Two Worlds of Aging

Institutional Shifts, Social Risks, and the Livelihood of the Japanese Elderly
Ethnosoziologie | Social Anthropology

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Band 2
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Institutional Shifts, Social Risks, and the Livelihood of the Japanese Elderly

Vitali Heidt
Acknowledgements

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Abstract

The vast and rapid demographic change in Japan, rendering over 25 per cent of the population older than the retirement age, poses a challenge not only to social security systems, but also the social integration of the elderly. The immense ageing process and the introduction of long-term care insurance in 2000 sparked the debate concerning social inequality and discussions, whether recent developments in Japanese social policy rather provide an egalitarian approach, such as long-term care insurance, or whether the country’s familialistic orientation towards the male breadwinner in family life is a disadvantage in social policy. The socialisation of care through the introduction of long-term care insurance not only changed the welfare mix between the institutions of the market, the state, the family and the community, but it also illustrated that social organisation, access to livelihood security systems and community engagement play a vital role.

This dissertation, therefore, aims to fathom why and how long-term care insurance as an element of social security in Japan contributed to addressing the social risks of ageing and what effects its introduction has had on the welfare mix. For this purpose, a mixed methods approach was utilised in order to provide a coherent and thorough presentation of the subject matter. Apart from the analysis of social policies and aggregate data, qualitative data from participant observation and interviews was collected during ten months of fieldwork in Japan.

The results indicate that long-term care insurance in Japan has not only partially relieved individuals and their kin from care burdens and that care facilities likely contribute to the social inclusion of the elderly, but also that the given institutional framework of long-term care insurance has had positive effects on the market and communities in welfare creations. Furthermore, the results point to significant gender differences in the perception and usage of long-term care services. Additionally, regional disparities come into effect and require local strategies of problem-solving. In particular, here it proves that local communities in rural regions provide a considerable contribution to welfare creation—which is planned to be enhanced by future reforms of the long-term care insurance policy.
Zusammenfassung

Vor dem Hintergrund des raschen und immensen demographischen Wandels in Japan, bei dem mittlerweile mehr als Viertel der Nation über 65 Jahre alt ist, wurden die Sozialausgaben zur Belastungsprobe und führten zur Einführung der Pflegeversicherung im Jahr 2000. Der Alterungsprozess und die Einführung der viel beachteten Pflegeversicherung hatten die Debatte über soziale Ungleichheit und Diskussionen, ob jüngste Entwicklungen der japanischen Sozialpolitik einen eher egalitären Ansatz verfolgen, wie die Pflegeversicherung, oder, ob die Prädominanz der male breadwinner-Ausrichtung und somit, ob die stark familialistische Sozialpolitik der japanischen Regierung benachteiligende Hindernisse sind, erneut befeuert. Die Pflegeversicherung veränderte durch die Sozialisierung der Pflege nicht nur im Wohlfahrtsmix die Balance zwischen den Institutionen des Marktes, der Staates, der Familie und der lokalen Gemeinschaft, es zeigte sich auch, dass soziale Risiken, u.a. durch regionale Disparitäten und Geschlechterunterschiede, im Entstehen begriffen waren.


Die Ergebnisse deuten darauf hin, dass in Japan durch die Pflegeversicherung nicht nur Individuen und ihre Angehörigen teilweise von der informellen Pflege entlastet worden sind und Pflegeeinrichtung zur sozialen Inklusion beitragen können, sondern dass sich durch den vorgegeben institutionellen Rahmen ebenso positive Effekte auf den Markt wie auch die lokale Gemeinschaft entwickelt haben. Die Ergebnisse zeigen jedoch auch, dass es bedeutende Geschlechterunterschiede in der Wahrnehmung und Nutzung gibt und, dass regionale Disparitäten zum Tragen kommen, die lokale Problemlösungsstrategien erfordern. Insbesondere zeigt sich hierbei, dass die lokale Gemeinschaft in ländlichen Regionen einen wesentlichen Beitrag zur Wohlfahrtsgenerierung leistet und diese durch Reformen der Pflegeversicherung weiterhin verstärkt werden soll.
Note on Convention and Ethical Standards

All names mentioned in this document are used in their cultural convention, i.e. first name last name for western names (John Smith) and last name first name for Japanese names (Yamamoto Akira).

I openly communicated and made clear the purpose of my interviews and participant observation for data collection upon entering each facility by introducing myself, my academic affiliation and my project to the staff members and during the volunteer sessions to the seniors with the staff present verbally and in written form beforehand.

