权益保障法, hereinafter called the Law) which provides a definition of an older adult (over 60 years old) and stipulates that the government and the society are responsible to provide an accountable aging service to all older adults. The Law requires the local government to set up its own development plan based on the opinions from the central government. *The Law* was amended in 2012 to declare population aging as a national issue. Following the amendment, in 2013, the State Council of China published *the State Council's Opinion on Increasing Development of Long-Term Care Service Industry* (国务院关于加快发展养老服务业的若干意见, hereinafter called the Opinion) in which the central government proposed several ideas that guided Chinese LTC policy for the next seven years. Some media refer to 2013 as "the first year of Chinese long-term care service" (Forbook, 2018). Those ideas included limiting government intervention, intensifying policy support, diversifying service types, enhancing supervision and regulation, overall planning for home-based LTC service, community-based LTC service and faculty-based LTC service. Based on *the Law and the Opinion,* the General Office of Hangzhou government published the *City Government's Opinion on Long-Term Care Service Reform and Development* (市政府关于加快养老服务业改革与发展的意见) in 2014. In this local document, the city government set detailed goals such as to increase the number of beds in LTC homes to 55 beds per 1,000 older adults, and to create 80,000 jobs for caregivers by 2020. Above all, *the Law* and *the Opinion* became the fundamental documents for further policies.

3.2.3 Service provision

3.2.3.1 Policies Governing Services in LTC homes

The operation of LTC homes in China is regulated by both central government and municipal government. In 2012, the State Administration for Market Regulation and the Chinese National Standardizing Committee published the *Basic Standard for Senior Care Organization* (养老机构基本规范, hereinafter called the Basic Standard), which came into effect on May 1st, 2013. Combined with the first edition of the *Measures for the Administration of Long-Term Care Institutions* (养老机构管理办法, hereinafter called the Measure), published by the ministry of civil affairs in 2013, these two documents established the first regulation system for Chinese LTC homes. Other than the daily administration, *the Measure* requires LTC homes to provide rehabilitation services, psychological support, recreation services, meal services, accommodation services, and daily services to residents. *The Basic Standard* further outlined those daily services should include washing and dressing service, dental care, feeding, excretion support, and bedsore prevention. *The Basic Standard* described in more detail the meal service, sanitation service, laundry service, care service, psychological support, and recreational service.

The Chinese government realized that there will be many more older adults living in LTC homes in the future and believed that it was necessary to further regulate service provision in LTC homes. As a result, the National Development and Reform Commission published *the Guiding Opinions on Strengthening the Standardization of Elderly Care Services* (关于加强养老服务标准化工作的指导意见) in 2014 and *the Guidelines for the Establishment of Service Standard System for Elderly Care Institutions* (养老机构服务标准体系建设指南) in 2017. With these documents, the central government required the Standardization of LTC services based on the capability of the older adults, service form (e.g., home care, community-based care), type, and operation management. In 2017, the State Administration for Market Regulation and the Chinese National Standardizing Committee then published *the Basic Specification of Service Quality for Senior Care Organization* (养老机构服务质量基本规范, hereinafter called *the Specification*) to

further regulate the homes. Compared to *the Measure* and *the Basic Standard* that have broad scope, *the Specification* is more detailed and focuses on service requirements. A good example would be care service. *The Basic Standard* only requires the home to provide necessary equipment, basic care, health management, and care required by physicians, whereas *the Specification* includes details such as the use of restraints, catheter management, medical access, and drugs management. Then in 2019, to ensure the safety in LTC homes, two departments published *the Basic Specification of Service Safety for Senior Care Organization* (养老机构服务安全基本规范, hereinafter called *the Safety Specification*). This document focused more on safety (e.g., choke prevention) and injury prevention (e.g., scald prevention) in LTC homes. Finally in 2021, the government published *the Specification for Daily Living Care Service in Senior Care Organizat*ion (养老机构生活照料服务规范, hereinafter called *the Daily Living Specification*) which provides step-by-step instruction for daily service. Refer to Appendix D for an example of services provided in LTC homes and differences between specifications and measures. The Chinese government is continually trying to perfect policies that determine the services in LTC homes to meet the rising demand caused by population aging.

3.2.3.2 Medical Service

Although *the Basic Standard* requires the LTC home to provide care service and necessary access to medical service for their residents, *the Basic Standard* does not require homes to provide medical services. However, the government encourages homes to provide medical services or to have a medical clinic in their facility. In *the Opinion*, the government started to promote an idea called "*combination between care and medical service* (医养结合, hereinafter called *the Combination*)" within which all local governments should introduce medical and health service into LTC homes and communities. Additionally, medical services should have a geriatric clinic, medical beds dedicated to the older adults, prevention and treatment of geriatric diseases (e.g., dementia), and provision of rehabilitation services. Medical clinics should also integrate public medical insurance into the system. After the publication of *the Opinion*, *the*

Combination became one of the core principles and goals for Chinese LTC home development.

In 2014, the General Office of Hangzhou Government issued the *Opinions of the Municipal Government on Accelerating the Reform and Development of the Elderly Service Industry* (市政府关于加快养老服务业改革与发展的意见), in which the government agreed to reduce requirements for setting up hospitals in the LTC homes. In 2015, the Ministry of Civil Affairs, along with the National Development and Reform Commission and eight other central departments, published a document called *the Implementation Opinions on Encouraging Private Capital to Participate in the Development of the Elderly Service Industry* (关于鼓励民间资本参与养老服务业发展的实施意见). As a method to encourage the development of the Chinese LTC industry, the government agreed to subsidize facilities that have medical equipment (e.g., medical clinic on site). Furthermore, in September of 2015, the Ministry of Finance, the Ministry of Civil Affairs, and the China National Committee on Ageing published *the Opinion Regarding the Promotion of Combining Medical and Care Services* (关于推进医疗卫生与养老服务相结合的意见). This document legally held lower levels of governments, such as provincial and city governments, accountable for implementing measures necessary to reach the goal of *the Combination*.

As a response to this requirement, the Civil Affairs Bureau of Hangzhou published *the Implementation Opinions on Encouraging the Construction of Combining Medical and Care Services in Hangzhou* (关于做好杭州市医养结合及护理型养老体系建设的实施意见) in 2017. This document raised specific goals, such as achieving more than two care beds per 100 older adults, supplementing 80% of LTC beds with medical care within the LTC institution, and assuring that at least 20% are rehabilitation beds. After this, the Civil Affair Bureau of Hangzhou published *the Measures for the Recognition and Operation Management of Senior Care Institutions with Integrated Care and Medical Service in Hangzhou (Trail)* (杭州市医养结合护理型养老机构认定及运行管理办法[试行]). This measure defined LTC homes with medical service as facilities

comparable to established medical institutions, such as geriatric hospitals, Traditional Chinese medicine hospitals, hospice care hospital, medical clinics or outpatient clinics, infirmaries, and nursing stations. Through this document, the LTC homes have obtained the "Medical Institution Practicing License". The document also required that at least 60% of LTC beds are equipped as medical beds and emergency bell, resident-PSW ratio should be 3:1. The eligible LTC homes must provide medical services, basic nursing, specialist nursing, hospice care, nutrition guidance, rehabilitation guidance, technical guidance about disinfection and isolation, psychological consultation, health education, medical advice, diagnosis, and other nursing services based on government qualifications. For homes that meet the above criteria, the government provides subsidies which will be further discussed in following sections. In response, local governments across China are implementing policies in accordance with the requirements of the Central Government to achieve *the Combination*. In the past five years, the central government and local governments have repeatedly issued documents to promote the ideas described in the *Combination* (Ministry of Civil Affairs, 2016, 2017, 2019a, 2019b, 2019c, 2020a, 2020b). Thus, it is probable that in the foreseeable future the combination of medical service and LTC will continue to be the focus of the Chinese government policy improvements.

3.2.3.3 LTC Home Quality Assurance

In *the Opinion*, the central government placed the supervision and inspection of the industry in a very important position. *The Opinion* requires the Ministry of Civil Affairs to improve the supervision system for elderly care services and provide guidance to improve the management standards and service quality in elderly care institutions. Moreover, in *the Measure*, there are regulatory requirements for the quality of LTC homes. There are two types of quality measures: public supervision and administrative supervision. Based on *the Measure*, LTC homes are expected to listen to the opinions and suggestions from the residents and their families. In fact, in 2019, the State Administration for Market Regulation and China National Standardizing Committee published *the Measurement of Customer Satisfaction for Senior Care Organization* (养老机构顾客满意度测评). This document included five major and 17 minor items. The

major items included care resources, service quality, price, customer complaints and customer loyalty. The document assigned weights to each of these items. Among them, the service quality accounted for 70% of the total score. The maximum number of points for each minor item was 10. Table 3-4 provides details on the proportion of score for each item. Although the government provides a satisfaction test method for the LTC homes to make self-improvements, these steps are not supervised by the government, meaning that administrative oversight is still necessary.

There are two types of administrative supervision: direct inspection, and rating and classification of nursing homes. *The Measure* dictates that the Civil Affairs Department must inspect LTC homes at least once a year. Additionally, governments will conduct random inspections or unified inspective actions which the central government stipulate certain or all municipals to launch inspections on the LTC homes simultaneously. For example, in 2017, the Ministry of Civil Affairs issued the *Notice on Launching a Special Action for the Service Quality Inspection of the Long-Term Care Homes* (关于开展养老院服务质量建设专项行动的通知). In the notice, the central government required local governments across China to perform a unified inspection action to investigate any problems or deficiencies in LTC home services, to clarify the content of failures, and to provide directions for further rectification. This inspection focused on LTC home qualifications (e.g., registration), service resources (e.g., staff), service quality, service management, facilities and equipment, overall environment, admission assistance, psychological counseling, and similar. The results of this inspection were published on the local government websites throughout the country.

Table 3-4

Index of Customer Satisfaction Evaluation of the LTC Homes in China

Major Item	Weight (%)	Minor Item	Weight (%)
Care Resources	20	Staff	10.0
		Facility and equipment	10.0
Service Quality	70	Admission and discharge	5.8
		Daily care	14.0
		Meal service	8.2
		Sanitization service	4.7
		Laundry service	2.9
		Care service	7.0
		Rehabilitation service	5.8
		Recreational service	5.8
		Psychological support	4.1
		Hospice service	3.5
		Safety	4.7
		Others	3.5
Price	5	Cost performance	5.0
Customer Complaints	2	Customer complaint	2.0
Customer Loyalty	3	Degree of support	3.0

Note. Adapted and translated from "*the Measurement of Customer Satisfaction for Senior Care Organization"*, by State Administration for Market Regulation and China National Standardizing Committee, 2019, p.2, (https://www.yanglaocn.com/ckfinder/userfiles/files/2019/1224/61d62872224dbdab13d7ba01479894fc.pdf). Copyright 2019 State Administration for Market Regulation and China National Standardizing Committee

China also has a ranking system to ensure and encourage the LTC homes to improve their quality. In 2017, the Quality and Technical Supervision Bureau of Hangzhou published

the local standard of *Rating of the Senior Care Institutions* (养老机构等级评定与划分). The Standard divides LTC homes into five levels, from one-star to five-stars based on the score determined by the Civil Affairs Department. The total score is composed of 16 major items, each comprising of three to 18 minor items that have different maximum scores. LTC homes are assessed every three years and the results are published on the local government website. In 2019, the Ministry of Civil Affairs issued *the Guiding opinion on Accelerating Establishment of National Unified Elderly Care Institution Rating System* (关于加快建立全国统一养老机构等级评定体系的指导意见) to standardize and nationalize the rating system. The national standard of *Rating of the Senior Care Institution* was published in the same year, and further refined in 2020. Like the local standard, the national standard also divides LTC homes into five levels, although the national standard includes extra requirements. For example, if a LTC home wants to achieve five-star rating, the home must have an occupancy rate of at least 50%, provide services such as admission support and palliative care, the manager must have a bachelor degree or higher, the home has to have at least one social worker per 200 residents, washrooms in at least 80% of the rooms, and have a maximum occupancy of four people per rooms for residents with moderate disabilities and six people per room for patients with severe disabilities. Compared to the local standard, the national standard rates the LTC homes based on: environment, equipment and facilities, management, and service. Out of the perfect score of 1,000 points, a five-star LTC home must score at least 900 points and have a score of at least 90% for each item. At present, the Standard is in a trial version, and the Chinese government will announce the official version in the future.

3.2.3.4 Admission and Assessment

In *the Measure*, the government requires LTC homes to establish an admission evaluation system to evaluate the physical and mental condition of the new resident and determine the level of care and nursing care needed. If there are any changes to the resident's physical or mental condition that require a care level modification, the facility should re-evaluate the resident's needs. Although the government does not require that homes use particular assessment tools, the Ministry of Civil Affairs published *the Guiding Opinion on Promoting the Evaluation of Elderly Care Service* (关于推进养老服务评估工作的指

导意见) which called for a standardized assessment process of the older adults. In 2013, the Ministry of Civil Affairs published *the Ability Assessment for Older Adults* (老年人能力评估), which assessed the residents' dependency level based on four major items: daily activity, mental state, sensory perception, and social participation. Each major item has several minor items (Table 3-5). In 2019, the Civil Affairs Bureau of Hangzhou refined the tool by simplifying the social participation section. The ability assessment is a very important step that scientifically determines types of services needed by the LTC resident, the level of care required, and the qualifications for LTC subsidies.

Table 3-5

Items in the Ability Assessment for Older Adults

Major Item	Minor Item
Daily activity	Feeding, showering, dressing, urinary continence, feces continence, toileting, walking, up and down stairs
Mental status	Cognition, aggressive behavior, depression
Sensor perception	Consciousness, vision, hearing
Social participation	Viability, working capability, spatial positioning, time recognition, facial recognition, communication skills

3.2.4 PSW Workforce

3.2.4.1 PSW Regulations

The idea of PSWs in China originated in the mid 1990s. At that time, PSWs were first defined as personnel who provided non-technical support for nurses. Then in 2018, PSWs were called "supportive care providers" and in 2019 further renamed as "medical support care providers" by the central government (Li & Ying, 2021). With population aging and the development of LTC homes, the job description of PSWs in China changed. Besides traditional daily care such as feeding and dressing, PSWs have started to provide sanitation and disinfection for residents, and to assist nurses with medical care such as replacing the fistula fecal bag and removing sputum around tube incisions (Li & Ying, 2021). However, at present there is no effective regulation policy for the employment qualifications of the PSWs and at the same time, the ministry of education has not issued

a unified, mandatory standard for the education of PSWs. Though *the Basic Standard* requires that PSWs hold a professional qualification, the professional qualification certificate requirement was removed by the State Council of China in 2017. By cancelling the qualification certificate, the central government lowered the requirement to allow individuals with low education to enter the LTC industry and to allow the LTC homes to recruit more people to work as PSWs. As the result of qualification requirement cancellation, the PSWs in China remain unregulated.

3.2.4.2 PSW Education and Certification

Similar to the regulation, the education of PSWs does not have a standard curriculum. However, the Chinese government is paying more attention to the education of PSWs today than in the past. Article 47 of *the Law* stipulates that the state should encourage institutions of postsecondary education, secondary vocational schools, and vocational training institutions to set up relevant majors or training programs to cultivate professional talents in elderly care. *The Measure* also requires homes to provide skill training to PSWs. As the government progressively recognized that the demand for PSWs was increasing, the government has introduced a series of policies which focused on the education of PSWs to strengthen the workforce. In 2014, the Ministry of Education issued *the Opinions on Accelerating the Cultivation of Talents in the Elderly Service Industry* (关于加快推进养老服务业人才培养的意见) to synchronize with *the Opinion*. The document pointed out that there were three tasks required: to accelerate the development of a professional elderly care education system, to improve the quality of professional education, and to strengthen the continuing education for elderly care service providers after they started to work. According to the document, to develop this professional training program, the government first needs to expand the scale of vocational education, and to establish more elderly care related programs at universities and colleges. Secondly, the government should provide undergraduate and postgraduate degrees for elderly care related majors. On the other hand, the Ministry of Education believes that building a co-op system between the LTC homes and education institutions, and reforming and strengthening the teaching material are crucial to improve the quality of education. Although the central government has raised requirements to improve

education quality, this study did not identify any specific measures or policies for education from either central or local governments in China. It is possible that these types of policy documents were not disclosed to the public, rather they were directly distributed to the educational institutions.