The names of all interviewed patients and seniors, if given in this work, were changed in order to guarantee their privacy and anonymity. Names of locations and facilities as well as care personnel, academics, representatives of local governments and their respective bodies who I interviewed remained unchanged. Only upon request would their names have been anonymised—which was not requested.
<table>
<thead>
<tr>
<th>Japanese Term</th>
<th>Translation</th>
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</thead>
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<tr>
<td>部長 (buchō)</td>
<td>superior staff member</td>
</tr>
<tr>
<td>分家 (bunke)</td>
<td>side-branch of family</td>
</tr>
<tr>
<td>地域包括ケアシステム (chiiki hōkatsu kea shisutemu)</td>
<td>Integrated Community Care System; care reform initiative by the MHLW</td>
</tr>
<tr>
<td>地域ネットワーク (chiiki nettowaku)</td>
<td>community networking</td>
</tr>
<tr>
<td>地区福祉団体 (chiku fukushi dantai)</td>
<td>neighbourhood welfare association</td>
</tr>
<tr>
<td>中流社会 (chūryū shakai)</td>
<td>middle-class society</td>
</tr>
<tr>
<td>副長 (fukuchō)</td>
<td>deputy</td>
</tr>
<tr>
<td>福祉 (fukushi)</td>
<td>welfare</td>
</tr>
<tr>
<td>福祉タクシー (fukushi takushi)</td>
<td>welfare taxi</td>
</tr>
<tr>
<td>外国人人 (gaikokujin)</td>
<td>foreigner (without any pejorative intention)</td>
</tr>
<tr>
<td>限界集落 (genkai shūraku)</td>
<td>marginal village</td>
</tr>
<tr>
<td>配食サービス (haishoku sābusu)</td>
<td>meal delivery</td>
</tr>
<tr>
<td>畑 (hatake)</td>
<td>rice field</td>
</tr>
<tr>
<td>はつらつ (hatsuratsu)</td>
<td>lively, vigorous</td>
</tr>
<tr>
<td>ヘルパーさん (helper-san)</td>
<td>home helper</td>
</tr>
<tr>
<td>保健福祉課 (hoken fukushi-ka)</td>
<td>municipal health and welfare department</td>
</tr>
<tr>
<td>訪問介護 (hōmon kaigo)</td>
<td>home care, visiting care</td>
</tr>
<tr>
<td>本家 (honke)</td>
<td>main-branch of family</td>
</tr>
<tr>
<td>家 (ie)</td>
<td>Family, home</td>
</tr>
<tr>
<td>いい雰囲気 (ii fun'iki)</td>
<td>friendly and cozy atmosphere</td>
</tr>
<tr>
<td>居酒屋 (izakaya)</td>
<td>bar, pub</td>
</tr>
<tr>
<td>住民税 (jūminzei)</td>
<td>municipal tax</td>
</tr>
<tr>
<td>介護福祉士 (kaigo fukushi-shi)</td>
<td>certified care worker</td>
</tr>
<tr>
<td>介護支援専門員 (kaigo shien senmon'in)</td>
<td>care manager, lit.: expert for care support</td>
</tr>
<tr>
<td>介護施設 (kaigo shisetsu)</td>
<td>care facility</td>
</tr>
<tr>
<td>Japanese Term</td>
<td>English Translation</td>
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<tr>
<td>---------------</td>
<td>---------------------</td>
</tr>
<tr>
<td>係長 kakarichō</td>
<td>chief clerk</td>
</tr>
<tr>
<td>看護 kango</td>
<td>nursing care</td>
</tr>
<tr>
<td>看護師 / 看護士 kangoshi</td>
<td>nurse</td>
</tr>
<tr>
<td>ケアワーカー keawākā</td>
<td>care worker</td>
</tr>
<tr>
<td>傾聴 keichō</td>
<td>lit.: attentive listener</td>
</tr>
<tr>
<td>敬語 keigo</td>
<td>honorific language</td>
</tr>
<tr>
<td>個人主義 kojin shugi</td>
<td>individualism</td>
</tr>
<tr>
<td>国民健康保険 kokumin kenkō hoken</td>
<td>National Health Insurance</td>
</tr>
<tr>
<td>国民年金 kokumin nenkin</td>
<td>National Pension</td>
</tr>
<tr>
<td>駒ヶ根市 komagane-shi</td>
<td>Komagane City</td>
</tr>
<tr>
<td>高齢福祉課 kōrei fukushi-ka</td>
<td>elderly welfare department</td>
</tr>
<tr>
<td>高齢者 kōreisha</td>
<td>elderly person</td>
</tr>
<tr>
<td>高齢者保健福祉推進十年戦略 Kōreisha Hoken Fukushi Suishin Jūka-nen Ōenryaku</td>
<td>Ten-Year Strategy to Promote Health and Welfare for the Aged, the so-called &quot;Gold Plan&quot;</td>
</tr>
<tr>
<td>高齢者寝たきり</td>
<td>Kōreisha Nettakiri</td>
</tr>
<tr>
<td>日本型福祉社会 nihon-gata fukushi shakai</td>
<td>Japanese-style welfare society</td>
</tr>
<tr>
<td>日本人論 nihonjinron</td>
<td>discourse on &quot;Japanese-ness&quot;</td>
</tr>
<tr>
<td>認知症 ninchishō</td>
<td>dementia</td>
</tr>
<tr>
<td>入浴 nyūyoku</td>
<td>bathing</td>
</tr>
<tr>
<td>おばあちゃん obāchan</td>
<td>granny, diminutive of grandmother</td>
</tr>
<tr>
<td>御茶飲会 ocha-nomikai</td>
<td>lit.: tea-drinking gatherings</td>
</tr>
<tr>
<td>押し車 oshigurama</td>
<td>wheeled walker</td>
</tr>
<tr>
<td>お年寄り otoshiyori</td>
<td>senior, elderly person</td>
</tr>
<tr>
<td>パチンコ pachinko</td>
<td>arcade game machine</td>
</tr>
<tr>
<td>ペンダント pendanto</td>
<td>pendant</td>
</tr>
</tbody>
</table>
ピンピンコロリ pinpinkorori a local concept of desirable passing, lit.: cheerful life, sudden death
老人福祉法 rōjin fukushi hō Welfare Law for the Elderly
サロン saron salon (preventive care measure)
整復師 seifukushi physiotherapist
生活保障 seikatsuhoshō social security systems
成年後見人 seinen kōken-nin adult guardian
洗湯 sentō traditional public bath
社会福祉協議会 shakai fukushi kyōgikai Social Welfare Council
社会福祉法人 shakai fukushi hōjin social welfare service corporation
社会人 shakaijin working adult, lit. person of society
支援 shien support, assistance
新中間階層 shin chūkan kaisō new middle class
新幹線 shinkansen bullet train
シルバー人材センター shirubā jinzai sentā a centre to broker small jobs for seniors, lit.: Centre for Capable Silver Persons
施設介護 shisetsu kaigo institutionalised care
市役所 shiyakusho city hall
商店街 shotengai shopping street, promenade
退職者 taishokusha retiree
滞在費 taizaihi "hotel costs", lit.: subsistence expenses
特別区 tokubetsu-ku special wards, administrative units in Tōkyō
通算年金通則法 tsūsan nenkin tsūsoku-hō National Pension Law
通所サービス tsūsho sābisu outpatient services
要介護 yōkaigo care level
要支援 yōshien support level
湯たんぽ yutanpo hot-water bottles, used as foot warmers

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<tbody>
<tr>
<td>ADL</td>
<td>Activities of Daily Living</td>
</tr>
<tr>
<td>IPSS</td>
<td>National Institute of Population and Social Security Research</td>
</tr>
<tr>
<td>LTC</td>
<td>Long-Term Care</td>
</tr>
<tr>
<td>LTCI</td>
<td>Long-Term Care Insurance</td>
</tr>
<tr>
<td>MHLW</td>
<td>Ministry of Health, Labour and Welfare</td>
</tr>
<tr>
<td>MIAC</td>
<td>Ministry of Internal Affairs and Communications</td>
</tr>
<tr>
<td>MOJ</td>
<td>Ministry of Justice</td>
</tr>
<tr>
<td>NEET</td>
<td>A young person that is Not in Education, Employment, or Training</td>
</tr>
<tr>
<td>NGO</td>
<td>Non-Governmental Organisation</td>
</tr>
<tr>
<td>NPO</td>
<td>Non-Profit Organisation</td>
</tr>
<tr>
<td>OECD</td>
<td>Organisation for Economic Cooperation and Development</td>
</tr>
<tr>
<td>UN</td>
<td>United Nations</td>
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1 Institutional change and the emergence of social risks

Developed societies in the West and in the East have experienced vast demographic changes and the advent of social upheaval in the last three decades, which are putting their governments, populations and financial standing under strain. As a worldwide forerunner, Japan's ageing population and the issues that entails, such as social security and livelihood support, have been at the centre of scientific debates. But not only has the greying of Japan's society kindled research interest, the discussion on the alignment of the Japanese welfare regime is also ongoing and prevailing, especially due to the fact that most of Japan's social security elements had been introduced or adjusted by the middle of the 20th century—with the latest addition being old-age care insurance.

The Japanese welfare regime was sometimes classified as "hybrid or unique" (Esping-Andersen, 1997, p. 179) among the widespread tripartite typology of Esping-Andersen (1990) or rather as utilising "functional equivalents" (Estévez-Abe, 2008, 3-5, 19-20) for its fragmentary and patchy social welfare policy design (Estévez-Abe, 2006), yet the most accurate finding might be that the Japanese welfare regime is still in flux, is "still in the process of evolution; that it has not yet arrived at the point of crystallization" (Esping-Andersen, 1997, p. 187). Whether or not the developmental phase of the Japanese welfare system has reached a certain level of, let’s say, 'maturity', the question of to what extent recent developments on societal, demographic and social security dimensions have influenced the development of inequality and the emergence of social risks among the Japanese elderly has to be debated. In the debate on the emergence of "new social risks" several institutional changes in post-industrial societies are addressed, e.g. the labour market, female labour force participation, or the care for an aged person (Bonoli, 2005). These new social risks are mainly examined from the supply side of labour and the accessibility of the labour market, or the decommodification of services (Bonoli, 2005).

1 Functional equivalents, according to Estévez-Abe, are welfare surrogates disguised as public works investments, protectionism over agricultural goods for farmers, and certain jobs as well as other regulatory safeguarding of the local and regional economies.
2012). But for people who do not belong to the working-age population the mechanisms and effects are different. Ageing as such and the livelihood of the elderly in a society that is still experiencing major changes to its social security systems are another area of emerging social risks and will be covered in the following chapters.

The discussion will focus on the factors contributing to the materialisation of social risk, the welfare institutions and their change over time as well as spatial varieties in ageing, institutional settings and care execution.

1.1 Inequality in ageing Japan

Inequality research in general came to the fore when Western nations embarked on large-scale reconstruction at tremendous velocity after the Second World War, which led to prosperous economies, exploding populations and, subsequently, to drastic social changes with the development of and intense discussions upon the topics of pauperisation, the so-called underclass and socially problematic areas. Japan as the "eastern West", however, was ostensibly ‘spared’ such developments. Research concerning inequality in Japan emerged in the post-war era of industrialisation, urbanisation and high-growth, and has depicted Japan as an apparently consistent and equal society. Under the label of *nihonjinron* (日本人論, discourse on Japaneseness²), a variety of peculiar, and more or less scientific, literature expressed the uniqueness of Japanese society (e.g. on the topic of passive love and dependence, see Doi, 1985) by depicting an overly homogeneous, equal and thus unique society. However, it was convincingly shown that the uniqueness, and with it the homogeneity, was merely and is still a

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² Despite the discourses posted under the label *nihonjinron,* other topics were *nihonron* (日本論), *nihonbunkaron* (日本文化論), etc., repeating the uniqueness of Japanese ethnicity, its unique cultural feats, such as religion, and nutrition as well as the unique geographical location and seclusion of the Japanese nation. Generally, the *nihon-ron* and *nihonjin-ron* literature and debates centre on four postulates that underline the uniqueness of the Japanese race, history, language, psychology and homogeneous social structure. *Nihon-ron* and *nihonjin-ron* debates contain more and less subtle elements of chauvinism and nationalism, which were interpreted differently in past decades.
social construction of perception and reality\(^3\) (Burgess, 2010; Dale, 1988; Mouer and Sugimoto, 1986).

Later on, the emergence of the so-called "new middle class" (新中間階層, shin chūkan kaisō) (Murakami, 1980) with converging values and attitudes was proclaimed in a widely noted article. As a direct consequence, inequality research stalled as the assumption of Japan being an equal, mass society was also adopted by Western scholars (Watanabe and Schmidt, 2003, p. 6). In the 1990s, the period in which the post-bubble economy revealed its aftermath, the myth of a Japanese mass society was increasingly questioned and discussions about social stratification and rising inequality became vital again.

The current notion of Japan is that of a stratified society (格差社会, kakusa shakai) instead of a middle-class society (中流社会, chūryū shakai). This change is not due to a sudden transformation of the Japanese social class structure as it stands to reason that inequality nonetheless persisted throughout the post-war era, but was concealed by the possibilities of intergenerational mobility in the high-growth period, e.g. from rural, agricultural community farmers to urban, big-enterprise employees, and became perceptible as the economy increasingly began to stall during the oil crises and the lost decade (Ishida, 2006; Ishida and Satoshi, 2008; Schad-Seifert, 2007).

Furthermore, objective and subjective class identification surveys revealed that the "90% middle-class society" was not a peculiarly homogeneous Japanese society, but a mere and often circulated myth that was based on biased and flawed questionnaires (Ishida, 2010, pp. 45–46)\(^4\). The "middle-class" results could be reproduced in other nations with the same questionnaire design. More neutrally designed cross-national surveys also revealed that subjective social status in Japan, Germany and the USA is comparably distributed around the middle, which shows that the "distribu-

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\(^3\) As Burgess (2010) illustrates, the term tan’itsu minzoku (単一民族, ethnically homogeneous) is still uttered by ministers and elite politicians up to the present day.

\(^4\) The questionnaire was divided into five possible answers: upper, upper-middle, middle-middle, lower-middle and lower stratum. The flaw was that three out of the five answers referred to the middle class and were, likewise, merely subsumed simply into the category of “middle class”. With the fact in mind that surveys are subjected to the error of central tendency on an ordinal scale / Likert scale designs, the result of a broad middle-class society is unsurprising.
tion of socioeconomic resources by class is largely similar across the three nations" (Ishida, 2010, p. 50).