However, the government created a special certification system for PSWs to ensure the continuing education was accomplished. In 2010, the central government organized skill competition between the PSWs (Ministry of Civil Affairs, 2010). Then in 2019, along with the Ministry of Human Resources and Social Security, the Ministry of Civil Affairs published *the Notice on Promulgating the National Vocational Skill Standards for Elderly Care Workers* (关于颁布养老护理员国家职业技能标准的通知). Later in the same year, *the National Occupational Skill Standard for PSWs* (养老护理员国家职业技能标准, hereinafter called *the PSW Standard*) was officially implemented. It was the first national certification implemented after the professional qualification certificate was cancelled. *The PSW Standard* divided PSWs into five levels: primary, intermediate, senior, technician, and senior technician. Each level has its own requirements. For example, to lower the threshold to enter the industry (compared to the requirement of the former standard and the professional qualification certificate) the *PSW Standard* reduced the education requirement for applying to the primary level certificate from middle school to no requirement. This means that any individual who graduate from a related major (such as nursing or social service) or has one year of experience as the PSW can apply for the primary level certificate. However, if the PSW wants to apply to a higher-level certification, there are a stricter requirement. For example, the intermediate level requires PSW to have two years of experience after receiving primary level of certification, to have four years of experience in the field, or to have a related degree from an authorized college. Only PSWs who have 4 years of experience after acquiring senior level certificate or who have 2 years of experience in the field after graduating from authorized colleges can apply for the technician level of certification. For the senior technician level, the applicant must have 4 years of experience in the field after acquiring the technician level. In addition to the requirements for experience, there are also requirements for skills. For example, senior technicians must be able to perform resident

assessments. Individuals with certain skill level certificates can receive support from the government, which will be discussed in the next section.

3.2.4.3 PSW Employment and Government Support

Although the salaries and benefits of the PSWs are low in China, to fulfil the increasing demand, the Chinese government has continuously issued and implemented supportive policies for PSWs. As scholars have pointed out, one of the characteristics of PSWs in China is that they are generally not well-educated and come from economically underdeveloped regions (Peng et al., 2017), hence they rely on the employers (i.e., LTC homes) to provide food and accommodation. In most cases, for the purpose of providing residents with timely and comprehensive services, homes are willing to do so. Although searches performed in this study did not identify policies that regulate the type of employment for PSWs, they usually work full-time and tend to have lower income compared to other employees in Chinese LTC homes. In the 2015 study, conducted by the research group of the Social Welfare Center of the Ministry of Civil Affairs, 89.7% of PSWs had income of less than 3,100 CNY (around $600 CAD) per month, which was lower than the average income of 3,380 CNY (around $654 CAD) in the health and social welfare industries (National Bureau of Statistic of China, 2015). To improve the situation, the central government has issued policies to improve the treatment of the PSWs and attract more individuals into the field. In *the Opinions on Accelerating the Cultivation of Talents in the Elderly Service Industry* (Ministry of Education, 2014), the Ministry of Education indicated that as a method of encouraging, the relevant school department shall include graduates from eligible colleges and professional schools into the current employment support policies, improve the working conditions, strengthen protection measures, and gradually increase wages and benefits. In response, Civil Affair Bureau of Hangzhou came up with *the Opinions of Hangzhou Municipal Government on Strengthening the Construction of Elderly Service Workforce* (杭州市关于加强养老服务人材队伍建设的意见) to synchronise policies with the central government. The city government proposed a series of supportive policies for the care workers, including social insurance subsidies, public rental housing guarantee policy, career protection, encouraging graduates to engage into the elderly care industry, and increasing salary and

benefits. Table 3-6 provides details of these supportive policies. It is believed that the government will continue to announce more supportive policies to support the PSW workforce.

Table 3-6

Summary of Supportive Policies for Care Workers in Hangzhou

Type	Description
Social insurance subsidy for career protection	Government will cover 50% of the total basic pension, medical and unemployment insurance premiums paid by companies that hire the care workers.
Public rental housing guarantee	1. Eligible individual can lease accommodation at a price lower than the market price 2. Eligible individual can get a monthly rental subsidy of up to 1,440 CNY (around $280 CAD)
Career protection	Encourage the LTC facilities to insure liability insurance for care workers. The government will cover up to 1/3 of the insurance cost.
Employment incentive	Graduates from related health major will receive from 21,000 CNY (around $4,060 CAD) to 40,000 CNY (around $7,740 CAD) based on their education level when they sign the contract with LTC facility.
Salary and benefits improvement	1. The government will annually release the guide price of salary in elderly care industry* – 5,350 CNY (around $1,035 CAD) per month. 2. A one-time reward will be given according to the certificate level. Amount TBD.

Note. * Elderly industry includes more than LTC homes. It includes community care centers and retirement homes. The information for the table is gathered from the Civil Affair Bureau of Hangzhou (2017), the Human Resources and Social Security Bureau of Hangzhou (2020), and the Government of Yuhang Municipality, 2020. From: http://fgj.hangzhou.gov.cn/col/col1684874/index.html, http://www.yuhang.gov.cn/art/2020/9/14/art_1532134_57461895.html, http://hrss.hangzhou.gov.cn/art/2020/8/18/art_1587843_54548733.html

3.2.5 Financial Policies

3.2.5.1 Financial Support for Resident

Although China has a universal health care system, LTC is not free. Since China has the largest number of older adults in the world, around 184 million (National Bureau of Statistic, 2021), the government only provides financial assistance to older adults who are

disabled or experience financial difficulties. *The Opinion* proposed that the government should focus on providing free or low-cost LTC services for seniors with financial difficulties. To build on this, the Ministry of Finance along with the Ministry of Civil Affairs issued *the Notice on the Establishment and Improvement of a Subsidy System for the Disabled Older Adults with Financial Difficulties* (关于建立健全经济困难的高龄失能老人补贴制度的通知) which became the guidance document for the local government. In the document, the Ministry of Finance permitted that the subsidy standards for older adults with financial difficulties can be independently determined by each local government based on the local economic level, price change and government financial status. The provincial government could formulate a unified subsidy standard if its financial status allows. Conversely, the municipal or city government can determine the Standard of subsidies based on actual financial conditions of government, fiscal surpluses level, and the market price of the LTC homes and services.

In response, the government of Zhejiang province published *the Regulations on the Promotion of Elderly Services in Zhejiang Province* (浙江省社会养老服务条例) in 2015, which stated that the government above county level shall establish and improve the subsidy standard. Then in 2019, the Civil Affair Bureau of Hangzhou issued *the Implementation Opinion of Elderly Service Electronic Allowance* (杭州市养老服务电子津贴制度的实施意见), which determined that older adults over the age of 80 will receive 40 CNY (around $8 CAD) per month, the older adults over age of 90 will receive 100 CNY (around $20 CAD) per month. Additionally, older adults with financial difficulties can receive a subsidy of up to 1,820 CNY (around $350 CAD) per month. It should be mentioned that these subsidies would be directly remitted by the city government to the beneficiary's social insurance account, which means these subsidies can only be used for social or medical services and cannot be withdrawn. In 2021, the General Office of Hangzhou government published the *Measures for the Implementation of Long-Term Care Subsidies for Disabled Seniors in Long-Term Care Facilities* (杭州市失能老年人入住养老服务机构护理补贴实施办法), according to which individuals who are over the age of 60 and assessed to be disabled can receive a subsidy up to 600

CNY (around $115 CAD) per month. Other than this subsidy, the Chinese government also provides free LTC home services to the “three nos” individuals (三无). *The Guiding Opinions on Regulating the Service Charge Management of Elderly Care Institutions and Promoting the Healthy Development of Elderly Service* (关于规范养老机构服务收费管理促进养老服务业健康发展的指导意见) published by the National Development and Reform Commission and the Ministry of Civil Affairs in 2015 defines the “three nos” as individuals who are not able to work, have no source of livelihood, and have no support network such as family. The document also stipulates that government funded LTC homes should be free to “three nos” population in accordance with *the Law*.

In general, the Chinese government provides limited financial aid to the residents who live in LTC homes. At the same time, the Chinese government is willing to learn from the experience of other countries and try new things. In 2016, the State Council of China published *the Several Opinions on Fully Liberalizing the Elderly Care Service Market and Improving the Quality of Elderly Service* (关于全面开放养老服务市场提升养老服务质量的若干意见), in which the State Council of China started to promote LTC insurance. In the earlier document published in 2016, the *Guiding Opinions on the Pilot Program of the Long-Term Care Insurance System* (关于开展长期护理保险制度试点的指导意见) published by the Ministry of Human Resources and Social Security, the government designated 14 provinces to explore the establishment of the LTC insurance system which raised funds through joint contribution systems and provided funds or service for individuals with disabilities. In response, the Civil Affair Bureau of Hangzhou issued *the Interim Measures for Long-Term Care Insurance in Hangzhou* (杭州市长期护理保险暂行办法, hereinafter called *the Interim Measure*) which stipulated that individual who are insured by the basic medical insurance for employees and the basic medical insurance for residents, are mandated to participate in LTC insurance. The insurance fee was about 0.3% of the provincial average salary in the previous year. The premium was approximately 120 CNY (around $22 CAD) per person per year of which 50% was paid by the individual and the remainder was allocated from the municipal government. Participants who have had disabilities due to aging, illness or disability can

enjoy the LTC insurance benefit after assessment of their physical disability. Once the assessment standard is determined, up to 70% of the cost will be covered by LTC insurance.

Simultaneously, the government is actively introducing a commercial LTC insurance system into the market. In 2019, the Ministry of Civil Affairs published the *Implementation Opinion on Further Expanding the Supply of Elderly Care Service and Promoting the Consumption of Elderly Care Service* (关于进一步扩大养老服务供给,促进养老服务消费的实施意见) which supports commercial insurance corporations to develop critical illness insurance, medical insurance, LTC insurance and other insurance types to effectively provide solutions for unaffordable care. The document also advocates that the Communist Party and government agencies, social institutions, and enterprises guide their employees to participate in the insurance. China's LTC insurance is still in the pilot phase, however it is foreseeable that a comprehensive LTC insurance system will be implemented in the future.

3.2.5.2 Public Vs. Private Payment Differences

There are both public and private LTC homes in China. Both types are regulated by the government, but the government only has pricing power over publicly funded LTC homes (State Council of China, 2016a). As one of the measures to encourage private investment in the LTC industry, *the Opinion* encourages the market to play a fundamental role, which means the government will let the market decide the price for privately funded LTC homes. It is also mentioned in *the Zhejiang Provincial Interim Measures for the Management of Elderly Care Service Charges* (浙江省养老服务收费管理暂行办法; Zhejiang Civil Affairs Bureau, 2014) that the payment rate of accommodation fees and care service fees should be determined by LTC homes based on the actual costs and reasonable profit. However, the price of publicly funded LTC homes is regulated by the government. This document also stipulates that publicly funded LTC homes should operate at a government-guided price. The city and municipal government shall set benchmark prices and floating ranges so that public LTC homes can independently determine the specific fees within the prescribed standard. Regrettably, searches

performed for this study did not produce a document describing Hangzhou's municipality pricing standard. However, the pricing of all public LTC homes funded by the municipal government have been published online. Looking at the Hangzhou Third Welfare Institution as an example, the accommodation fee ranges from 1,100 CNY (around $200 CAD) to 7,500 CNY (around $1,450 CAD) per month depending on the room type. The service fees range from 630 CNY (around $140 CAD) to 2,230 CNY (around $450 CAD) per month based on resident's care requirements. Although the government only provides a limited number of subsidies, the price of publicly funded LTC homes is still affordable for the public.

3.2.5.3 Financial Support for LTC Homes

The government provides a variety of financial supports to LTC homes through policies that encourage social investment in LTC industry. *The Opinion* requires the government to improve investment policies and establish a support system to attract private capital into the LTC industry. Based on the *Implementation Opinion of the General office of Hangzhou Municipal Government on Encouraging Social Forces to Establish Elderly Care Service Institutions* (杭州市人民政府办公厅关于鼓励社会力量兴办养老服务机构的实施意见), there are four types of financial help: tax concessions, daily operation subsidies, construction subsidies, and ranking subsidies (General Office of Hangzhou Government, 2014). Tax concessions include the following: (1) not-for-profit homes can be exempted from corporate income tax, (2) not-for-profit homes can be exempted from property tax and land use tax, and (3) LTC homes can be exempted from paying employment security funds for personnel with disabilities. Daily operation subsidies include: (1) LTC homes pay rates comparable to residential users for their electricity, water, and gas usage; (2) LTC homes pay 70% of the Standard fees for firefighting training; (3) except for the charges stipulated by laws and regulations, no additional fees may be charged to LTC homes; and (4) where the charging standard is set with boundaries, LTC homes will be charged according to the lower limit. Table 3-7 provides details about these subsidies. Other than the construction subsidy, the government also provides loans to LTC homes at a preferential rate (China Development Bank, 2015). The Chinese government also gives extra funding to homes planning to build medical clinic.

Based on the scale, the Chinese government provides subsidies from $20,000 CAD to $600,000 CAD. On the other hand, to cope with fraudulent declarations, the State Council of China in 2019 issued the *Opinions on Establishing and Improving the Comprehensive Supervision System of Elderly Services to Promote the High-quality Development of Elderly Service* (关于建立健全养老服务综合监督制度促进养老服务高质量发展的意见), in which the State Council of China required that local governments supervise the distribution of subsidies. The local government should regularly conduct random checks and verifications on the authenticity and accuracy of information on subsidy funds applied and used by the LTC homes. It is worth noting that the document did not mention the recovery of the remaining funds. Compared to residential support, the government has spent more money on supporting the construction of LTC homes (HangzhouGovernment Civil Affair Bureau, 2021; Hangzhou Municpal Government, 2014b; Hangzhou Munipal Bureau of Finance, 2020).

Table 3-7

LTC Homes Subsidies in Hangzhou

Type	Home type	Funding item	Amount ($ CAD)	Property type	Location
Construction subsidy	Non-for-profit	Subsidy for beds	2,400/bed	Owned	Urban
			1,200/bed	Owned	Rural
			1,600/bed	Rented	Urban
			1,000/bed	Rented	Rural
		Extra fund for care bed	800/bed	Owned	Urban
			400/bed	Rented	Urban
			400/bed	Owned	Rural
			200/bed	Rented	Rural
	For-profit	subsidy for beds	1,920/bed	Owned	Urban
			1,280/bed	Owned	Rural
			640/bed	Rented	Urban
			320/bed	Rented	Rural
		extra fund for care bed	640/bed	Owned	Urban
			320/bed	Rented	Urban
			320/bed	Owned	Rural
			160/bed	Rented	Rural
Ranking subsidy	Five-star	One-time subsidy	10,000	All	All
	Four-star		6,000	All	All
	Three-star		2,000	All	All

Note. Adapted from The Instruction of Admission, by the Civil Affair Bureau of Hangzhou, 2021. From http://mz.hangzhou.gov.cn/col/col1588522/index.html. Copy right 2021 the Civil Affair Bureau of Hangzhou.

3.2.6 Summary

In summary, long-term care service is regulated by all levels of the government in China. The government is responsible to provide basic medical and long-term care services. Medical care in LTC homes is not mandatory, but it is encouraged. The quality assurance is evaluated both by the government and residents of the LTC homes. PSW workforce is not regulated, and although PSWs have a certification system, having a certificate is not mandatory. Multiple government supports are available for PSWs. Limited financial supports are provided to LTC home residents and the LTC insurance is in the pilot stage of development. Only publicly funded LTC homes have pricing regulated by the government. Hence, public homes are more affordable compared to private homes. Finally, multiple financial supports are provided for building new LTC homes, but no recovery system of unused funds was identified in China.

3.3 Japan

LTC policies in Japan are guided by Japanese political culture briefly explained here. As a country that has been deeply influenced by Chinese culture since ancient times, Japan has a culture of collectivism where greater good is more important than individual benefits. However, unlike China, Japan launched a reform movement in 1868, known as the Meji revolution and began to introduce political ideas from Western countries (Fujita, 2017). Among them, the Bismarck model, the predecessor of the modern welfare system developed in Germany, has had a deep impact on Japan.

3.3.1 General Information

Japan's political system lies between Ontario and China. Japan has a Western style parliamentary system and a central-local bicameral administrative system similar to China, but Japan's political and administrative system also has its uniqueness. The power of the House of Representatives is significantly greater than the House of the Senate. Most bills are often passed by the House of Representatives. On the other hand, the Japanese parliament has the power to enact various laws to restrict local administration. However according to *the Local Autonomy Law* (地方自治法), local government at any level have the right to issue local regulations to regulate the behavior of local residents without violating the laws issued by the central government, which is very similar to China's administrative system. However, unlike China, Japan's central government and local governments are equal and have no affiliation relationship.