Changes in inequality are a result of structural transformations and their concomitant social (ageing, household and family structures) and institutional (labour market, tax and social security systems) adaptations (Ota, 2005; Tachibanaki, 2006). In the tradition of conflict theories, the last decade's social science research on inequality in Japan focused on social stratification and subjective class identity (Ishida, 2010; Ishida and Slater, 2010; Shirahase, 2010), employment conditions (Satō and Imai, 2011), social security and its different outcomes based on gender (Ōsawa, 2011), and inequality through ageing (Fukawa, 2008; Tokoro, 2009). Even though inequality and poverty in Japan have reached levels above the OECD average (Jones, 2007), they are believed to rise further due to increasing irregular employment, reluctant changes in social security systems and their persisting legacies of gender inequality (Ōsawa, 2011, pp. 49–54) and through the ageing process and a greying population itself (Coulmas, 2007; Coulmas and Lützeler, 2011; Shirahase, 2011).

Inequality in Japan was and is examined from these various perspectives, spectrums and on different levels, ranging from macro to micro level. From large-scale to small-scale, these approaches regularly cover the topics of economic development, the labour market, social welfare, generations and cohorts, regional characteristics, class mobility, household compositions and the diversity of life courses.

Despite the breadth of perspectives on the materialisation of inequality, the scientific discourse in the last two decades in Japan has tended to centre on the topic of demographic change, especially the emergence of an ageing population and income inequality. There are two main perspectives on inequality in an ageing society (Shirahase, 2011, p. 116):
a) economic inequality among the elderly is smaller than that among the working population due to the relatively similar income from pensions— as opposed to the more diverse income from wages,
b) old age reveals the accumulated disadvantages and advantages that manifest themselves over a lifetime (Abe, 2010, see also below for the developmental risk and protection of life courses).

In this regard, ageing exhibits a twofold, and at first glance conflicting, argument on inequality. The first argument pursues an intergenerational con-
cept of inequality in which the differences within a generation are compared to those within another generation, i.e. employees versus retirees. Following this, the reasons for rising economic inequality between generations in Japan are likely to be found in macro-level explanations, e.g. the rapidly ageing Japanese society leads to an increasing imbalance in economic capacity and income between the working and retired generations (Ohtake, 2008; Shirahase, 2011). Such a disequilibrium results from high retirement rates among the population, the so-called "2007 problem", with citizens dropping out of higher wage incomes and transferring to significantly lower pension incomes.

It is assumed that by retiring, seniors experience less inequality as a group from an intergenerational macro-perspective since every retiree's income is likely to decrease and the difference between individuals will diminish. These differences, on the other hand, accumulate over a lifetime and underline the fact that the course of a life plays a vital role in the inequality debate. Disadvantageous periods in the life course, such as irregular employment, time spent not in employment, education, training (NEET) or even short periods of poverty contribute to inequality and social exclusion. Further on, its accumulative effect has been shown, as has its major impact on the likelihood of old-age economic deprivation and poverty (Abe, 2010, pp. 27–28).

However, inequality is by and large measured economically through income and wealth distribution. Closely connected to research on poverty, inequality research provides information about this distribution, while poverty research focuses on the lower segment of income distribution in particular, which has varyingly defined thresholds of disposable income within a society. As economic inequality and poverty represent merely relational wealth and income distribution and have a significant value by

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5 Generation here is defined by the average childbearing age of women, which is approximately 29 in Germany and 30 in Japan (Organization for Economic Cooperation and Development, 2015). It is therefore not meant in the historical-cultural approach used in Karl Mannheim's (1964) description of a generation as a shared historical experience. Although shared experiences also bond every generation, such as experiencing one’s youth during the post-war period, being employed during the high-growth era and being labelled as the "2007 problem" in media and political discourse, the same ascription applies to cohorts.

6 The European Union defines persons with a disposable income below 40 per cent of all incomes as poor, while the WHO, OECD utilise the median to define poverty. In Germany, people with a disposable income below 60 per cent are considered to be
definition, it is the quality of distribution and access to commodities and services that matters in the end.

1.2 Gaps in the social security system

Ever since the bubble economy in Japan burst in the mid-1990s, social scientists have eagerly explored the effects of this vast economic recession and its social consequences (Ishida and Slater, 2010; Kingston, 2004, 2011; Yamasaki et al., 2005). But the discussions on the whereabouts of the Japanese welfare regime and accessibility of its services have also been vocal (especially Arts and Gelissen, 2002, 149-150, 152 show researchers' issues when classifying the Japanese welfare state; Ebbinghaus, 2006, pp. 56–62; Esping-Andersen, 1997; Holliday, 2000; Lee and Ku, 2007; Peng, 2000; Seeleib-Kaiser, 2001, pp. 235–239, 2002). By trying to delineate the general question of whether risks are amplified or minimised by changing institutional arrangements, two strands of social scientists especially, focusing on differing aspects of social welfare and social security are influential in this regard—with different conclusions in their assessment.

1.2.1 Dysfunctional elements of social security

One strand (Abe, 2003, 2010; Ōsawa, 2011; Shirahase, 2008, 2011) argues that the Japanese social security systems are functioning insufficiently. This is the conclusion of a research focus on aspects of economic old-age security and gender issues in relation to social exclusion. In particular, the combination of economic and social assistance measures to enable old-age livelihood is flawed tremendously in the sense that "the livelihood security system of Japan is not only dysfunctional, but actually functioning in reverse, in a sense of furthering social exclusion" (Ōsawa, 2011, p. i). Such an assessment is based on an analysis of the Japanese social security and employment system which exhibits highly gender-based traits in terms of its orientation towards male breadwinning and income-centrism (Ōsawa, 2007). It is argued that the Japanese labour market, as well as preceding poor (German Federal Statistical Office, 2012). Tachibanaki (2006, p. 21) however argues the difference between the median and 40 per cent is negligible.
national labour policies, regulate social security normatively by providing the security of full-time employment for men, while part-time employment, household tasks and child-rearing are activities expected of women (Ōsawa, 2011, 8, 23). Such a system is not only discriminatory against women, but results in more frequent life course ruptures and thus greater disadvantages for women than for men. Extrapolating these findings from the Japanese labour market, which still provides strongly seniority-based wages (Song, 2014, pp. 35–39), these ruptures culminate in lower wages for women, higher turnover rates through household income supplementing part-time occupation, and eventually in decreased old-age financial security. Families are pressured from an institutional and financial perspective into the planning of employment strategies around the central male breadwinning orientation with women's employment used in a supportive role to circumvent service shortages and tax burdens. Families, in this regard, are institutionally and also normatively reiterate traditional gender role models.

Figure 1-1: Income and expenditure in elderly one-person households with non-working persons

Source: Own representation, data Ministry of Internal Affairs and Communications, 2012a.

Note: *88.2 per cent of elderly one-person households are non-working households. "Non-consumption" includes direct taxes and social insurance premiums.
Figure 1-2: Income and expenditure in elderly two-person households with non-working persons

Source: Own representation, data Ministry of Internal Affairs and Communications, 2012a.

Note: 77.7 per cent of elderly two-person households are non-working households. Husband at least 65 years or above; wife at least 60 years or above. "Non-consumption" includes taxes and social insurance premiums.

Employment with social insurance contributions is the prerequisite of old-age security. The livelihood of aged persons depends significantly on social security payments. The main sources of income in elderly households are social security payments, which constitute approximately 75 to 80 per cent of the income in elderly households (see also Figure 1-1 & Figure 1-2) (Ministry of Internal Affairs and Communications, 2012a).

As shown above, elderly households depend highly on social security payments for their livelihood. But, furthermore, aged-person-only households experience a financial imbalance between income and expenditure, thus displaying a deficit and need for welfare support. Particularly at risk are those citizens who were employed in pension-disadvantaged employment, such as the former self-employed or irregularly employed, as well
those who interrupted their employment due to childrearing, being a housewife\textsuperscript{7} or providing informal care for the family.

The Japanese Pension System (国民年金, \textit{kokumin nenkin}) provides a basic pension based on the years of contribution and paid-in contributions, but admittedly also provides a basic pension for every Japanese citizen, even those who do not make any contributions to it. These non-contributors, the so called co-insured, are generally dependent spouses of socially insured employees and constitute a fairly large group of 10.44 million Japanese citizens (National Institute of Population and Social Security Research, 2014a). However, only full-time employees are eligible to enter the valuable corporate pension schemes (see Figure 1-3 above). People on low incomes, usually in irregular employment\textsuperscript{8}, and co-insured spouses are consequently rendered vulnerable in terms of economic security by receiving pension benefits. Households consisting of elderly people and single elderly women especially, who receive only basic pension coverage, in general experience several shortcomings in their daily life. These range from mobility issues to a lack of social interaction, which are side effects of the more severe lack of sufficient pension coverage, and hence have a major impact on their livelihood. Eventually, the result is tremendously high dependence on welfare among the elderly, with more than half of Japanese citizens of 60 years\textsuperscript{9} and above depending on public assistance payments (Tokoro, 2009, p. 57).

\textsuperscript{7} House husbands among the current generation of retirees are non-existent in Japan. Even today, only 2.3 per cent of men in the workforce take parental leave, according to the MHLW (The Japan Times, 2015b).

\textsuperscript{8} Regular employment is characterised by three distinctive attributes: a) indefinite contract, b) full-time employment and c) direct employment under the employer’s directions or orders (Tsuru, 2014), with the result that non-regular employment lacks these attributes (whereas c) might be disputed).

\textsuperscript{9} The mandatory retirement age was 60 until 2013 and will, according to the Law Concerning Stabilization of Employment of Older Persons (高年齢者雇用安定法, \textit{kōnenreisha kōyō antei-hō}), gradually go up to the age of 65 by 2025.
The current acuteness of the economic plight among seniors is reaching a new high:

"The number of welfare recipients totaled 2,174,331 in March [2015], […] surpassing a record reached a year earlier, the welfare ministry said Wednesday. The number of households consisting of persons aged 65 or older who were receiving welfare came to 786,634, or about 49 percent of the total. […] As economic recovery efforts progress, the number of so-called 'other households' and single-mother households receiving welfare has been declining, but a growing number of elderly recipients is pushing up the overall count." (The Japan Times, 2015a)

The number of dependent seniors would certainly be even higher if the actual mandatory retirement age, which was 61 years in 2015, would have been used as the measuring threshold. Furthermore, it elucidates the precarious situation in which retirees find themselves when they experience the economic risk of marginal income and loss of status upon retirement.
The fact that the pension systems function in this way demonstrates that they are flawed for those on a low income during their working lives since they remain in a dependent state due to having insufficient coverage and needing public assistance. Furthermore, falling out of social insurance coverage, and taking-up 'residual' welfare services and public assistance is still an unresolved issue in the Japanese social security system and often connected to feelings of shame and subordination. Such a "chasm [...] [and] dualism in Japan's social security system both emphasizes and is emphasized by social exclusion in the 'mainstream' [e.g. pensions] systems and the 'residual' Programs" (Abe, 2003, p. 68). In that way, that dependence and the need for help are procreative. Osawa's statement about both dysfunction and the reverse function of social security institutions is appropriate and gained in intensity during the 'lost decade' and the Koizumi administration due to changes in social policies (Ōsawa, 2011, pp. 141–145).

Osawa's argument about the institutional blocking of female career building and inequality diminishment is reasonable and appropriate in that context since data indicates that elderly women face the highest risk of poverty and inequality. A closer look reveals that countermeasures exist—even though only under certain conditions. The role of survivors’ pensions
in poverty alleviation is oddly enough not systematically covered in literature on social security systems, although it has a noteworthy gender impact on livelihood institutions. With the enormous amount of women working in irregular employment, the criticism is that they do not acquire the benefits of the Employees' Pension Insurance scheme since only full-time employees are eligible for it. Hence, women adjust their working style and remain dependent spouses for taxation and pension payment reasons (National Institute of Population and Social Security Research, 2011, p. 18). In regard to the meagre benefits women acquire with the National Pension, in contrast to full-time employees, their economic livelihood might deteriorate if their partner passes away. This unfortunate event is the general case and leads to an immensely misbalanced sex ratio among the old-age population (Figure 1-4). To prevent this hardship, the survivors’ pension comes into effect and reflects the segmentation of the Japanese pension system as well: basic, employees’ and mutual aid survivors’ pensions. Benefit levels range from the full amount of the dead spouse's pension in the Survivors' Basic Pension to three quarters of the dead person's benefit amount in the Survivors’ Employees' Pension (Ministry of Health, Labour and Welfare, 2009). Despite the idea that receiving survivors’ benefits should help elderly women to maintain their livelihood and lifestyle, their risk of experiencing poverty is still the highest among all other age groups (Shirahase, 2011, p. 118). Furthermore, the precondition for a survivors’ pension is a legal marriage, but in the last two decades the tendency to remain unmarried has persisted and, in fact, marriage rates have even declined. This shows that although the element of the survivors’ pension which safeguards a person’s livelihood still exists, its function as an institutional countermeasure to cope with gender inequalities in old age is vanishing.