A total or 28 documents published from 1960 to 2021 were included in this thesis. Policy sources were published by the Ministry of Health, Labor and Welfare (MHLW) (n=13), the Cabinet of Japan (n=1), the Parliament of Japan (n=2), the Bureau of Social Welfare and Public Health of Tokyo Metropolitan (n=6), the Japan national Council of Social Welfare (n=1), the Ministry of Internal Affairs and Communications (n=1). The included sources were laws (n=2), a government decree (n=1), a ministry decree (n=1), a government evaluation report (n=1), official documents from the MHLW websites (n=15), local regulations and standards (n=4), local official documents (n=3) and an association report (n=1)

3.3.2 Regulation

In 1960, the Parliament of Japan passed *the Act on Social Welfare for the Elderly* (老人福祉法), in which the central and local governments were stipulated to be responsible to promote the well-being of the older adults. In the same Act, the parliament provided definitions for many existing LTC services and facilities, including the elderly living support service (老人居宅生活支援事業), the elderly home care service (老人居宅介護等事業), the elderly day care service (老人デイサービス事業), the elderly short-stay service (老人短期入所事業), the small-scale, multifunctional at-home care (小規模多機能型居宅介護事業) such as LTC home with less than 10 residents, publicly funded long-term care home (特別養護老人ホーム), retirement home (養護老人ホーム), and low-cost retirement home (軽費老人ホーム). The act also regulated the operation of the private long-term care homes. In 1997, the Japanese parliament passed t*he Long-Term Care Insurance Act* (介護保険法) which is the foundation of the modern Japanese long-term care system. The act regulated all items related to elderly care services, from public contribution to the government contributions and the items such as the insured individual and the services that can be covered. It is worth noting that the act also stipulates that only care services provided by private long-term care homes that were recognized by the government (特定施設) can be covered by the insurance. The entire Japanese long-term care industry now operates based on this act. The content of the act will be presented in the service provision and financial sections and will be mainly discussed in the financial section. To fit the scope of this study, only content related to publicly funded LTC homes (特別養護老人ホーム) and recognized private long-term care homes (特定施設) that fit the requirement of *the Long-Term Care Insurance Act* will be discussed. Also, the Japanese government regards residents in the private LTC home as people who rent a home with care, hence the private LTC homes are technically defined as home care.

3.3.3 Service provision

3.3.3.1 Policies Governing Services in LTC Homes

The operation of LTC homes in Japan is regulated by the government, irrespective if the home is privately or publicly funded. However, Japan's publicly and private LTC homes are regulated by a variety of different regulations. In 1998 the MHLW published *the Standard for Personnel, Equipment and Operation of Designated Long-Term Care Facilities for the Elderly* (指定介護老人福祉施設の人員、設備及び運営に関する基準) which is designed to regulate publicly funded LTC homes. The same year, the MHLW published *the Standard for Personnel, Equipment and Operation of Designated Home Care Service* (指定居宅サービス等の事業の人員、設備及び運営に関する基準), in which the Japanese government regulated the home care service, including private long-term care homes. To the Japanese government, private LTC homes are part of the home care service. These two standards are similar in terms of content as both require LTC homes to provide daily care services (e.g., dressing), sanitation services (e.g., shower support), and excretion assistance for the older adults. In addition, both standards require the LTC homes to make a care plan for each individual living in the facility. The care plan should identify issues that the resident may face during daily living, goals of the care, and any concerns that may require attention in the care implementation process. The LTC home must involve the resident or their family during the process of making the care plan. After the plan is completed and before it is implemented, the LTC home must get the permission from the resident or their family and must leave a physical copy with the resident or their family. The LTC home also must cooperate with other health care providers or facilities to keep residents in good health.

Compared to the Standards used to regulate private LTC homes, the Standards for public LTC homes have additional, more detailed regulation. For example, public LTC homes must pay attention to possible bed sores, there must be at least one full-time RN in the home 24/7, and homes must provide recreation, rehabilitation, and social services. In the care plan section, the Standard requires public LTC homes to have a care manager

who makes care plans, regularly meets with staff, performs resident assessments, and adjusts the care plan based on the results of assessments.

As mentioned earlier, local governments have the right to make more detailed regulations based on the two standards. In 2012, the Tokyo government published *the Tokyo Metropolitan Ordinance on Equipment and Operation Standards for Special Elderly Care Home* (東京都特別養護老人ホームの設備及び運営の基準に関する条例), *the Tokyo Metropolitan Ordinance Enforcement Regulations on Equipment and Operation Standard for Special Elderly Care Homes* (東京都特別養護老人ホームの設備及び運営の基準に関する条例施行規則), *the Tokyo Metropolitan Special Elderly Care Home Equipment and Operation Standards Ordinary Enforcement Guidelines* (東京都特別養護老人ホームの設備及び運営の基準に関する条例施行要領), and *the Tokyo Metropolitan Private Long-Term Care Facility Operation Guidelines* (東京都有料老人ホーム設置運営指導指針). These documents provide more detailed regulations on staffing, qualifications requirements, and shift work in LTC homes, all of which will be discussed in subsequent chapters.

3.3.3.2 Medical Service

All levels of government in Japan require LTC homes to provide sufficient equipment and personnel to meet the medical needs of residents. Under the requirement of *the Standard for Personnel, Equipment and Operation of Designated Long-Term Care Facilities for the Elderly* (指定介護老人福祉施設の人員、設備及び運営に関する基準) and *the Standard for Personnel, Equipment and Operation of Designated Home Care Service* (指定居宅サービス等の事業の人員、設備及び運営に関する基準), LTC homes in Japan have to establish a system of cooperation with medical and dental institutions in order to prepare for sudden changes in the medical or dental conditions of residents. Each LTC home must announce the name of the cooperating institution, details of cooperation, and medical services that are available to the residents. The Standards also require LTC homes to have a medical clinic within the home. Interestingly, there are no detailed requirements for the medical clinic within LTC homes. According to the

requirements in two standards for medical clinics within LTC, the homes only need to comply with *the Medical Care Act* (医療法) in Japan, described below.

The term “medical clinic” refers to the place where a doctor or dentist conducts medical practice or dentistry for less than 19 patients at one time. Under the requirements of the Act, the medical room has to be lower than the 3rd floor, the minimum average space for each patient has to be larger than 6.4 square meters, and needs to have the necessary equipment to prevent potential emergency incidents (i. e., air regenerating device, restraint equipment). The article even regulates the width of the corridor leading to the medical clinic (over 1.2 meters), and the height and width of the steps (height less than 0.2 meter, width over 0.24 meter).

Requirements for medical personnel in LTC homes, are not regulated by the Medical Care Act,, but the two standards. The residents to RN ratio must be lower than 30:1 to 50:1 depending on the number of beds in the LTC home to provide sufficient medical care with helps from PSWs (PSW-resident ratio is required to be 1:3). The Standard used to regulate public LTC homes requires sufficient number of physicians to monitor residents’ physical conditions. However, the Standard used to regulate private LTC homes does not have any requirements for physicians. In summary, the Japanese government requires both public and private LTC homes to provide residents with necessary medical services, but the requirements differ between types of LTC homes.

3.3.3.3 LTC Home Quality Assurance

Japan’s LTC home quality assurance system, is based on government inspections and third-party evaluations. Japanese government at all levels has the right to inspect any LTC home at any time. The inspection only checks whether the LTC home is operating in accordance with government policies, or if significant incidents have occurred or could potential occur (e.g., elder abuse). To address this, in 2004 the MHLW issued *the Guidelines about Third-Party Evaluation on Social Welfare Facilities* (福祉サービス第三者評価事業に関する指針について) and proposed the concept of third-party evaluations. The third-party are both for-profit and non-profit health care organizations designated by the Japanese government. Under this policy, the government authorized

private or public third-parties to perform assessments of the LTC home, provide training and provide evaluation standards. The third-party provides evaluations for publicly funded LTC facilities (including public LTC homes) that voluntary agree to be evaluated. The evaluation results are published on a government funded social welfare website, such as Tokyo Welfare System Third-Party Assessment Navigation (http://www.fukunavi.or.jp/fukunavi/hyoka/hyokatop.htm).

In terms of evaluation standards and tools, the Japanese approach is quite unique. To evaluate the service quality of a public LTC home, Japan's government is using an approach that combines resident survey developed and standardized by the government and whether the LTC home is providing correct service content for residents. The evaluator assesses the concept and principle of operation of a LTC home, as well as the impression about the staff. With the resident survey, the evaluator collects answers directly from residents about food service, daily service, equipment and hardware, staffing, living environment, care plan, and complaints from residents. To assess whether the LTC home is correctly providing services, the Standard divided the service type into six categories: information of service provided to residents, responses at the beginning and end of the service, care plan, provision of the service, privacy of residents, and standardization of daily operation. Within each category, there are several objectives. If the LTC home achieves the objectives, the evaluator will check the box. In general, the more objectives achieved, the better the quality of service in LTC homes. Appendix E provides an example showing evaluation results published on the Tokyo Welfare Navigating Website.

Because of the special nature of the private LTC homes in Japan, where the private LTC home is defined as home care, the quality assurance system is not mature enough.. As the result, the Japanese government cannot compel the private LTC homes to uphold standards of care comparable to the public LTC homes. In *the Administrative Evaluation and Monitoring of the Operation of Private Long-Term Care Home* (有料老人ホームの運営に関する行政評価・監視) published by the Ministry of Internal Affairs and Communications, the government states the situations of evaluating private

LTC homes that most of private LTC homes were not willing to be examined. This study has not been able to identify any policy regarding third-party evaluation of private LTC homes in Japan. Several prefectures in Tokyo have participated in voluntary third-party evaluations for private LTC homes that are members of the Japanese Association of Retirement Housing (Ministry of Internal Affair, 2016). Based on the report from Ministry of Internal Affairs and Communications (2016), only 8.4% of private LTC home have joined this association. Extensive search conducted for this study did not identify other documents suggesting that the Japanese government intention to introduce new policies regarding third-party evaluations of private LTC home.

3.3.3.4 Admission and Assessment

Under the requirement of *the Standard for Personnel, Equipment and Operation of Designated Long-Term Care Facilities for the Elderly* (指定介護老人福祉施設の人員、設備及び運営に関する基準) and *the Standard for Personnel, Equipment and Operation of Designated Home Service* (指定居宅サービス等の事業の人員、設備及び運営に関する基準) the Japanese government requires both private and public LTC homes to be in charge of the admission process. The public LTC homes are responsible to rank applicants according to their physical conditions. Residents in critical conditions come first, and those with alleviated conditions follow behind. The government requires both public and private homes to assess residents upon check-in and develop individualized care plans. The government plays the most important role in the process of admission and assessment, because based on the assessment, the government has the right to determine level of service the resident is entitled to for reimbursement. This is all related to the Long-Term Care Insurance Act where Japanese government requires that every applicant must be assessed by an agency designated by the government before using any long-term care service, and only those who meet the criteria are eligible to apply for government reimbursement. Different crisis levels are eligible for different type of services.

The payment of services and the government coverage are further described. The Japanese government divides people who need to use long-term care services into seven

levels: Support Required Level 1, Support Required Level 2, Care Required Level 1 to 5. Being classified into Support Required Level 1 and 2 means that the individual has ability to live independently, and the government only needs to provide help to prevent the situation from deteriorating such as providing rehabilitation service and renting necessary equipment (e.g., walker). For individuals classified into Care Required Level 1 through 5, the person has lost the ability to live alone and needs continuous help from others. Only individuals classified above Care Required Level 3 are eligible to apply for admission to public LTC homes. Being classified as the Care Required Level 3 indicates that the individual has lost the ability to eat or excrete independently, is unable to stand on their own and has certain level of cognitive impairments. All levels are divided by the government designated agency according to the standards made by the Japanese government.

There are two rounds of assessments. The first round is conducted by the designated agency and entered into a computer program developed by the government. The first round of assessment includes the following items: direct living assistance (e.g., dressing, eating), indirect living assistance (e.g., housekeeping, laundry), cognitive ability, physical ability, and overall medical condition. The Japanese government has developed a decision tree algorithm that assigns an estimated care time to each aspect and determines the crisis level based on the total estimated care time. Table 3-8 shows how crisis levels are assigned based on the total amount of estimated care time. Individuals who pass the first round, enter the second-round of assessments conducted by a LTC committee composed of five experienced physicians or nurses. Only individuals who pass both rounds of assessment are eligible for reimbursement from the LTC insurance.

Table 3-8

Category of Crisis Level and Reference Time for Certification of Each Category

Crisis Level	Reference time (min)	Condition of the individual
Support required 1	25<t<32	Basic activities of daily living can be performed by individual but need measures to maintain the condition.
Support required 2	32<t<50	
Care needed 1	32<t<50	A stage in which the ability to perform activities of daily living is further reduced from support required level, and partial care is required.
Care needed 2	50<t<70	In addition to the care needed level 1, the condition of the individual requires partial long-term care for activities of daily living.
Care needed 3	70<t<90	Compared to the care required level 2, the condition of individual is significantly reduced from the aspects of activities of daily living and requiring almost full care.
Care needed 4	90<t<110	Compared to the care required level 3, the movement ability is significantly impaired, which makes it difficult for individual to carry out daily life without long-term care.
Care needed 5	t>110	The movement ability is further reduced than the care required level 5, and it is almost impossible to carry out daily life without long-term care.

Note. Information gathered and translated from the MHLW.

https://www.mhlw.go.jp/topics/kaigo/kentou/15kourei/sankou3.html

3.3.4 PSW Workforce

3.3.4.1 Regulations for PSWs

In terms of social context, Japan does not have a professional self-regulatory organizations like Ontario's Registered Nurses' Association, and the central government is responsible to regulate certain professions such as physicians and nurses. PSW workforce is not regulated by the Japanese government. Under the current policy, the government does not require PSWs working in public or private LTC homes to have qualifications. Under the requirement of *the Tokyo Metropolitan Special Elderly Care*

Home Equipment and Operation Standards Ordinary Enforcement Guidelines (東京都特別養護老人ホームの設備及び運営の基準に関する条例施行要領), the only requirement of PSWs is to have the knowledge and the enthusiasm for their work. On the other hand, Japan has a good education and certification system for PSWs.

3.3.4.2 PSW Education and Certification

The *Document Regarding the Legislation of the Qualification System for Certified Social Welfare Workers* (福祉関係者の資格制度の法制化について) was issued by the joint planning subcommittee of the third welfare-related councils, the Central Social Welfare council. *The Certified Social Worker and Certified Care Worker Act* (社会福祉士及び介護福祉士法) was enacted on May 21, 1987 and promulgated on May 26, 1987 during the 108th National Assembly. With *the Certified Social Worker and Certified Care Worker Act*, the Japanese government officially defined the certified PSW as a career recognized by the Japanese government. The government defined the certified PSW as a career in which a PSW uses their knowledge and skills to provide care according to the physical and mental needs of a person who has difficulty in daily life due to physical or mental disability.

The qualification test is standardized across the country and divided into written and practical parts. The scope of the test covers social welfare theory, welfare theory for the elderly and the disabled, rehabilitation theory, social welfare assistance technology (e.g., care robot that includes practice test), recreation service method, psychology of the elderly and disabled, introduction to economics, general medicine, mental health, long-term care theory and practice. According to the Act, there are three ways to acquire the certification. The first one is to pass the certification test after three years of experience working in LTC industry (e.g., community care center) or in LTC homes.

The second way to be certified is to graduate from a government designated program and pass the certification test. All designated programs are being taught as either two year or one year program at college, or a specialized high school program using Japanese government approved standardized curriculum. According to the *Certified*

Social Worker and Care Worker Program Designation Rules (社会福祉士介護福祉士学校指定規則), designated programs must provide courses on the structure, function and disease of the human body, psychological theory and psychological support, social theory and social system, and along various other subjects described in Appendix F.

The third way to obtain the certification is through the Economic Partnership Agreement (EPA). To maintain sufficient health care workforce (including PSWs), the Japanese government signed multiple EPAs with Southeast Asian countries, such as Vietnam and Indonesia. These agreements allow PSWs who have more than three years of experience working as a PSW in their country to take the certification exam. These exams are organized by the Japanese government in countries with the EPA agreements. In summary, Japan's PSW education system is regulated by the government, has well developed and standardized curriculum, is layered from high school to college level of education, and is set up to recruit experienced PSW workforce through emigration from Southeast Asia.

3.3.4.3 Employment and Government Support

Japan only requires the total employment time, which is related to the requirement for fulltime PSW-residents ratio, named by the government as "full-time equivalent system" (常勤換算方法). Under the requirements of *Regarding the Full-Time Equivalent System* (常勤・非常勤及び常勤換算方法について) and *the Tokyo Metropolitan Ordinance on Equipment and Operation Standards for Special Elderly Care Home* (東京都特別養護老人ホームの設備及び運営の基準に関する条例), only PSWs who work more than 32 hours per week are considered full-time employees. Also, the home must meet resident to full-time PSW ratio requirement of 3:1. However, it is difficult for some LTC homes to recruit full-time employees. Therefore, the government allows the LTC home to combine the total working time of all employed PSWs (no matter part-time or full time) to satisfy the number of required PSW working hours. In other words, to meet the 3:1 ratio, for every three residents, the LTC home must have enough PSWs to work a total of at least 32 hours per week. For example, if a LTC home has 30 residents, the home needs

to recruit at least ten full-time PSWs or enough part-time PSWs to work the equivalent of 320 hours per week.

According to the Changes in the Number of LTC Staff (MHLW, 2021), the shortage of 220,000 PSWs created a gap between the needs and available workforce. Therefore, the government has introduced several measures to ensure enough PSWs in the future. These measures include providing additional education, raising salaries, reducing labor intensity, reimbursing tuition fees, and providing living allowances. The Japanese government believes that improving the skill level of PSWs will help them improve their incomes, so it has introduced multiple certification programs, such as *the Sputum Suction Education Program* (喀痰吸引等研修). Any PSW who passes this program will receive a government certificate and have opportunities to obtain higher salary.

The main source of income within a Japanese PSWs' salary is the LTC service fee paid by the user. The LTC service fee is set by the Japanese government, so to increase the salary of PSWs, Japan will adjust the rate of the LTC service fee every two or three years, as explained in a document *Regarding the Care Service Fee in 2021* (令和３年度介護報酬改定の主な事項について). For example, the Japanese government increased some of the fees for dementia-related services, increased the long-term care service fee, but reduced the charge for intensive care. Within the same document, the Japanese government also proposed salary increase for PSWs but did not specify the amount of increase. As a measure to ensure the PSW workforce, the Japanese government was trying to reduce labor intensity for PSWs, the government has proposed the following measures: increase parental leave, use nursing robots to reduce the staffing during night shifts, increase the use of new technologies to ease labor intensity, and use information. The Japanese government also provides funding subsidies that include different amounts of livings expenses, and tuition subsidies for students through the *Study Funding and Loan System* (修学資金貸付制度) since 1993. Appendix G provides details of subsidy types and requirements for re-payment exemptions. In addition to increasing the number of new PSWs, the Japanese government has also proposed a policy to encourage formerly

certified PSWs, who have changed their careers, to return to the LTC industry. Eligible individuals receive $4,400 CAD in work support fee, which is exempted from repayment after two years of service as a certified PSW.

3.3.5 Financial Policies

3.3.5.1 Financial Support for Residents

Japan passed the Long-Term Care Insurance Act in 1997, and officially implemented it in 2000. Under this Act, only people over 65 years old, or eligible people over 45 years old, are eligible to use the LTC insurance. The Japanese government covers 70% to 90% of the care service fees based on the income level of the individual's household. This is important as most women in Japan resign from their job after marriage, making their husband the only regular income earner in the household. All citizens over 40 years old are obliged to participate in the LTC insurance, and the cost is based on the average income of the region and household income. Here is an example using data for Meguro district of Tokyo. The minimum amount of monthly LTC insurance payment is 1,860 JPY (approximately $20 CAD). Only people with no income are eligible for this amount. The maximum payment is 22,320 JPY (approximately $246 CAD) per month for a household with a total yearly income of 20 million JPY (approximately $220,000 CAD). Under *the Long-Term Care Insurance Act,* the financial resources for LTC insurance consists of 50% premiums collected from citizens 40 years of age and over, and 50% from public sources such as taxes. The 50% from public sources is divided to 25% from the Japanese government, 12.5% from the city government (e.g., Tokyo) and 12.5% from the local government (e.g., Meguro district).

Although the Japanese government has set standards for LTC services fees regardless of whether the LTC home is public or private, the Japanese government has not set a price standard for living expenses such as accommodation fees or food costs. On the other hand, the government has support measures for low-income population. For low-income residents who live in a public LTC home, the government has set a maximum charge standard presented in Table 3-9. The *Long-Term Care Insurance Act* also specifies a payment threshold based on the household income level of the insured

individual. If the insured individual's monthly out-of-pocket payment for care service fees exceed the threshold, the insured individual has the right for reimbursement from the government for the portion that exceeds the limit. Table 3-10 provides further information on the income level and personal payment ceiling in Meguro District of Tokyo.

Table 3-9

Maximum Living Cost and Income Level in Meguro District of Tokyo

Income level ($ CAD/Year)	Maximum payment based on room type ($ CAD/day)				Maximum payment for meal ($ CAD/day)
	Private room (unit type)	Semiprivate room (unit type)	Private room	Multi-bedroom	
None	9	5	5	4	3
0-8,800	9	5	5	4	4
8800-13,200	14	14	9	4	7

Note. Unit type LTC homes are facilities that provide LTC care to small group of people (around 10) in one unit (e.g., one floor, one block). Information gathered from: https://www.city.meguro.tokyo.jp/kurashi/kaigo/kaigoriyoannai/genmen.html

Table 3-10

Relationship Between Household Income Level and Maximum Personal Payment Ceiling in Meguro District of Tokyo

Income level ($ CAD/year)	Maximum Payment ($ CAD/month)
None	165
0-8,800	165
8,800-13,200	270
13,200-84.821	490
84,821-127,783	1024
Over 127,783	1543

Note. Personal living cost in LTC homes is not included in the payment ceiling. Information gathered from: https://www.mhlw.go.jp/content/000334526.pdf

3.3.5.2 Private vs. Public Payment Differences

The cost difference between the private and the public home in Japan is not reflected in service costs, but in daily living expenses such as accommodation fee. Other than the services provided in users' own home, long-term care service is offered through both public and private LTC homes in Japan. The Japanese government is responsible for reimbursing most of the LTC service fees in both types of homes according to predetermined charging standards. In contrast, the government does not have the right to set the price of living expenses charged by public homes to residents with high incomes and private homes to all residents.

Japan has adopted a billing system that is different from that of most countries. Most other LTC services provided in users' own home such as cleaning service or shower support are calculated on hourly bases or pay-per service. Further, based on the national average income, Japan sets the unit price for LTC services every two to three years. According to *the Unit Price of One Unit Set by the Minister of Health, Labor and Welfare* (厚生労働大臣が定める一単位の単価) published in 2015, one unit is worth 10 JPY (approximately $0.1 CAD). The unit price varies slightly depending on the type of LTC service and the region. For example, for home care services, the unit price in Tokyo is 10.4 JPY (approximately $0.1 CAD), and in Sapporo, Hokkaido, it is 10.04 JPY (approximately $0.1 CAD). The number of units required for the same type of service is always the same. Regardless of the region, the price of home care is 579 units per hour (MHLW, 2021).

The LTC home services provided by LTC homes (both public or private) are calculated based on the number of days stayed in the home. The unit price of LTC home is 10.09 JPY (approximately $0.1CAD) in Tokyo, and the number of units required per day varies from 580 units to 1084 units depending on the facility type and the level of care. There are two main types of LTC homes in Japan, regardless if they are funded privately or publicly. One is the regular LTC home similar to LTC homes in Ontario (Canada), and the other type is called "the unit type" which is comparable to LTC homes in Sweden. The unit type home has less than 10 single rooms per floor and residents share one common living space. This setup allows residents to maintain their personal

environment and daily routine. Table 3-11 provides more information about unit requirements for LTC home services. The units listed in the table cover care and daily support services, but if the resident requires additional services, such as enhanced care or special meal services, additional fees are applied.

Table 3-11

Required Units for Different Long-Term Care Home Service

Care need level	Required unit based on facility type (unit/day)			
	Regular LTC home	Regular home (small size)	Unit type LTC home	Unit type LTC home (small size)
Level 1	580	742	663	813
Level 2	651	809	733	879
Level 3	723	880	807	951
Level 4	794	947	877	1,018
Level 5	863	1,013	947	1,084

Note. Small size stands for home with less than 30 beds. The public LTC home in most cases will only take the individual whose care need level is identified higher than care need 3. The Private home will only take the individual whose care need level is higher than 1. The total price can be obtained by the unit price which is 10.09 JPY (approximately $0.1CAD). Information gathered and translated from: https://www.mhlw.go.jp/web/t_doc?dataId=82ab4582&dataType=0&pageNo=1, and https://www.mhlw.go.jp/file/05-Shingikai-12601000-Seisakutoukatsukan-Sanjikanshitsu_Shakaihoshoutantou/0000034742.pdf

It is also worth mentioning the differences in living expenses caused by the nature of private and public LTC homes. Under *the Long-Term Care Insurance Act*, private LTC home services are categorized as a type of home care service, which is defined as "service received at home" (居宅において介護を受けるもの) (MHLW, 1997, C.41). Therefore, living in private LTC home in Japan is closer to the concept of renting an apartment which provides LTC home level of care, similar to the assistive living in US. Hence, compared to public LTC homes, private LTC homes in Japan have the right to charge their residents various miscellaneous fees, such as deposits, admission fee (a payment before admission), and even gift money (a unique non-refundable expense when

renting a house or a room customary in Japan). As a result, the cost of living in a private LTC home is often much greater than cost of living in a public LTC home.

3.3.5.3 Financial Support for Homes

Under the requirements of *the Long-Term Care Insurance Act* and *the Act on Social Welfare for the Elderly*, the local government has responsibility to promote development of social welfare for older adults in the region. Supporting LTC homes is integral part of this responsibility. The government's subsidy has two aspects: tax concessions and construction or renovation subsidies. According to the information published on the Japan National Tax Agency website (n.d.), any care service expenses incurred in a private or public LTC home will not be taxed. The local government has the responsibility to provide financial subsidy for construction or renovation of both public and private LTC homes in need. Usually, public LTC homes get more subsidies than private homes. For example the construction subsidy, provided by the Tokyo Metropolitan Government, is up to 2 million JPY (approximately $22,030 CAD) per bed for the private LTC home, and up to 5 million JPY (approximately $55,080 CAD) for the public LTC home. Table 3-12 provides further details about construction subsidies provided by the Tokyo Metropolitan Government.

Table 3-12

Construction Subsidies Provided to Public and Private LTC homes by the Tokyo Metropolitan Government

Type of subsidies	Subsidy amount for the private and public LTC home ($CAD/bed)	
	Public LTC home	Private LTC home
Construction	55,080	22,030
Reconstruction	66,100	22,030
Renovation	55,080	11,015
Augment	27,540	n/a

Note. Information gathered and translated from: https://www.fukushihoken.metro.tokyo.lg.jp/kourei/shisetu/tokuyou/2021tokuyousetumeikai.files/2R034gatusseibihihojoseidonogaiyou.pdf, and https://www.fukushihoken.metro.tokyo.lg.jp/kourei/shisetu/yuuryou/kankeisiryo/R02seidogaiyou.files/R3gaiyou.pdf

3.3.6 Summary

In summary, long-term care service in Japan is regulated by all levels of the government. The private LTC homes and the public LTC homes are regulated by two different policies. Medical care in LTC homes is mandatory. Quality assurance is focused on the public LTC homes as there are no requirement for the private LTC home to partake in third-party assessments. The government is responsible to designate qualified agency (e.g., physicians) to assess seniors before LTC home admission to determine the crisis level. PSW workforce is not regulated but there is a well-developed PSW education and certification system. There are multiple support measures available to PSWs. Japan has unique long-term care insurance system where government supports individuals with low income to live in the public LTC home. The Japanese LTC policies regulate the LTC service fee but not accommodation fee. There are several financial supports for both private and public LTC homes, but public homes tend to have more subsidies than private homes.

3.4 Comparisons Between LTC Policies in Ontario (Canada), China and Japan

3.4.1 Regulation

The systems of governance that influence creation of LTC policies in Ontario, China and Japan share interesting similarities and differences. China and Japan are unitary states, where state is governed as a single entity by a centralized government, while Canada has a federal system. This means that Canada allows provincial governments to have independent LTC policies. Although China and Japan have similar national structure, the differences in political system, population and geographical size make them different in regulatory details. For example, in Japan, the central and local governments have the same level of power in administration (e.g., policy making) that are not affiliated with each other, while in China central government has the right to supervise all lower levels of government (e.g., provincial or local).

The affiliation between different levels of government also affects the level of detail and implementation of policies. For instance, the Ontario government has the right to formulate LTC acts and policies to fit provincial needs. In China, local governments must follow the general guidelines and directions set by the central government to formulate detailed policies that fit local context. In Japan, central government formulates detailed policies and acts, but since levels of government in Japan are not subordinate to each other, the local government has the right to make additional rules without violating the policies and acts set by the central government. Table 3-13 summarizes government types, government levels, level of detail and fundamental document governing LTC homes policies in the three countries.

Table 3-13

Summary of Government Regulations and Fundamental Documents Guiding Long-Term Care Policies in Ontario (Canada), China and Japan

Country	Government types	Government level	Level of prescriptive	Fundamental document
Ontario (Canada)	Federalism	Provincial	Specific	*Long-Term Care Home Act*
China	Unitary System	Central and local	Unspecific for government guidance Specific for government standards	*Law of the People's Republic of China on Protection of the Rights and Interests of the Elderly (老年人权益保障法)*
Japan	Unitary System	Central and local	Specific (e.g., local government has the right to make local regulations)	*Act on Social Welfare for the Elderly (老人福祉法)* *Long-Term Care Insurance Act(介護保険法)*

3.4.2 Service Provision

3.4.2.1 Policies Governing Services in LTC Homes

Table 3-15 and Table 3-16 provide summaries of similarities and differences between service provision in three countries. All three countries have specific policies that govern service provision in LTC homes, however, the number of policies differs greatly, reflecting dissimilarities in governing styles and the level or prescriptiveness in some countries. Ontario regulates service provisions in LTC homes with only one document (the LTCHA) regulated by the single Ministry (MOHLTC). China has five documents issued by the central government alone, and numerous corresponding documents issued by local government (e.g., three in Hangzhou). This suggested that LTC in China are regulated in a multi-level and multi-sectoral way. Japan has two central documents and a number of local documents (e.g., four in Tokyo), which means that service provision in Japan is regulated both by the central government and local government. It is worth mentioning that the services LTC homes are required to provid are similar in all three countries. They include daily support service (e.g., dressing, showering), pain management, restorative care, dietary service, accommodation services (e.g., laundry, cleaning), mental support and recreational services. In Ontario and Japan,

making an individualized care plan for each resident is mandatory under the government policies, but there is no such requirement in Chinese policies.

The services LTC homes are required to provide are surprisingly similar in all three countries. They include daily support service (e.g., dressing, showering), pain management, restorative care, dietary service, accommodation services (e.g., laundry, cleaning), mental support and recreational services. In Ontario and Japan, making an individualized care plan for each resident is mandatory under the government policies, but there is no such requirement in Chinese policies.

Whereas service provision requirements are similar, there are significant differences in the level of detail provided in the policies. The level of detail in Ontario's service requirements is more detailed than in Japan, but not as detailed as in China. In the LTCHA and its regulations, the Ontario government puts forward requirements for the types of services that must be provided and explains the goals and implementation methods for each service. This is different in China where the government has specific requirements for each step of the LTC service provision. Chinese government puts forward specifications and standards for each step in the LTC service provision as descripted in the Appendix D. Japan's service provision requirements are the least detailed, only explaining what services must be provided by the LTC home. Table 3-14 summarizes information about LTC services provided in the three countries.

Table 3-14

Summary of Policies and Services in Each Country

Country	Number of documents	Required services	Level of Prescriptive
Ontario (Canada)	One	Accommodation service Care plan Continence care Daily support service Dental care Dietary service Fall prevention Medical service Mental support Pain management Recreational service Religious and spiritual practice Restorative care Skin and wound care	Moderate
China (Hangzhou)	Eight (five from central, three from local government)	Accommodation service Daily support service Dietary service Mental support Pain management Recreational service Skin and wound care	Specific
Japan (Tokyo)	Six (two from central, four from local government)	Accommodation service Care plan Daily support service Dental care Dietary service Recreational service Restorative care	Unspecific

3.4.2.2 Medical Service

Only China does not mandate medical services in LTC homes. Both Ontario and Japanese policies require LTC homes to be equipped with certain level of medical service, including 24-hour medical service access, 24-hour access to RN, and on-call program for physicians. Additionally, Japan has more requirements for medical services than Ontario. For example, Japan requires that all LTC homes must designate a hospital within their region to deal with any emergency medical situation. Also, Japan is the only country with explicit requirements for design of a medical clinic within an LTC home. Although the Chinese government does not currently require LTC homes to provide medical services, the government has put forth the concept of *"combination between care and medical service (医养结合)"* at the forefront of the development of the elderly care

industry. Through financial support and policy incentives, the Chinese government hopes to have all LTC homes integrated with existing medical services. This study uncovered that funding and LTC policy incentives in China regarding developing medical care in LTC homes far exceed those in Japan or Ontario. Finally, only Ontario does not specify required resident RN ratio in LTC homes. The Chinese government requires the resident-to-nurse ratio of 6:1, whereas the Japanese government requires the resident-to-nurse ratio of 30:1.