1.2.2 Things are not so bad after all

The assessment of the Japanese social security system in regard to supportive measures through medical care and care for the elderly is quite positive. The argument is (Campbell, 2002; Campbell and Ikegami, 2000; Campbell et al., 2010; Tamiya et al., 2011; Yong and Saito, 2012) that the Japanese health and care system is oriented towards an egalitarian and equalising construction in order to foster the provision of welfare for the elderly and to promote their social inclusion. It is made possible by the
structure and organisation of the Japanese care systems and the incremental orientation towards help from social communities and social organisations.

The Japanese model of statutory elderly care is comparatively new and was introduced in April 2000. Before that, the Japanese government had tried to invoke the myth of a Japanese-style welfare society since the late 1970s. The family was supposed to act as caregivers for the aged and the impaired. The intention of the government was the following:

“By promoting the slogan of a 'Japanese-type welfare society' (Nihon-gata fukushi shakai) during the 1980s, the government reduced social expenditures and instead called upon the population to recall the traditional virtue of caring for their aged in the family without public support” (Lützeler, 2002, p. 283).

The outlines of demographic developments among the Japanese population at the end of the 1980s brought new concerns. In order to cope with the pressing concern of care for the elderly due to demographic changes based on superannuation and the decline in the birth rate and to guarantee a high quality of living, in 1989 the Gold Plan was ratified with the particular aim of expanding medical care for seniors. While medical care for the elderly became almost free of charge as a consequence, formally institutionalised care for the elderly was still lacking. For that reason, frail seniors sought care in medical facilities and occupied personnel and beds in these and de facto altered their function into that of care facilities. Not only was it a problem of personnel training and equipment, but also a financial issue since these 'care costs' were borne by the healthcare budget, and the step towards institutionalised care for the elderly became increasingly evident. With the progressing ageing of society—in 2000 over 17 per cent of the population were over the age of 65—and a high ratio of 'hospital care for the elderly', statutory nursing and care for the elderly became necessary. Long-term care insurance (LTCI) was introduced in April 2000. It is a mandatory levy for every citizen above the age of 40 and offered to needy people above the age of 65 years in exchange for a variety of services10.

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10 Every Japanese person above the age of 65 is eligible to receive LTCI services if they are provided by local municipalities. People with disabilities such as dementia can utilise those services from the age of 40 (Ministry of Health, Labour and Welfare, 2002b).
Care for the elderly is segmented into institutional care, for frail and bedridden seniors, as well as day care and visiting care for elderly people who require assistance. But while care services through for-profit and non-profit organisations is covered by the LTCI, informal care for the elderly provided by family members and relatives is not and will not be compensated. The ulterior motive behind such a policy set-up was threefold:

- it aimed to foster the development of institutionalised public and private care facilities,
- to provide frail elderly people with the chance to leave home and avoid over-protection from family caregivers, and furthermore
- it was considered—particularly by women’s organisations—that in-cash-benefits for informal care would pressure women into a ‘care giving hell’ in their homes, with the result that the idea was abandoned by policymakers (Campbell et al., 2010, pp. 90–91).

Besides its broad accessibility, the LTCI offers an obstacle which proves to be especially problematic for low-income seniors. Introduced with the motive of reciprocal financing and preventing overuse of the system, the co-payment rate of ten per cent of the services used causes problems for people on a low income. It is levied independently of income and, depending on the care level and service usage, may cause considerable costs for the individual senior. The result was that "[t]here has been a considerable out-cry from low-income households who cannot bear the premium or/and the co-payment" (National Institute of Population and Social Security Research, 2011, p. 32). Hence, it is assumed that seniors reject taking up the service and still rely on family and neighbourly help. A study in regions with lower infrastructural availability of facilities for the aged showed that people’s willingness to make use of LTC services is constrained by structural, financial but also sociocultural reasons (Asahara et al., 2002). The reasons lie in shortages of day care services and nursing homes, the 10 per cent co-payment rate and the normative reliance on family care. In total, it results in elderly people on a lower income resisting taking up the LTCI and preferring to rely on "free" informal care instead. Impaired and low-income seniors find themselves constrained to move into their children's house or nursing homes as a result of their refusal to accept outside support and their dependence on filial piety (Asahara et al., 2002, pp. 169–170), but also due to cost-saving reasons.

As it turns out, being institutionalised in a nursing home proves to be more cost-effective for seniors than living individually or using visiting or day care services. Thus, "seniors have had economic incentives to enter
LTC facilities. [...] Entering a facility is more affordable than remaining in the community" (Tsutsui and Muramatsu, 2007, p. 1459) due to the capped amount of co-payments for institutional care, but uncapped co-payments for utilised LTC services in visiting and day care. The consequence was that an "average nursing home resident costs LTCI more than three times as much as an average community-based service user" (Tsutsui and Muramatsu, 2007, p. 1459).

The funding of the LTCI is unfortunately constructed in a way that regularly constitutes a burden for prefectures and municipalities with above-average ageing. Local governments, as LTC insurers, are pressured any time expenditure exceeds revenues, which is due to the fact that each prefectoral and municipal government has to contribute to the financing of the LTCI (Campbell and Ikegami, 2000; Ministry of Health, Labour and Welfare, 2002b). The result is that regions with high ageing, consequently a lower number of LTCI premium contributors and at the same time a higher number of LTC service users, face financial risks and often fiscal deficits. Although, after minor reforms, five per cent of the system's total revenue is already used to decrease regional disparities, there is still a discrepancy in LTC service distribution and usage between urban and rural areas, and it is likely to rise (Mitchell et al., 2008) since ageing in rural regions is proceeding faster than in urban regions.

Nevertheless, the introduction and general set-up of the LTCI underlines its egalitarian design. The service uptake criteria are only oriented by the assessed needs of the elderly. What is essential are the seniors' health status, their degree of independence in everyday life and their need for assistance. By giving seniors the chance to take up out-of-house care or to have visits from exterior caretakers, the system is able to enhance the seniors’ social sphere, which deteriorates the older they become. Consequently, the LTCI constitutes a solid safety net for needy seniors and their relatives.

1.2.3 Changes in family structures

While the passage above depicts the severity of seniors' dependency on public assistance measures for their economic well-being, in an ageing society there is also a need for care for the elderly. However, the underlying complexity of societal, social and political processes, especially in regard to old-age care and the entailing issues of intergenerational responsibility...
shifts, the emergence of comprehensive welfare and care measures, and the ideological and normative policy formation and orientation of the 20th century, is a crucial point. The "patchiness" of social security systems in post-war Japan and particularly in its old-age welfare and care, however, has developed under a long-standing eschewal by the national government. Public services which enable livelihood developed sporadically in post-war Japan, while the political focus remained on private measures to ensure livelihood. The notion of political avoidance of investments in a comprehensively old-age policy was even further expressed by the somewhat bizarre, but politically favoured connection to discourses on Japanese-ness (e.g. nihonron, nihonjinron). In 1979, the Japanese government proclaimed the model of a "Japanese-type welfare society" [日本型福祉社会, nihon-gata fukushi shakai] in which—[...] founded on the self-help efforts of individuals and the solidarity of families and neighborhood communities that the Japanese possess—an efficient government guarantees appropriate public welfare according to priorities" (Campbell, 1992, p. 220).

Evading the arising demographic and, of course, the financial issues, the latter partly fuelled by the anxiety of the effects of the oil shocks, the national government downgraded the responsibility for welfare, care and livelihood for the elderly from the national level to that of families. By pushing normative models of expected behaviour into the foreground, the government decided that care for the elderly, in particular, was meant to be a burden of the family and not the state in a strict sense of subsidiarity. However, the future demographic and social development was looming at that time already, still without anticipation of the upcoming devastating effects of the bubble economy.

Nevertheless, pressing and vast demographic changes in the contemporary 'society of ageing and a low birth rate' (高齢少子化社会, korei shōshika shakai) led to the extension of old and the materialisation of new welfare and care services for the elderly after all11. The main cases which promoted welfare for the elderly in post-war Japan were the 1963 Act on Social Welfare for the Elderly, which covered medical and care costs for the aged, the 1982 Health and Medical Service Act which covered medical expenses of the elderly, the 1989 The Gold Plan, which promoted

11 See Chapter 2 for comprehensive coverage of the development and status quo of Japanese Long-Term Care Insurance.
the establishment of infrastructure for the elderly’s needs, and the Long-Term Care Insurance Act, which was enacted in 2000 and introduced a comprehensive care system for the elderly. However, the assessment of the expansion of the welfare services remains quite unambiguous in its verdict:

"The outcome is an expansion in public welfare and services as the state takes on a greater role and responsibility in providing and coordinating social welfare. This shift, however, is not necessarily a sign that Japanese people have achieved greater citizenship rights as understood in some of the western welfare states; rather, it should be viewed as primarily a purposeful strategy aimed at facilitating economic growth." (Peng, 2000, p. 89)

A major factor in the transition of care responsibility is the significant transformation of household and family structures in post-war Japan. While multigenerational households were common in pre-war and immediate post-war Japan, nuclear and one-person households became dominant forms in contemporary Japan and tripled in number (Figure 1-5, Figure 1-6). Even more striking is the stronger increase in these household forms in peripheral regions (Tsutsumi et al., 2008, p. 37).

In an ageing society, the increase in elderly one-person households poses social risks as the health monitoring function of the family vanishes. And while the number of all households with aged persons was already 41.5 per cent in 2011 (19.4 million households), 24.2 per cent (4.7 million) were elderly one-person households. An astonishing 72.2 per cent of those elderly one-person households are inhabited by women (all data Ministry of Health, Labour and Welfare, 2011b). This data underlines the exposed position of elderly women in Japanese society. Evidence indicates that household type and the status of cohabitation increases the risk of the elderly experiencing inequality. An "increase in the ratio of one-person households has a positive effect on income inequality" (Ohtake, 2008, p. 902; see also Shirahase, 2011), i.e. elderly individuals living with their children have a better economic standing than individuals who live alone, which particularly applies to elderly households. The effect of the household type results in interesting findings (Shirahase, 2011, pp. 122–124):

– the risk of the elderly experiencing inequality is higher in one-person households
– the inequality among household types with the elderly in general has decreased, including one-person households, but
– nonetheless, the poverty rate in all types of households rose, and most affected were households with aged persons.
1 Institutional change and the emergence of social risks

Figure 1-5: Households by family type (million)

Source: own representation, data MIAC 2012c.

Figure 1-6: Households by family type with members over 65 years (million)

Source: own representation, data MIAC 2012c.
The findings of a decrease in inequality but a simultaneous increase in poverty among elderly households clearly indicates that the elderly in general are prone to experience impoverishment. The decline in inequality, though, results from a long-term reduction in the absurdly high relative poverty rate of elderly one-person households. The rate was 70 per cent in the 1970s for aged women and was reduced to 48.5 per cent by the mid-2000s, while the poverty rate among aged men in the same time period was reduced by 20 per cent, and still amounts to around approximately 30 per cent (Shirahase, 2011, p. 122). The risk of poverty rises with age, with the result that even though in 2004 general relative poverty was 13 per cent for all households, for elderly one-person households it was 20 per cent (Shirahase, 2011, p. 122) and for seniors above the age of 80 years the poverty rate was in fact 55.9 per cent (Fukawa, 2008, p. 925).

Although the inequality decreased among all aged households, including elderly one-person households, the poverty rate amid these household types rose. This seemingly contradictory relationship between inequality and poverty is mutually influenced, but is not necessarily causally linked. The inequality among the elderly may decrease as the distribution of elderly income becomes more homogeneous, e.g. by receiving pensions, while at the same time the income amount might be so meagre that the poverty rate among elderly citizens rises—and simultaneously inequality among seniors declines. Shirahase (2011: 123-124) attributes the inequality decline among households with aged persons to a higher contributive ratio of the elderly’s income to the household income.