3.4.2.3 LTC Home Quality Assurance

Ontario, China and Japan all have a system in place to assure the quality of LTC home services, but they differ in terms of type, method of regulation, and the tools being used during inspection. In Ontario, quality assurance is mainly led by the government, and any failure to comply with the LTCHA results in punishment, such as monetary fine. The government grants rights to designated agencies (e.g., contractor or individual) to allow them to conduct mandatory yearly inspections of LTC homes. If the LTC home fails to improve after repeated warnings, the designated agency has the right to impose high and increasing fines on the LTC home or withdraw the funding support from the MOHLTC. China also uses government-led inspection supervision method, and combines reward with punishment. Inspections are carried out by the government alone and are divided into quality inspections and voluntary rating inspections. LTC homes with higher quality will be rewarded, while LTC homes with lower quality may be punished or even ordered to suspend business. Compared with the assessment methods in Ontario and China, Japan's regulatory approach is much more moderate. In addition to regular government inspections, the Japanese government has adopted a private-led, third-party inspection model, and there are no reward or punishment mechanisms involved. All public and private LTC homes that participate voluntarily are evaluated by private third-party institutions trained by the government. The focus of the entire inspection is on a resident survey assessing their experiences with the service in the LTC home. All survey results are posted online. However, due to the non-mandatory nature of these evaluations for private LTC homes, and the lack of punishment or reward, the effects of this quality assurance method are unknown.

In conclusion, the governments of the three countries have adopted three differenment approach to ensure the quality of service in LTC homes. Ontario (Canada) mainly uses warnings as the main method and punishment a supplementary measure to ensure that all LTC homes provide residents with service accordance with government requires. On the other hand, China has adopted a combination of rewards and punishment to ensure the quality of services in LTC home. In contrast, the Japanese System does not seem to be as mandatory as Canada and China. Hence, the effectiveness of such system remains unknown.

3.4.2.4 Admission and Assessment

Policies and tools for admission and assessment of residents in LTC homes exist in all three countries, but their importance differs greatly. The Ontario government adopted the Method for Assigning Priority Levels (MAPLe) where only individuals assessed as high or very high risk are granted admission to a LTC home. The designated agency (e.g., contractor or individual) in specific geographic region is further responsible to determine the position of the applicant on the waiting list. Nonetheless, the assessment tools and admission processes are different in China and Japan.China has centrally-issued assessment tools developed by its own, but since government does not monitor the admission process it does not seem particularly important to assess every resident. Only the older adults who apply for cash subsidies are assessed. Ontario and Japan differ from China because the number of residents admitted to LTC homes is directly related to the financial burden on the respective government, so both countries conduct strict assessment protocols for older adults who apply for LTC home admission. The Japanese government, in contrast, leave the responsibility for ranking older adults who apply for LTC homes to the homes, but all applicants are required to undergo an assessment to determine the stage of crisis. Japan’s LTC insurance system dictates which services can be reimbursed by the government depend on the crisis stage. Only applicants ranked as Care Needed Level 3 or higher can be granted admission to public LTC homes.

Table 3-15

Service Provision Similarities Shared by Ontario (Canada), China, and Japan

	Government role	Policies governing services in LTC homes	Medical service	LTC home quality assurance	Admission and assessment
Similarities	Governments of all countries are obliged to provide citizens with accessible LTC service (including the LTC home service).	All countries regulate, to some extent, the services provided in LTC homes.	Ontario and Japan require provision of medical services in LTC homes.	All countries have a unique system to ensure the quality of services in LTC homes.	All countries require assessment of residents at admission using country specific assessment tool.

Table 3-16

Service Provision Differences between Ontario (Canada), China, and Japan

	Government role	Policies governing services in LTC homes	Medical service	LTC home quality assurance	Admission and assessment
Ontario (Canada)	LTC policies are regulated by the provincial government	Has most types of service, no details required	Min one RN on site 24/7. Min one physician on site No requirement for patient-PSW or patient-nurse ratio	Self-check by the LTC home. Government inspection program RAI-MDS 2.0	Strict admission assessment Multiple ranking standards Regular 12 week RAI-MDS 2.0 assessments
China	The central government determines the direction, local governments decide details	Very detailed standards	Not mandated in LTC home. Recommended patient-nurse ratio is 6:1	Satisfaction survey Mandatory government inspection Service quality ranking system	Assesses only individuals applying for cash subsidies
Japan	The central government determines the detail, local governments have the right to add details	Broad requirements	Min one RN on site 24/7 Mandatory patient-PSW ratio is 3:1, and patient-nurse ratio is 30:1	Mandatory government inspection. Volunteered third-party inspection program	Strict assessment of applicants Classified based on the care dependent level

3.4.3 PSW Workforce

3.4.3.1 PSW Regulations

Table 3-17 and Table 3-18 provide summaries of similarities and differences between three countries in PSW workforce policies. This study identified a gaping hole in that none of the three countries have effective regulations for PSW workforce. Only Ontario has lax requirements where the LTCHA states that PSWs working in LTC homes have to obtain a certificate issued by a designated college. However, people without such a certificate are also allowed to work as PSWs as explained in the follow-up details of the LTCHA.

3.4.3.2 PSW Education and Certification

An interesting diversity in education and certification systems for PSWs emerged from the policy analysis. China and Japan have certification systems, while Ontario and Japan developed education standards. Ontario government does not stipulate a standardized curriculum and teaching methods for PSW education programs. However, the government has issued the *Personal Support Worker Program Standard* and the *Personal Support Worker Training Standard*. Within this standard, the government predetermined the level of skills that a qualified graduate from PSW programs needs to have to guarantee the vocational ability. This study did not find evidence to show if the Ontario government has developed other certification systems.

China entered elder care industry in recent decades and is still developing good education system for PSWs. Multiple policies have been issued by the central government requiring the local education departments to standardize the teaching methods and curriculum for PSW education, albeit this work seem to still be in progress as there is no evidence of their existence. In contrast, the Chinese government has introduced a complete certification system for PSWs based on their previous education and work experience. The biggest advantage of this system is that it does not prevent experienced caregivers, who have low education but long careers in caregiving, from obtaining high-level certifications.

Japan has the oldest PSW education and certification program among the three countries. Although anyone in Japan with passion can work as a PSW, Japan is the first country among these three to have certificated PSWs. The Japanese government has also established a nationally standardized education curriculum, textbook, and education time. Japan also signed EPAs with neighboring countries to encourage recruitment and certification of experienced PSW from abroad to immigrate and work in Japan. This shows that Japan is the only of the three countries that has a long-term plan for stabilizing and growing the PSW workforce.

3.4.3.3 PSW Employment and Government Support

The PSW employment type is an intriguing policy area, as this study failed to find evidence on employment type requirements. Ontario requires LTC homes to hire enough PSWs to meet the care and shift needs, whereas Japan asks the LTC homes to recruit enough PSWs to meet the 32 working hours per week prescribed by the government, and China apparently does not address this issue in any of its policy documents. According to the author's personal experience, while working in a LTC home in China, most PSWs worked full-time in the LTC home.

The governments in all three countries have policies to provide support to PSWs, still there are significant differences in terms of method and the degree of the support. Only after disastrous consequences of the COVID-19 pandemic in LTC homes, Canadian government created policies to increase PSW hourly wage and reduce tuition fees, to mitigate lack of support before pandemic. In contrast, Chinese government support through policies is mainly focused on financial assistance, pension and rental subsidies for PSWs to attract students or other laborers to enter the elderly care industry. Japan's method is quite unique. In addition to financial support and salary increases, Japan has increased the length of paid maternity leave, reduced PSW fatigue and increased work motivation by increasing care robots and other IT technologies.

Table 3-17

PSW Workforce Similarities Shared by Ontario (Canada), China, and Japan

	Regulation	Education and certification	Employment and government support
Similarities	No detailed regulatory policies for PSWs	Ontario and Japan have PSW education standard China and Japan have PSW certification systems	All countries have supportive policies for the PSW. All countries do not have regulations on employment type

Table 3-18

PSW Workforce Differences between Ontario (Canada), China, and Japan

	Regulation	Education and certification	Employment and government support
Ontario (Canada)	Requirement for PSW diploma can be bypassed.	PSW eduction program standard exists but is not detailed	Post-COVID temporary increase in salary Tuition reimbursement All supportive policies implemented after the pandemic
China	Required qualification certificate for PSW was revoked in 2017.	No education standard Five-level certificate based on working experience	One-time rewards Recommended salary rate Pension subsidy Housing subsidy
Japan	No regulation, anyone with passion for caring can be PSW	Standardized education curriculum National certification exam	One-time rewards Tuition reimbursement Use of technology Increase in salary

3.4.4 Financial Policies

3.4.4.1 Financial Support for Residents

Table 3-19 and Table 3-20 provide summaries of similarities and differences in financial policies between three countries. All three countries comparatively analyzed in this study provide some type of financial support to LTC home residents. The differences mainly involve the form and the amount of support. Ontario's approach seems to be the most

direct. Ontario government covers the care cost for all LTC home residents and provides the most comprehensive support for low-income residents that includes accommodation and meal costs. Only applicants who have been rigorously screened are eligible for subsidies from the Long-Term Care Home Rate Reduction Program. Because of its large population, China does not have the option to provide that much support for LTC residents. It does, however, provide free basic LTC home services for "*three NOs*" population, and small amounts of cash subsidies for low-income households who need help with activities of daily living. Compared with Ontario and China, Japanese policies of financial support for residents are particularly complicated due to Japan's long-term care insurance system. The Japanese government does not provide cash assistance for LTC services, or free service to anyone, except for those who are completely incapacitated. However, Japan will adjust premium, increase the reimbursement ratio of the LTC expenses, and lower the charge limit (for public LTC home) based on the income of the insured persons. Also, to prevent people from going bankrupt due to LTC service costs, Japan has set a maximum monthly payment limit based on the income level. In summary, policies guiding financial support for residents can be described as Ontario gives the service, China gives the money, and Japan reimburses the cost.

3.4.4.2 Private vs. Public Payment Differences

Due to different regulatory system for LTC homes in the three countries, the methods of charging residential fees in public and private LTC homes are different. The simplest is in Ontario where all LTC homes, whether public or private, for-profit or non-profit, are regulated by the government using the same pricing structure. This means that regardless of the quality of service, all LTC homes in Ontario charge the same rate of accommodation fee. In China, due to market-oriented reforms, the government has no right to regulate the pricing of private LTC homes, who set their own charging standards. As for Japan, the government reimburses all LTC service costs, hence the cost is the same for public or private LTC homes. However, all LTC homes, can set their own charging standard for accommodation fees and meal costs.

3.4.4.3 Financial Support for LTC Homes

All three countries have financial support policy for LTC homes, but the direction and the nature of subsidies are different. Ontario has the most complex, comprehensive, and generous, but also the most rigorous subsidy system. The government provides financial subsidies to cover many aspects, from operating LTC homes to equipment maintenance funds, and construction subsidies. The amount of subsidy does not differ between public and private LTC homes. However, all subsidies are subject to strict inspections. Any unexplained expenditure or activity that does not meet strict requirements of the MOHLTC may cause the government to revoke the subsidy and request re-payment. The subsidy system for LTC homes in China is primarily concentrated on construction subsidies. Here, non-for-profit homes get more, and for-profit homes usually receive less support, except for a small part of subsidies given to homes with excellent quality. The construction subsidies are not recycled as long as the construction fits the requirement from the government. Therefore, Chinese subsidy policies are closer to rewards. For Japan, this research identified only subsidy for construction of LTC homes. Like China, private for-profit homes usually receive less funding. The construction subsidy is issued according to the government's review and must be used exclusively for the construction. Therefore, the subsidy system for LTC homes in Japan is closer to Ontario system.

Table 3-19

Financial Policies Similarities Shared by Ontario (Canada), China, and Japan

	Financial support for residents	Public vs. private payment	Financial support for LTC homes
Similarities	Clear subsidies for residents.	Payments in public LTC homes are regulated	All countries have subsidies for LTC homes All countries have construction subsidies. In China and Japan, private LTC homes receive less funding. Canada and Japan have policies allowing recovery of subsidy.

Table 3-20

Financial Policies Differences between Ontario (Canada), China, and Japan

	Financial support for residents	Public vs. private payment	Financial support for LTC homes
Ontario (Canada)	LTC service cost is covered by the government. Accommodation fee for low-income residents is covered.	All LTC homes (both public and private) are regulated.	Provide most type of financial support Strict audit system
China	Only limited cash subsidies for care-dependent residents.	Government only regulates the price of public LTC homes.	Service quality rewards Unused fund will not be recycled
Japan	Cover up to 90% of LTC service cost. Low-income residents are covered	LTC service fee is regulated. Pay-per-service system. Accommodation fee for low-income residents in public home is regulated.	Provide only construction subsidies

4 Discussion

The purpose of this study was to explore similarities and differences in LTC policies between Canada (Ontario), China, and Japan. The goal was to identify promising practices potentially beneficial for policy improvement that would enhance the quality of life for residents in the LTC homes and prevent disasters, like the one caused by COVID-19 in Canada, from happening again. The study provided comprehensive description and comparative analysis of policies in effect prior and during COVID-19 pandemic. At the time of writing this thesis (December 2021), COVID-19 pandemic was at the end of its 2nd year and LTC policy changes were evolving, especially in Ontario.

Informed by the literature review and the Wendt et al. framework (2009), four policy areas were selected for closer examination: regulation, service provision, PSW workforce and financial policies. Findings show that LTC policies in the three countries have significant similarities in policy direction, and numerous differences, which reflect distinct cultural contexts and core principles guiding provision of care for the older adults. Reflecting on the core principles, it seems that Ontario's priority is to provide patient centered care, China's priority is to ensure the basic LTC services become available to rapidly growing aging population, and Japan's priority is focused on keeping older adults living independently for as long as possible. These insights emerged from the comparative analysis of the fundamental policies from each country and will be further elaborated.

The discussion chapter starts with an outline on how each country enacts its core principle through policies. This is followed by the discussion on the similarities and differences between countries, previous research on policy development, implications for future policy development, implications for future research, and study's strengths and limitations.

4.1 The Core Principles

The LTC policies in Ontario focus on provision of patient-centered care. The principle policy document, the LTCHA, secures all aspects of residents' rights in the LTC homes. Further, the Excellent Care for All Act (2010), which is also valid for LTC homes, stated that the primary focus of care in Ontario health care system is patients' experience (residents' in the case of LCT home). In terms of service provision, Ontario mandates the LTC homes to provide programs such as fall prevention, pain management, spiritual service, recreational service, and social service to ensure the residents' physical and mental wellbeing. In terms of financial policies, Ontario provides service subsidies, such as *the Attending Nurse Practitioners in Long-Term Care Homes Initiative Funding Policy* and the *Falls Prevention Equipment Funding Policy* to ensure there are enough resources for LTC home to provide comprehensive service to residents. The strict audit system required by the Ontario government ensures the money was used on the resident. Overall, the Ontario government has been focusing on providing better services and environments to help the residents achieve a higher quality of life in the LTC homes.

Compared with Ontario's aspirations to assure quality, China's current focus seems to be on quantity. In numerous documents, the government stated that securing the LTC needs for the population was the priority (e.g., *the State Council's Opinion on Increasing Development of Long-Term Care Service Industry* [国务院关于加快发展养老服务业的若干意见]). The guiding principle for the Chinese government's LTC industry is to establish enough numbers and diversity types of LTC facilities homes to satisfy ongoing increase in the population of older adults from 184 million in 2021 to 487 milion in 2050 (State Council of China, 2018). The Chinese government is not satisfied with the current number of LTC beds (about 5 milion) and is providing financial support for LTC providers to encourage construction of new homes witht the aim of 35 million beds in 2030 (Ministry of Civil Affairs, 2019a, 2020). Another example how the core principle is enacted are policies guiding increase in PSW workforce. Abolition of the qualification certificate requirement (Ministry of Human Resources and Social Security, 2017) for PSWs and proclamation of detailed operating standards, can be interpreted as the

government's attempt to lower the PSW's employment threshold. By providing subsidies and rewards, the government strives to attract more labor into the LTC industry.

The Japanese government's guiding principle of elder care seems to be prevention, or at least slowdown of physical and cognitive function deterioration in the older adults, hence reducing their dependency on the LTC system. In the *Long-Term Care Insurance Act*, the Japanese government stated that Japanese citizens should be aware of the changes in mind and body that occur with aging, and constantly strive to maintain and improve their health. Furthermore, even if citizens are using LTC service, they should still try to improve their independence through rehabilitation. The service provision and service fees in Japan comply with this principle. The insured individual can only be reimbursed for the LTC service that meets their care dependency level. In other words, residents at any care dependency levels have the responsibility and obligation to independently complete the activities of daily living within their capability.

Overall, the LTC policy development and implementation seems to be built on the core principles that are substantially different in the three countries. These underlining principles could also explain why countries differ in the details of the LTC policies (addressed below). Further examining core principles is important when our goal is to improve policy development by learning from the experiences of others.

4.2 Similarities, Differences, and Reasons Behind them

Even though Ontario, China, and Japan have different political structures and policy-making processes, they share a comparable policy direction in terms of service provision, PSW workforce and financial policies. They main similarity is that they have clear laws and acts specifying the government's responsibility for providing accessible LTC services for the older adults. Despite differences in details for service provision, all three countries have clear requirements for service provision, independent LTC home quality assurance systems, no regulations for PSW workforce, policy support for recruitment of more PSWs, and financial subsidies for both residents and for the LTC homes.

Similarities were noted in the way three policy areas (service provision, PSW workforce and financial policies) influence each other. Financial LTC policies have a

profound effect on service provision. For example, Ontario government provides financial assistance for programs provided in all LTC homes (e.g., fall prevention program) and any change in the service funding package will affect daily operation and provision of services in the LTC homes. Although not as serious as in Ontario, China's LTC financial policies also have strong impact on service provision. This is reflected in the impact of LTC financial policies on the service quality of its LTC homes and the speed of construction of new homes Japan's LTC financial policies directly determine the price of the service and the financial burden on the people. The LTC financial policies significantly affect support for PSWs, which will directly impact the number of PSWs working in the field. Interestingly, two tendencies were noted in the way the service provision and PSW workforce policy areas influence each other. The development of the PSW education system is inversely related to the level of education requirements in the service provision.

The difference in LTC service provision policies details are distinct and likely caused by the countries' core principles of care. For example, there are substantial differences in the level of prescriptiveness in policies for service provision that reflect both China's and Ontario's core principles of care. More type of services required in Ontario LTC homes align with their aim to provide patient-centered care, while Chinese detailed policy allows uneducated individuals to work as PSWs to assure larger workforce. Another example are assessment requirements. Ontario has a strict assessment system to assure the older adults with greatest need have access to a LTC bed, while Japan's assessment system is linked to its core principle that aims to provide the most suitable service according to the individual's physical and mental capability assuring that the individual's independent living ability is respected and well supported.

The differences in PSW workforce policies seem to have also have association with core principles. Some examples are the cancellation of the qualification certificate in China that demonstrates country's determination to increase the number of PSWs, and Japan's development of the national PSW education and certification system that aims to prevent LTC residents from physical deterioration.

The differences in financial LTC policies more directly reflect the differences in the core principles. The funding packages and strict funding audit system in Ontario ensures that all government funds are used to serve residents. In contrast, China's financial support mainly focuses on supporting construction of new LTC homes, by providing large non-recoverable and low-threshold financial supports. Although Japan provides the least amount of funding to its LTC homes, it has the most detailed payment system. All additional services, beyond the scope of the care level but required by the user, are 100% paid by the user. In this way, the Japanese government enables people to maintain an independent lifestyle for as long as possible, which is in line with Japan's core principle.

4.3 Previous Research on Policy Development

The literature review performed for this study did not produce any published articles on comparative analysis of LTC policies between countries after the COVID-19 outbreak. However, it identified several articles reporting policy issues within each country. These are described further to echo specific policy concerns and research that contributed to their development in Ontario, China, and Japan. For example, the findings show that the RAI-MDS 2.0 tool Ontario government uses to assure the service quality in the LTC homes, only collects numerical data, such as numbers of falls, infections or worsened pressure ulcers. It does not include subjective testimonials, such as interviews with residents or staff. This is consistent with a critique by Armstrong et al. (2016), which suggested the RAI-MDS 2.0 is decontextualized and may cause issues in accuracy. This may help understand why Canadian LTC policies require the use of designated inspector who is allowed to interview the residents to assure the service quality.

Another example are medical services. The Canadian government tried to increase the number of nurse practitioners in the LTC homes by issuing the *Attending Nurse Practitioners in Long-Term Care Homes Initiative Funding Policy* (2021). The government's action aligned with the findings of Carter et al. (2016) suggesting that the presence of NPs is positively associated with residents' health. On the contrary, medical services in China's LTC homes are in an early stage of development, still creating concepts rather than issuing a standardized policy. This reflects findings by Shen et al.

(2015), Ma et al. (2016), and Si et al. (2019) which showed that current medical services are insufficient in China's LTC homes.

Next example is PSW workforce. It is well established in Ontario that limited education and experiential practice time influence ability of the PSW workforce to provide good service (Kelly & Bourgeault, 2015; Kelly, 2017). This is a direct consequence of the lack of policy for education requirements and standardized curriculum for PSWs. Similarly, research by Li et al. (2019) and Peng et al. (2017) in China identified low level of professional skills and low level of income as failures of policies for PSW education. Moreover, research scholars (Banerjee et al., 2015; Kelly, 2017; Peng et al., 2017; Miyazaki, 2018; Yang et al., 2019) in all three countries found that the governments are increasing the funding for PSWs to attract workforce and reduce PSW shortage. Finally, research in China (Song, 2020) suggests that LTC policies should establish a better balance between funding the LTC homes and funding the resident. This study found that financial support policies in China focus mainly on funding LTC homes rather than residents, which echoes the call for change proposed by Song (2020).

4.4 Implications for Future LTC Policy Development

Improving LTC care policies governing LTC homes is crucial for maintaining the quality of lives for LTC residents. If the governments do not make any changes, policy failures may happen again, repeating disastrous consequences of COVID-19 pandemic. However, policy change has significant impacts and needs to be made and implemented with great care. It may take a long time and multiple attempts to achieve the desired result. Hence, learning about existing solutions from other countries may be the most effective and low-cost approach. In this part of the discussion, the focus shifts to identifying promising practices that could be potentially beneficial for policy improvements. The question will first be addressed from the perspective of Ontario (Canada), keeping cultural and contextual differences in mind.

Compared with China's current core principle of developing sufficient number of LTC homes to serve the needs of the elderly population, Ontario is more focused on the quality and types of LTC service. However, the Ontario government has paid limited

attention to the development of the number of the LTC homes in the country. This is evident in the official data. In 2021, there were 627 LTC homes located in Ontario, with around 78,000 beds, which is two homes fewer than in 2015 (N=629) (MOHLTC, 2015; CIHI, 2021). Limited availability of LTC beds have caused very long waiting lists. The MOHLTC reported in 2020 that approximately 38,000 individuals are waiting for the LTC home admission. As a result, two reports have been calling for the Ontario government to intensify investment to increase the number of the LTC homes and reduce the waiting time (OLTCA, 2019; MOHLTC, 2020).

In contrast, the number of LTC homes in China increased from 31,291 in 2018 to 34,369 in 2019, and the number of beds increased from 7.27 million to 7.75 million (Ministry of Civil Affairs, 2019, 2020). In most of the guidance documents (e.g., *the State Council's Opinion on Increasing Development of Long-Term Care Service Industry* [国务院关于加快发展养老服务业的若干意见]), the Chinese government mentioned the concept of decentralization, which gave the local government the power to regulate the LTC homes in their region based on local context. As a result of decentralization, the local governments were encouraged to appropriately relax the regulation, and actively provide supportive measures. These supportive measures included speeding up procedures, reducing approval requirements, and providing financial support for new LTC homes. These policies have encouraged many private institutions and public organizations to build new LTC homes. However, this approach in Chinese LTC policies have had notable drawbacks such as fraud and poor construction quality.

The Ontario government provides a wide variety of funding packages, and more generous financial support for LTC homes than the Chinese government, but the current LTC policies in Ontario are extremely strict. As stated before, Ontario has an overly rigorous audit system for subsidies provided to LTC homes. All financial subsidies need to be classified and recorded according to their types. Any recording errors or misuse of funds, or even unused budget, affect the government's funding for the LTC home in the following year. These requirements add an administrative cost and limit the income generation capacity for private LTC homes. This leads to reductive measures, such as reducing the staff and quality of the service, to reduce the cost in order to obtain profit.

This is in line with Daly's (2015) opinion that the quality of the private LTC homes is generally worse than the public LTC homes. The policy restrictions have also diminished the enthusiasm of various organizations, especially for-profit organizations, to build new LTC homes in Ontario. This is not to say that the LTC policies in Ontario do not fulfill their purpose. These detailed regulations have largely ensured the quality and safety of residents in the LTC homes.

Acknowledging that benefits of a policy in one country are unlikely transferable to another, the findings offered here are ideas for possible alternative approaches to increase the speed of the LTC home development through moderate deregulation. This is supported by the report *Challenges and solutions: Rebuilding long-term care for Ontario's seniors* published by the OLTCA in 2020. In the report, the OLTCA argues that the Ontario needs another 15,000 beds in 2023 only to cope with the current waiting lists, but is unlikely to achieve this goal due to the unstable funding. The report called for "streamline or eliminate low-risk and redundant requirements of the regulations to reduce the administrative burden and allow staff to spend more time caring for residents" (OLTCA, 2020, p. 5). In summary, some ideas of solving the shortage of LTC homes in China might be useful signposts for Ontario to develop its own way to solving the same problem.

Another example for potential improvement of the LTC situation in Ontario is Japan's policy solution for the problem of PSW workforce shortage. Japan's focus is on prevention, and because of its high rate of elderly population, Japan's development of LTC home policies is more comprehensive. Due to the unregulated nature and lack of information about the PSW workforce, the author of this study was unable to identify data on how many PSWs are currently in the field and how many are needed. However, there is data showing that in 2018, 80% of LTC homes in Ontario had difficulty filling shifts, and 90% had difficulty recruiting PSWs (OLTCA, 2019). The situation has been exacerbated by the COVID-19 pandemic, as many LTC homes reported that the PSW shortage had impacted the quality of the service and the safety of the staff (MOHLTC, 2020). In Japan, however, the number of PSWs is steadily increasing. The data shows that the number of PSWs in 2017 in Japan was 1.9 million, and it increased to 2.1million

in 2019 (Ministry of Health, Wealth and Labor, 2019). This demonstrates that Japan's support policy for PSWs is effective. The Ontario government has introduced several support policies for PSWs during the pandemic, such as salary increase and tuition reimbursement, but because these policies were new and implemented temporarily their effectiveness remains unclear. In contrast, Japan's PSW policies have a longer history (Certified Social Worker and Certified Care Worker Act, 1987), and are more stable and comprehensive. The Japanese government standardized the education protocol to ensure the unified professional skill level of the PSWs, provided education bursaries to encourage the youth to join the field, provided rewards to recalled former PSW employees, and eased the work pressure by introducing care robots, all with the goal to retain and bring more PSWs into the LTC industry. The Japanese government has provided a possible policy development model to ensure stabilization of the PSW workforce through better funding and more diversified support.

Among the various policies that Japan has formulated for PSW workforce, one deserves special attention – Japan's overseas PSW recruitment policies. Although Japan is not a country of immigration, according to a report by Nomura Research Institute (2020), since Japan established the overseas PSW introduction plan in 2008, it has attracted a total of 13,257 foreign PSWs to work in Japan by 2020. Canada, on the other hand, is an immigrant country where people from all around the world find homes and new careers. A *New Direction: Ontario's Immigration Strategy (2021)* published by the Government of Ontario, states that 29% of labour in Ontario are immigrants. The government aims to increase the proportion of economic immigrants from 52% to 70%. Although it seems that both the Canadian government and Ontario government are attempting to introduce foreign PSWs into the field, this goal is hard to achieve due to the high requirements proposed by the immigration agency. According to the Government of Canada (2020), only 1% of temporary foreign workers were working in the healthcare and social assistance sector. There are two ways for foreign care worker to work in Ontario (Canada), through immigration or work permit (Government of Canada, 2021f). Currently foreign workers have to go through Ontario Immigrant Nominee Program to apply for immigration. There are two major streams for foreign workers such as PSWs: Foreign Worker stream and In-Demand Skill stream (Government of Ontario, 2021c).

Under the requirement of the Foreign Worker stream, one of the eligible criteria is that a job offered to the applicant must be in a skill occupation at Type 0, Level A or B. Unfortunately, the PSW job falls into Level C (Government of Ontario, 2021c; Government of Canada, 2021c). As for In-Demand stream, while PSW occupation is categorized as an in-demand eligible occupation (Government of Ontario, 2021d), other immigration requirements usually cannot be achieved by a foreign PSW. Other requirements are that the job offer must be full-time and permanent, and the offer must meet or be higher than the median wage for the job, which is $19 CAD per hour in London, Ontario area (Government of Canada, 2021d). The applicant also must have at least nine months of working experience in Canada. Multiple policy requirements for employers are also in place, such as applying for and passing the Labour Market Impact Assessment (Government of Canada, 2021e). Policy requirements are the same even if the foreign PSW wants to work in Canada temporarily (Government of Canada, 2021f). In summary, compared with Japan's overseas economic partnership agreements that help secure immigrant PSW workforce for LTC industry, the immigration thresholds in Canada do not seem to be attractive for neither foreign PSW immigrants or their potential LTC homes employers. It seems that concerted effort is necessary, at multiple levels of Canadian and provincial governments, to adjust policies and encourage inflow of PSW immigration workforce to Canada.

Another learning point offers itself. The governments in China and Japan have a clear plan for the future and formulated policies toward a long-term goal. Multiple documents from both countries have proved evidence for this (e.g., *the 13th Five-Year Plan for the Development of National Aging Industry and Construction of the Elderly Care System* in China["十三五"国家老龄事业发展和养老体系建设规划], *the Eighth Development Plan Long-Term Care Industry* [第８期介護保険事業計画]). Ontario, however, just started developing a vision for the future with changes proposed in Bill 283 initiated during COVID-19 pandemic (Legislative Assembly of Ontario, 2021). One explanation for this difference may lay in China's one-party system and Japan's unique bureaucracy system that have given a clear direction for their domestic policy development. On contrary, both Canada and Ontario have cyclic multi-party elections

that often create opposing plans and strategies which result in unfulfilled election promises due to lack of funding or opposition from other parties (Flynn, 2011). One is left wondering if Ontario and Canada lack motivation for self-change. Findings of this study provide evidence worthy of reflection on how Ontario (Canada) might improve its LTC policies.

Now the attention switches to the lessons identified in this study that China and Japan might benefit from. Canadian and Japanese LTC policies provide some useful pointers for China. Although for now, ensuring a sufficient number of LTC homes and PSWs is the top priority for China, the quality of service cannot be ignored. Several scholars have pointed out obvious quality deficiencies in China's private LTC homes, that have led to extremely low occupancy rate in some homes (Shen et al., 2015; Shum et al., 2015; Ma et al., 2017). Ontario provides a good example on how increased financial support for LTC homes and strong regulation of all types of LCT homes can improve the quality of life for residents. A valuable lesson from Japan is its unique long-term care insurance system which provides services according to the classification of care dependency levels. This could reduce the number of older adults in need of LTC. Japan reduces the burden on residents and their families by reimbursing service fees. These are all useful guides for Chinese LTC policy developers.

As the oldest society on the planet, Japan will have to develop solutions for elder care before other nations. In that light, Ontario offers some guidance on how to achieve balance between health care cost and incomes. Japan's increasing LTC insurance fee and increasing maximum payment ceilings (Ministry of Health, Welfare and Labour; 2021), signal that the financial situation of Japan's LTC insurance system is in a state of imbalance (Kimoto, 2020). This is caused by the growing population of older adults, but also by the pay-per-service system, which users maximize repeatedly utilizing sometimes unnecessary care services, causing greater government expenses for reimbursements. This long-term, multiple, and diverse consumption of LTC services has led to large expenditures from Japan's LTC insurance system. Ontario has reduced this repetitive cost by buying out care services from LTC homes, which means that no matter what kind of service the resident uses, or how many times the service is used, the cost borne by the

government stays the same. Maybe this is an idea worth exploring in the future Japanese LTC policy development.

4.5 Implications for Future Study

This study provided a comparative overview of the four LTC policy areas and identified several gaps worthy of future research. The following are some recommendations for future comparative LTC policy research in other policy areas in need of improvement.

- Thoroughly examine differences in policy requirements for physical LTC home environments (e.g., size, home design, presence of animals, residence vs. medical model).
- Examine differences in policy requirements for technology usage in LTC homes.
- Explore LTC policy changes before and after the COVID-19 pandemic.
- Explore in more detail how different countries fund their LTC systems.
- Investigate in more depth differences in staffing policies for all LTC staff.
- Study in more depth the differences in tools and processes of the LTC admission.

To assure methodological rigor, the following recommendations for future research could be beneficial:

- Compare countries that shares certain level of similarities (e.g., political systems, health care systems).
- Explore the context of culture, political influences, and history of policy development.
- Use original texts of the policy documents and consult experts to approve translations.
- Involve topic experts, with knowledge about included countries, as advisors in the study.
- Explore policy areas that best fit the scope of the research project.
- Explore details of documents collected during research (e.g., type, implementation date, issuing department).
- Explore other documentation and research related to the included policies.

The comparative policy analysis used in this study is applicable to any policy area. Researchers need to be aware that policy areas are closely related, and focusing on only one policy area may result in a narrow focus. It is important to find a balance between policy details and the overall system.

4.6 Strengths and Limitations

There are several strengths of this study that should be highlighted. First, the research included three countries in three different states of societal aging. Based on the definition provided by OECD (2020), societies with 15% to 20% of total population over the age of 65 qualify as aged society, societies with over 21% of population over the age of 65 qualify as super-aged society. Japan represents a super-aged society (28.2% of older adults in 2019 [UN, 2019]), Canada is just becoming an aged society (18.5% of older adults in 2021 [Statistic Canada, 2021]), and China that will become an aged society in the future (13.5% of older adults in 2021 [National Bureau of Statistic, 2021]). This rich tapestry of societal differences is enhanced by different population sizes (i.e., Canada 38 million, China 1.41 billion, Japan 125 million), different income levels (e.g., GDP per capita: Canada – $43,258 USD, China – $10,500 USD, Japan – $39,538 USD), and different economic development status (e.g., total GDP: Canada – $1.64 trillion USD, China – $14.7 trillion USD, Japan – $4.98 trillion USD) (World Bank, n.d.). Therefore, the reported findings draw on great diversity. Second, the study described four basic policy areas identified in the literature review and supported by Wendt et al. (2009) framework and provided comprehensive information from policies and related documents. Third, the study used a method of comparative policy analysis and included original documents in English, Chinese, and Japanese, assessed, summarized and interpreted by a tri-lingual author, hence bypassing shortcomings of policy translations. Coupled with the author's understanding of the context and culture of three countries (CW lived in all three countries), this study provides unique intuitive understanding of the factors behind the differences in the LTC policies.

Several limitations of this study need to be acknowledged. First, due to the differences in the search engines in the three countries and the complexity of policies, it is possible that some policy documents were missed and were not included. The

differences in keywords may have also imposed limitations. Compared with English which mostly uses terms “long-term care home” or “nursing home”, Chinese and Japanese language have many more terms for the LTC home (e.g., “养老院”, “养老机构”, “养老福利设施”, “介護施設”, “指定介護福祉施設”, “老人ホーム”, etc.). Second, due to China’s unique political system, many policy documents are classified and unavailable to the public, similar situation may also apply to Ontario (Canada) and Japan. Third, this study was scoped to assure completion within two years of MSc degree, hence some related policy documents in Japan and Ontario (Canada) were excluded. For example, the Long Term Care Home Act in Ontario, has deep connections with other policy documents such as *the Local Health System Integration Act* (2006), the *Labor Relations Act* (1995), the *Health Care Consent Act* (1996), and the *Public Accounting Act* (2004). Similarly, some supplementary documents on the content of the Act were not included. In Japan, the Long-Term Care Insurance Act is closely aligned with the Medical Care Act (医療法, 1948). Therefore, due to limited time, some detail from related policy documents might have been omitted. Forth, the level of detail in highly specialized documents, such as formulas used to calculate funding for each LTC bed based on the acuity of the resident in the *Long-Term Care Homes Level-of-Care Per Diem, Occupancy and Acuity Adjustment Funding Policy* (2019) exceeded the scope of the study and was left out. Lastly, misunderstanding of the content, due to complexity of legal language used in policies is possible. The particularities of legal language might have not been interpreted perfectly, especially when analyzing Japanese documents. Three expert consultants, familiar with LTC policies in each country, were involved in review of the findings. They provided feedback on accuracy of interpretation of the policies and their implementation in LTC practice.

5 Conclusion

Policy failure in provision of LTC for older adults can have devastating consequences for residents living in LTC homes, as witnessed in Ontario during the COVID-19 pandemic. The speed of governments’ response to improve LTC policies was directly related to the safety of residents living in the LTC homes. Among the three countries included in this analysis, Ontario had the slowest response and the outcomes in LTC homes were the

most serious. COVID-19 signaled the urgent need to improve the LTC policies in Ontario. Comparative analysis provided ideas for improvements by learning from experiences of others. The purpose of this study was to explore the similarities and differences in LTC policies between Ontario (Canada), China, and Japan. The goal was to identify promising practices that could be potentially beneficial for policy improvement.

Using Wendt et al. (2009) framework to collect data, the author identified documents covering four major policy areas: regulation, service provision, PSW workforce, and financial policies. Major similarities and differences of LTC policies between Ontario (Canada), China and Japan were reported. Findings show that LTC policies are guided by deeper cultural and philosophical underpinnings of care provision, named the core principles, that differed in the three countries. Some similarities and numerous differences in the policy details were noted. Based on the new knowledge, Ontario (Canada) excels in patient-centered care and financial strategies, Chinese government shows the way on how to rapidly develop the LTC industry (including increasing the number of LTC homes), and Japan's policies offer an important lesson on how to expand, train and stabilize PSW workforce.

Policies are living documents, often revised and improved. The information provided in this thesis could be of value for LTC policy makers at all levels of government, LTC care providers, equipment designers, LTC home builders, family members and LTC residents. The measure of every society is its care for those that can't care for themselves. This study provided some ideas on how to enhance LTC policies and better care for the most vulnerable group in all our societies, dependent older adults approaching the end of life.

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Appendices

Appendix A Overview of Service Provision under the The Long-Term Care Home Act and O. Reg. 79/10 Regulation Governing Provision of Care in Ontario Long Term Care Homes.

Type	Long-Term Care Home Act	O. Reg. 79/10
Care plan	1. Every resident shall have a written plan of care which contains the planned care, goals, and directions. 2. The plan should be developed based on the assessment of the resident. 3. The plan should cover all aspects, include but not limited to medical, nursing, and personal support. 4. The resident should be involved in the development of the care plan. 5. The staff who provide direct service to the resident should be aware of the care plan. 6. The resident should be reassessed, and the care plan shall be reviewed every six months or based on resident's situation 7. The provision of the care plan, outcome and effectiveness of the care plan should be documented.	1. The care plan shall be a 24-hour admission plan and be developed within 24 hours of the admission of the resident. 2. The plan must identify information of the resident. The information includes but not limited to the risk the resident may cause to himself/herself or to others; level of assistance required by the resident; drugs and treatment; known health conditions; skin condition; personal preferences (e.g., meal, daily routine). 3. The assessment of resident should be finished within 14 days of admission; the plan of care should be fully developed within 21 days of admission. 4. The care plan must include the resident's demographic information and participation status of developing the care plan. 5. The care plan must include but not limited to following information: resident's daily routine, cognition ability, communication ability, vision, mental status, physical functions, health conditions, drugs and treatments, and safety risk. 6. Nutrition assessment has to be done for the resident on admission and whenever there is a significant health change. 7. A documented care conference regarding each resident's care plan shall be held annually, in which related staff and the residents should participate.
Nursing and personal support service	1. Every LTC home should have organized 24-hour nursing service and personal support service	1. Personal care should be daily and individualized, daily. Services include hygiene care and grooming. 2. Bathing: at least twice a week

		3. Oral care: mouth care (morning and evening), offer an annual dental assessment 4. Foot and nail care: cutting fingernail and toenail 5. Transferring and positioning: staff should support residents with proper devices and techniques 6.Personal items and personal aids: labelling and cleaning 7. Mobility device: wheelchairs, walkers, and canes 8. Dress: assist residents with getting dressed properly 9. Bedtime and rest routines: support residents with desired bedtime and rest routines 10. End-of-life care: provide end-of-life care for residents in need
Fall prevention and management	n/a	1. Have strategies to prevent or reduce falls (e.g., monitoring drug use, use device and assistive aids) 2. Have post-fall assessment for residents. 3. Have equipment, supplies, and devices ready in the cases of falls.
Skin and wound care	n/a	1. Provide routine skin care, treatments, and interventions; have strategies to prevent infection, skin breakdown 2. Provide skin assessment to residents in need 3. Have equipment, supplies and devices ready for use
Continence care and bowel management	n/a	1. Provide treatments and interventions to improve bowel status, prevent constipation. 2. Provide toileting program, maximize residents' independence 3. Assess residents in need, document in the individualized care plan 4. Provide toilet assistance to residents in need

		5. Have equipment, supplies and devices ready for use
Pain management	n/a	1. Have strategies to communicate with residents who have difficulty communicating with others 2. Provide pain management service, comfort measures 3. Document the outcome of the pain management service
Restorative care	1. Restorative care shall maximize residents' independence 2. Provide service based on the assessments of residents.	1. Therapy services: on-site physiotherapy, occupational therapy, and speech-language therapy 2. Social work and social services work: provide social work and socials service work to residents in need 3. Have equipment, supplies and devices ready for use
Recreational and social activities	1. Provide recreational and social activities to meet the interests of residents	1. Have appropriate equipment, device for recreational and social activities 2. Communicate with residents and their families with the schedule 3. Have multiple types of activities for residents to choose 4. Have residents' input in the development of activities 5. Provide information of activities to residents 6. Provide necessary support and assistance to the residents who have interest but not capable to do so independently
Dietary services and hydration	1. Provide organized nutrition care and dietary services that meets the nutrition needs of the residents 2. Provide hydration service to meet the hydration needs	1. Consult with a registered dietitian develop and implement nutrition plan; identify potential risk within the nutrition plan and develop strategies to minimize the risk 2. Monitor and document residents' food and fluid intake

	of the residents	3. Monitor weight change of residents 4. Dietary services consists of menu planning, food production, dining and snack, and provision of supplies, equipment, and devices 5. Menu planning: menu cycle should be a minimum of 21 days; include multiple choices of food; include regular and therapeutic meal; meet the nutrition need; approved by a registered dietitian and the resident council 6. Provide at least three meals daily at appropriate time; snacks in the afternoon and evening 7. Food production: provide 240hour perishable food, three-day supply of non-perishable food, nutrition supplements; have standardized recipes; food are prepared, stored, and served in an appropriate way 8. Keep record of purchases of food productions, menu cycle, and menu substitution for at least one year 9. Dining and snack service: provide assistance to residents in need
Religious and spiritual practice	1. Provide organized program to residents who are religious to practice their religious	1. Provide worship services, resources, and consultation to residents in need 2. Provide assistance and help to help residents participate their desired religious activities
Accommodation services	1. Provide organized housekeeping services, laundry services, and maintenance services 2. Provide clean, sanitary, and safe environment to residents	1. Housekeeping: provide 7-day-per-week housekeeping service, cleaning of the home, cleaning and disinfection of the resident care equipment, supplies and devices with appropriate way 2. Pest control: provide organized preventive pest control program. 3. Laundry service: change residents' linens at least once a week; label residents; personal items and clothes; provide sufficient supplies (e.g., towels) 4. Maintenance service: provide 7-day-per-week maintenance service; all equipment, supplies and devices functioning well

Note. Information gathered and organized from The Long-Term Care Home Act and O. Reg. 79/10. Information above in the table does not include all requirements and regulation listed in the LTCHA or the O.Reg.79/18. For more detail information, please check the original text on https://www.ontario.ca/laws/statute/07l08 (LTCHA) and https://www.ontario.ca/laws/regulation/100079 (the O.Reg.79/18). © Queen's Printer for Ontario, 2007. The Queen's Printer for Ontario holds copyright in

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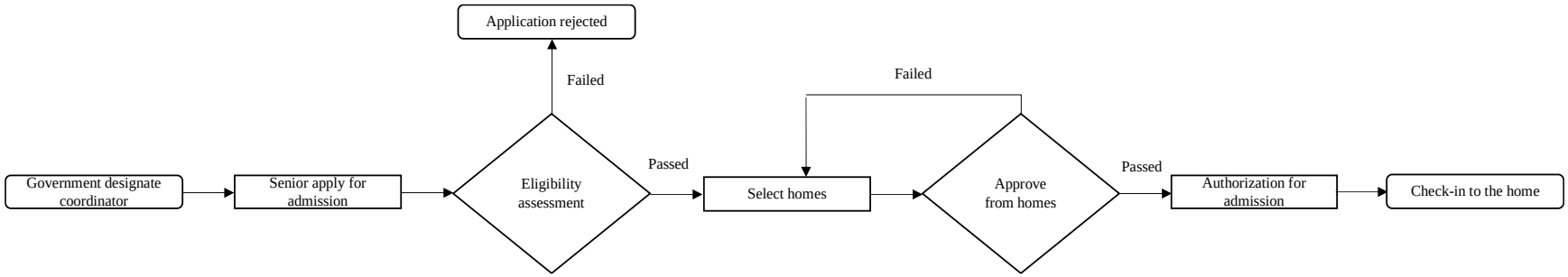
Appendix B The Process from Admission Application to Actual Check-in of the Long-Term Care Home in Ontario



Appendix C Overview of Long-Term Care Homes Waiting List Categories and Definition of Each Category under the Regulation O. Reg. 79/18 (excerpt).

Category	Definition
1	1. The applicant requires immediate admission with arising crisis from his/her condition; or 2. The applicant occupies bed in a hospital or psychiatric facilities; or 3. The applicant cannot get a bed in a hospital or facilities within 12 weeks after the closure of beds in the hospital; or 4. The applicant is a resident in another LTC homes whose bed will be closed within 12 weeks; or 5. The applicant occupied a bed in hospital which is experiencing severe capacity pressure and requires; requires an alternate level of care and immediate admission
2	The applicant does not meet the requirements of category 1; 1. The applicant has a spouse or partner long-stays in the LTC home; and meet the requirement of eligibility of living in a LTC home
2.1	The applicant does not meet the requirements of category 1 and 2; and 1. The applicant lived in a specialized unit fit the requirement under the subsection 198 (7) of the regulation; or 2. The applicant transferred to the area of the home fit the requirement under subsection of 205 (1) of the regulation and applied for admission for LTC homes before or within six weeks after being transferred; or 3. The applicant occupied a high acuity priority access bed in a LTC home and applied for transferring to a regular bed in a LTC home; or 4. The applicant occupied a high acuity priority access bed and was transferred to the area of the home fit the requirement under subsection of 206.7 (2) of the regulation and applied for admission for LTC homes before or within six weeks after being transferred
3A	The applicant does not meet the requirement of category 1, 2, or 2.1; the home fits the interests of the applicant (e.g., ethnic, language); or his/her spouse stays in the LTC home mentioned above; and

	1. The applicant is not a resident of a LTC home but requires or is receiving high level of service fits the requirement of the Home Care and Community Service Act (e.g., hospital); or 2. The applicant occupied a bed in a hospital and requires alternative level of care; or 3. The applicant is a resident of a LTC home but seeks for transferring; or 4. The applicant is a short-stay resident in a LTC home who applies for a long-stay bed in the LTC home
3B	The applicant does not meet the requirement of category 1, 2, or 2.1; the home fits the interests of the applicant (e.g., ethnic, language); or his/her spouse stays in the LTC home mentioned above; and The applicant who does not meet the requirement of 3A
4A	The applicant does not meet the requirements of category 1, 2, 2.1, 3A, or 3B; and, 1. The applicant is not a resident of a LTC home but requires or is receiving high level of service fits the requirement of the Home Care and Community Service Act (e.g., hospital); or 2. The applicant occupied a bed in a hospital and requires alternative level of care; or 3. The applicant is a resident of a LTC home but seeks for transferring to another home; or 4. The applicant is a short-stay resident in a LTC home who applies for a long-stay bed in the LTC home
4B	The applicant does not meet the requirement of category 1,2, 2.1, 3A, or 3B; and, The applicant who does not meet the requirement of 4A
Veteran	1. The applicant is a veteran that is applying for a veteran priority access bed, and the home has a veteran's priority access bed
Exchange	1. The applicant is the target of the exchange agreement between the LTC home and at least one facility such as hospital, group home to exchange certain

	residents to meet the requirement of the resident; and, 2. The result of the exchange will result in the same number of residents in each home; and, 3. The applicant occupies a bed in a facility such as hospital, psychiatric facilities, supported group living residence, supportive housing program or a LTC home.
Re-admission	1. The applicant once occupied bed in a LTC home but was discharged by the LTC home or absent on a medical or psychiatric issue
Related temporary	The LTC home is or will be a related temporary LTC home; and 1. The applicant is or was a long-stay residents before the closure of his/her bed
Re-opened	The LTC home is or will be re-opened; and 1. The applicant is a long-stay resident of the original LTC home; or 2. The applicant is a long-stay resident of the related temporary related LTC home
Replacement	The LTC home is or will be a replacement LTC home; and, 1. The applicant is a LTC resident in the original LTC home; or 2. The applicant is a long-stay resident of the related temporary LTC home

Note. This table contains selected information extracted from the O. Reg. 79/10 and it does not include all requirements and regulations listed in the LTCHA or the O.Reg.79/10. For more detailed information, please check the original text on https://www.ontario.ca/laws/regulation/100079. The Queen's Printer for Ontario holds copyright in Ontario statutes, regulations and judicial decisions. The Queen's Printer permits any person to reproduce the text and images contained in the statutes, regulations, and judicial decisions without seeking permission and without charge. The legal materials must be reproduced accurately, and Crown copyright in the legal materials must be acknowledged in the following form: © Queen's Printer for Ontario, 2010.

Appendix D Examples of Policies for Selected Services Developed from The Measure to Detailed Specifications Implemented Over Time

Service	*The Measure (2013)*	*The Basic Standard (2012)*	*The Specification (2017)*	*The Safety Specification (2019)*	*The Daily Living Specification (2021)*
Daily Service	The LTC home shall provide daily service	Daily service should include: 1. Dressing – changing clothing, organizing clothing 2. Bedsore prevention – position changing, skin cleansing	Daily service requirement: 1. Daily service include but not limited to dressing, personal hygiene service 2. Daily service should ensure the safety of the residents	Bedsore Prevention: 1. Residents at risk should be checked regularly: if the skin is dry, whether the color has changed, whether the quilt is dry 2. Preventive measures include: changing positions, cleaning the skin, making the bed, and removing debris 3. Document the situation	Dressing: 1. Help the resident with positioning 2. Stretch one hand from cuff of the clothes to the bottom of the clothes than gently pull the wrist of the older adult and put the arm into the sleeve 3. Gently put resident's head into the collar, then flatten the body part
Meal Service	The LTC home shall provide meal service	Meal services should: 1. At least include food processing and distribution, the production process should be safe and hygienic, and the food delivery should be insulated and airtight 2. The meal service provision shall be undertaken by qualified	Meal service requirement: 1. Food preparation should meet the requirements of food supervision and management protocol and comply with relevant food safety regulations 2. Storage after processing should be separated for raw and cooked food	Choking prevention: 1. Provide suitable meals to prevent choking 2. Residents at risk of choking should stay in the sight of the staff when eating, or the staff should feed them	Hydration: 1. Temperature check 2. Record water intake 3. Provide hydration every two hours Meal feeding:

	personnel with a health certificate and professional training 3. Recipes should be formulated according to the physical conditions and needs of the elderly, regional characteristics, ethnic and religious habits, and a balanced diet should be provided	3. The recipe should be adjusted every week, announced to the residents, and archived. In case of temporary adjustments, the residents should be notified in advance 5. Establish a system for keeping food samples for inspection, keep samples every day, and mark necessary information	Accidental ingestion prevention: 1. Implement regular inspection to prevent the residents from eating spoiled food by mistake. 2. Institutions that provide drug management should sign a medication management agreement with the elderly or relevant third parties, and accurately verify the distribution of drugs.	1. Help the resident with sanitization 2. Help older adult with positioning 3. Temperature check 4. Feed older adult with caution 5. Record food intake 6. At least 3 times a day Tube Feeding: 1. Help the resident with positioning 2. Stomach tube check 3. Feed with caution 4. Record food intake, reaction, and the mealtime

Sanitization Service	The LTC home shall provide sanitization service	Sanitization service should: 1. Include environmental cleanliness, room cleanliness, bed unit cleanliness, and facilities and equipment cleanliness. 2. Set up full-time positions and be equipped with corresponding cleaning and sanitation personnel and equipment. 3. Environmental cleanliness includes environmental classification management of living areas and medical areas, and classification and treatment of domestic and medical wastes. 4. When adopting outsourcing service, service quality should be monitored.	Sanitization service requirement: 1. Public areas and residents' rooms should be tidy, the floor should be dry, the items should be placed safely and reasonably, and the air should be free of odor. 2. The residents' rooms should be cleaned daily, their personal belongings and daily necessities should be organized, bedding and curtains should be changed regularly. 3. The public areas and facilities and equipment should be cleaned and disinfected regularly. 4. Contaminated items should be cleaned and disinfected separately.	n/a	n/a
Laundry Service	The LTC home shall provide laundry service	Laundry service should: 1. Include collection, registration, sorting, disinfection, washing, drying, finishing and	Laundry service requirement: 1. Disinfect the equipment regularly to keep the laundry environment clean	n/a	n/a

		returning of clothes. 2. Be undertaken by special agents with necessary equipment. 3. When adopting outsourcing service, service quality should be monitored.	and tidy. 2. Clothing should be cleaned regularly according to the type and collection time. 3. Clothing should be washed separately from bedding. 4. Contaminated clothing should be collected, cleaned, and disinfected separately.		
Mental Support	The LTC home shall provide mental support	Mental support should: 1. At least include services such as communication, emotional counseling, psychological counseling, and crisis intervention. 2. Be undertaken by psychological counselors, social workers, medical staff, or care workers who have undergone psychology-related training. Psychological consultation and crisis intervention should be undertaken by psychological counselors and social workers.	Mental service requirement: 1. Hospice service should be provided. 2. The home should respect the religious beliefs, ethnic customs, and personal wishes of the elderly, and help them to pass the end of their lives with peace and dignity. 3. The home should guide the relevant third party to accept the dying situation of the residents and assist in handling the afterlife of the residents as needed.* H	Prevention for self-injury and injuries from others: 1. When it is found that the residents are at risk of hurting others and self-injury, the home should intervene and provide mental support, and inform the third party. 2. There should be a special agent to manage flammable and explosive items, toxic and hazardous items, sharp items. 3. In the event of self-injury or harmful event, the home should intervene in time, report to the police, and call for medical	n/a

		3. Communicate with the elderly at the right time to grasp the mental or spiritual changes of the elderly. 4. Protect residents' privacy.		emergency if necessary, and inform the relevant parties in time.	
Recreational Service	The LTC home shall provide recreational service	Recreational service should: 1. According to the needs of the physical and mental conditions of the residents carry out activities such as literary and artistic activity, drawing, chess and card, fitness, watching movies, and sightseeing. 2. Provide necessary safety protection measures	Recreational service requirement: 1. Provide more than one cultural and recreational activities suitable for the physiological and psychological conditions of the residents every day 2. During the activity, the home should pay close attention to the physical condition of the elderly to ensure that the elderly can enjoy activities safely	Accident prevention in recreational service: 1. Observe the physical and mental state of the elderly in recreational activities. 2. The home should perform anti-slip treatment to the ground, have protective layer on the wall corner and furniture.	n/a
Other**	-	The home should also provide counseling service, safety protection, and accessing to medical service.	The home should establish basic management system, assessing residents on a regular basis.	Contingency plan: 1. The home should have contingency plan for different injury cases. 2. The home should assess their contingency plan annually.	n/a

		3. The home should provide safety education for both staff and residents

Appendix E An Example of the 2020 Third-Party Evaluation Results in one Long Term Care Home in Tokyo

Major Item	Minor Item	Result
Overview	Principle	1. Provide compassionate mental care practice 2. Values a homely atmosphere 3. Supports independent living with dignity and personalized service. 4. Strives to utilize the dignity of living dependently and remaining function 5. Aims to cooperate with the community and become the welfare base for the community
	Advantage	1. This facility has improved the environment and strengthened the system so that it can respond promptly and is actively accepting users who are highly dependent on medical care by improving cooperation with medical care, nursing, and long-term care. 2. By utilizing the management record system, each professional in this facility cooperates to grasp the situation from various perspectives, review the plan, and make urgent changes promptly. 3. With the establishment of job authority, division of duties, and meeting system, the staff of this facility have made suggestions for improvement, and bottom-up facility management is being practiced.

Survey	Aspects for improvement	1. Even in situation where it is difficult to hold events or recreation service, it is expected that each staff member will devise ways to provide recreational service for residents. 2. By deepening the awareness of the work contents of other professionals and creating an environment for multidisciplinary team cooperation, it is expected that the satisfaction of residents will increase and lead to the improvement of services.
	Are you satisfied with meal service?	Yes: 80% No: 0% More or Less: 10% No response: 10%
	Are you receiving necessary daily support??	Yes: 80% No: 0% More or Less: 20% No response: 0%
	Are you able to relax in this LTC home?	Yes: 70% No: 30% More or Less: 0% No response: 0%
	Do employees care about your health?	Yes: 90% No: 0% More or Less: 10% No response: 0%
	Is the facility clean and tidy?	Yes: 100% No: 0% More or Less: 0% No response: 0%
	Is the hospitality and attitude of the staff appropriate?	Yes: 90% No: 0% More or Less: 10% No response: 0%
	Is the staff's response in the incident of illness or injury reliable?	Yes: 100% No: 0% More or Less: 0% No response: 0%
	Is the home's response to troubles between residents reliable?	Yes: 80% No: 0% More or Less: 10% No response: 10%
	Are you treated with respect?	Yes: 90% No: 0% More or Less: 10% No response: 0%
	Is the privacy of the residents protected?	Yes: 90% No: 0% More or Less: 10% No response: 0%
	Are you or your family involved in making the care plan?	Yes: 20% No: 50% More or Less: 30% No response: 0%
	Do you understand the explanation of the care plan?	Yes: 0% No: 80% More or Less: 20% No response: 0%
	Are the claims and requirements from the resident being addressed?	Yes: 90% No: 0% More or Less: 10% No response: 0%

	Have you been told that you can consult with an external complaint channel (e.g., government)	Yes: 10% No: 90% More or Less: 0% No response: 0%
Third party evaluation	The Home provides service information to residents who wish to use the service.	Yes: 100% No: 0%
	Explain the service to the residents and obtain their consent.	Yes: 100% No: 0%
	The home creates individualized care plan based on the wishes from the resident and opinions from related party.	Yes: 100% No: 0%
	Situation of the resident is recorded, and a management system is established.	Yes: 100% No: 0%
	Information on the resident's situation is shared among staff members.	Yes: 100% No: 0%
	The home supports the resident's independent living based on the care plan.	Yes: 100% No: 0%
	Residents' conditions and intentions are reflected in the meal service	Yes: 100% No: 0%
	The home devises ways for residents to enjoy their meals.	Yes: 100% No: 0%
	Residents' conditions and intentions are reflected in the shower support.	Yes: 100% No: 0%
	Residents' conditions and intentions are reflected in the excretion service.	Yes: 100% No: 0%
	Residents' conditions and intentions are reflected in the transportation service.	Yes: 100% No: 0%
	Rehabilitation service is provided based on the condition of the resident.	Yes: 100% No: 0%
	The home provides support to maintain the health of the resident.	Yes: 100% No: 0%
	The home provides support to help residents live comfortably.	Yes: 100% No: 0%
	The home provides support to help residents to enjoy their lives in the home.	Yes: 100% No: 0%

The home makes efforts to cooperate lives of residents with the local community.	Yes: 100% No: 0%
The home always tries to interact and cooperate with the family of the residents.	Yes: 100% No: 0%
The home is using every way to protect the privacy of residents	Yes: 100% No: 0%
The home protects the rights of residents and respect the will of residents when providing services	Yes: 100% No: 0%
The home is making efforts to standardize business operation by providing things such as guidebooks.	Yes: 100% No: 0%
The home is making efforts to standardize the business operation to improve the quality of services.	Yes: 100% No: 0%

Note. Sample size of the survey is 10. There are multiple subsections within each item evaluated by the third party. For further detail please visit:

http://www.fukunavi.or.jp/fukunavi/controller?actionID=hyk&cmd=hyklstdtldigest&BEF_PRC=hyk&HYK_ID=2021001934&HYK_ID1=&HYK_ID2=&HYK_ID3=&HYK_ID4=&HYK_ID5=&JGY_CD1=&JGY_CD2=&JGY_CD3=&JGY_CD4=&JGY_CD5=&SCHSVCSBRCD=&SVCDBRCD=&PTN_CD=&SVCSBRCDALL=&SVCSBRCD=001&AREA1=&AREA2=&AREA3=&HYK_YR=&SCHHYK_YR=&NAME=&JGY_CD=1310100001&MODE=multi&DVS_CD=&SVCDBR_CD=21&SVCSBR_CD=&ROW=0&FROMDT=&SCH_ACTION=hyklst&KOHYO=&GEN=&HYKNEN=&LISTSVC=&ORDER=&HYK_DTL_CHK=&PRMCMT_CHK=&HYK_CHK=&JGY_CHK=&SVC_CHK=&DIG_MOVE_FLG=&MLT_SVCSBR_CD1=&MLT_SVCSBR_CD2=&MLT_SVCSBR_CD3=&MLT_SVCSBR_CD4=&MLT_SVCSBR_CD5=&MLT_SVCSBR_CD6=&MLT_SVCSBR_CD7=&MLT_SVCSBR_CD8=&COLOR_FLG=&COLOR_HYK_ID=&BEFORE_FLG=&MLT_DTL_SVCSBR_CD1=&MLT_DTL_SVCSBR_CD2=&MLT_DTL_SVCSBR_CD3=&MLT_DTL_SVCSBR_CD4=&MLT_DTL_SVCSBR_CD5=&MLT_DTL_SVCSBR_CD6=&MLT_DTL_SVCSBR_CD7=&MLT_DTL_SVCSBR_CD8=&HIKAKU_SVCSBRCD=&TELOPN001_NO1=&TELOPN001_NO2=&TELOPN001_NO3=&TELOPN002_NO1=&TELOPN002_NO2=&TELOPN002_NO3=&TELOPN003_NO1=&TELOPN003_NO2=&TELOPN003_NO3=&S_MODE=service&MLT_AREA=13101&H_NAME=&J_NAME=&SVCDBR_CD=21&STEP_SVCSBRCD=0

Appendix F Mandatory Courses and Teaching Time in Designated Schools Regulated by the Japanese Government

Table F-1.

Mandatory Courses and Teaching Time in Designated Long-Term and Short-Term Programs Regulated by the Japanese Government

Subject	Teaching Time (hour)	
	Short-term program	Long-term program
Human dignity and independence	N/A	Over 30
Human relationship and communication	N/A	Over 60
Understanding of the society	N/A or 15*	Over 60
Basics of long-term care	180	180
Communication skill	60	60
Skill of daily support	300	300
Process of care	150	150
Care exercise	60	120
Care practice	210 or 270*	450
Theory of human body and mind	60	120
Theory of development and aging	30	60
Theory of dementia	30	60
Theory of impairment	30	60
Medical care	50	50
Total	1205 or 1220	1850

Note. *: Individuals with one year of experience in work field are eligible for shorter period of studying time. Information gathered from: https://elaws.e-gov.go.jp/document?lawid=420M60000180002

Table F-2.

Mandatory Courses and Teaching Time in Designated Program Regulated in High School by the Japanese Government

Subject	Teaching Time (hour)*
Basics of social welfare	117
Basics of long-term care	146
Communication skills	58
Skills of daily support (medical care)	292
Care process	117
Care exercise	86
Care practice	379
Understanding of human body and mind	233
Elective course	117
Total	1,546

Note. *: The teaching time is calculated by the author from the required credits, and the number after the decimal point is rounded off. Information gathered from: https://elaws.e-gov.go.jp/document?lawid=420M60000180002

Appendix G Type and Amount of Subsidies and Requirements for Repayment Exemption for Different Educational Program

Program	Type	Amount ($ CAD)	Repayment exemption requirement
College	Living expense	550/Month	Working as a certified PSW for five years after graduation
	Admission support fee	2,200/One-time	
	Work support fee	2,200/One-time	
	Test preparation fee	440/Year	
High School	Admission support fee	330/One-time	Working as a certified PSW for three years after graduation
	Care practice fee	330/Year	
	Work support fee	2,200/One-time	
	Test preparation fee	440/Year	
Practitioner	Test preparation fee	2,200/One-time	Working as a certified PSW for two years after graduation

Note. Information gathered and translated from https://www.mhlw.go.jp/stf/seisakunitsuite/bunya/hukushi_kaigo/kaigo_koureisha/newpage_15126.html

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Wu, C. R., Zecevic, A., Smith, M., & Sibbald, S. (2021). *Preventable? Policy Failures that affected Long-Term Care Home Infections During the COVID-19 Pandemic: A Scoping Literature Review*. 2019 HRS Graduate Research Conference, Western University, London, ON, February 4, 2020. Poster Presentation.