What can be derived from the previous paragraphs? Basically three major points here have to be considered and analysed in the following sections:

- Social security institutions cannot satisfyingly ensure the economic livelihood of the elderly. As various sources indicated, seniors face the risk of poverty upon retirement as their financial coverage is insufficient, in particular those who were not in regular employment.
- Ageing itself poses a significant social risk through a complexity of social processes, such as retirement, biological deterioration and, as a consequence, withdrawal from the social sphere of life.
- Predominantly female seniors are exposed to risk at high ages. Due to their longer life expectancy, they already constitute a considerably large group of aged individuals, which renders the probability of them encountering the risk of poverty and social exclusion as above-average.
This, however, can be also attributed to the normative life course this
generation of women has experienced.

1.2.4 Subjective dimensions of ageing

The focal point of the preceding debate about pensions versus care for the
elderly is based on a top-down institutional analysis, and only little atten-
tion has been paid to everyday experiences of the elderly in the context
and interplay of social security systems. In order to understand how an el-
derly individual is affected by these institutions and their set pieces, the
topic also has to be inspected from a bottom-up perspective. Only then can
we conclude what the outcomes for individuals are and how they are per-
ceived. Not only does objective perception play an integral part in this ap-
proach, e.g. by being above or below the poverty threshold, but so does
the subjective experience of living conditions and institutional support.

Research, as a consequence, has to transcend approaches of merely
quantifying social issues; instead, attention has to be brought to the out-
comes of welfare policy on an individual level. Hence, the required per-
spective has to be put on the interplay between and support of social secu-
rity systems and their effect on inequality reduction. Additionally, and on
a broader scale, the impact of institutional and demographic change on the
emergence of social risk has priority.

Even though policy and institutional analysis reveals the complex net-
work of the governmental social security systems and their interplay (see
1.2.1 and 1.2.2), a vague and ambivalent answer remains. On the one
hand, it is argued that inequality is rising, while it is argued on the other
that equality is guaranteed. To seek the answer, another analytical level
has to be employed which has received little attention so far and investi-
gates the subjective level of the outcomes of institutional change, i.e. the
subjective dimension of social security systems in the life of aged persons
and how the phase of ageing is perceived. This subjective dimension of
ageing is a recent topic in social sciences and overlaps with happiness and
well-being research and their psychosocial (Ryff, 2014; Tamiya et al.,
2011), gerontological (Wahl et al., 2012) and anthropological (Karasawa
et al., 2011) approaches.

Ageing is not understood here as the cause of inequality but as an am-
plifier of inequality, which accumulated throughout life. Thus, we have to
look at how experiences in the course of a life have an influence on the
phase of retirement, whether they are experienced as advantageous or disadvantageous, and whether these events lead to a socio-economically disadvantaged position in later life (see Kanomata, 2007 for an argument about the importance of a person’s first occupation for the later stages of their life).

Primarily income-based concepts are often utilised to distinguish inequality, social participation or even the exclusion of the elderly (e.g. Jones, 2007; Kanomata, 2007; Tachibanaki, 2006), but are not considered to be expedient for this project since these approaches exclude by design many factors that are significant, or at least relevant, for the livelihood and well-being of elderly people. Income is certainly decisive in enabling life chances and minimising risky events, but it has a different weighting at different stages in life. While income may exhibit crucial importance in the midst of life, to ensure subsistence and enable social life, in the last third of life it dwindles in importance. The reasons for this value change lie in the fact that:

a) elderly citizens receive income from pension claims that they obtained during their working life and their consumption of goods declines, and

b) declining human contact and social interaction lead to an appreciation of non-monetary interests.

While values such as income are pushed into the background, subjective values, e.g. perceived health and social interaction, gain ground and become more essential factors during the ageing process since both deteriorate (Böhme and Lungershausen, 1988, pp. 68–71; Grainger, 2004, but also data from my own participant observation). Thus, in order to grasp and illustrate the breadth and influence of different factors on the elderly’s livelihood, the subjective dimensions of ageing and aged livelihood have to be examined.

Findings on subjective class experience and status, based on the analysis of the Social Stratification and Mobility survey between 1955 and 2005, support the assumption above and at the same time contradict the notion that a low socio-economic status also results in identification with a lower class. In a cross-country analysis only "a positive relationship between household income and class identification" (Andersen and Curtis, 2012, p. 129) could be determined. However, in Japan in particular three factors are identified as significantly influencing class identification: age, education and household income (Shirahase, 2010, p. 37). The results in Japan are surprising since, even though living alone poses the highest risk of the elderly experiencing economic inequality and poverty and the rise
in elderly one-person households was tremendous, it was not reflected in class identification among the elderly. Subjective class experience in Japan, in contrast, has rather a "positive effect for age" (Shirahase, 2010, p. 38), which means that—in spite of changing socio-economic circumstances—the tendency to identify oneself with a higher social class position while ageing exists. Since 1975 this trend has been surprisingly constant for elderly age groups\textsuperscript{12}. Although rising inequality among elderly citizens through declining individual and household income is indicated, even an income deficit and a high relative poverty rate among the elderly of 30 and 50 per cent (Fukawa, 2008, p. 925; Shirahase, 2011, p. 122), it surprisingly did not have much effect on class identification. Only about ten per cent of the 65-year-olds and above perceived themselves to be part of a lower class. This incongruence in the seniors' perception of their social and economic status is indicative of the assumption that income in later life phases only plays a subordinate role to the subjective experience of status, class and inequality. Individual income in particular hence only hints at living circumstances in old age, but it cannot be concluded how living conditions and real life situations are actually experienced by the elderly. Shirahase once again underlines that “individual income [...] does not directly determine class identification. Occupation had a more important effect than income on movement from middle to lower class identification” (Shirahase, 2010, pp. 50–51). Nevertheless, it has to be noted that engagement in post-retirement employment only amounts to 67.7 per cent for retirees between the ages of 60 and 64 years, and 53.2 per cent between 65 and 69 years (Iwai, 2011, p. 196). Although post-retirement employment declines as age rises, it remains unclear to what extent pre-retirement and post-retirement occupation\textsuperscript{13} influences the experience of the subjective class and whether the influence of this variable dwindles with age. As regards the effect of occupation on subjective class, as a reason for incongruence, the former and current occupations have to be kept in mind as possible biases for subjective and 'real' class experiences.

\begin{tabular}{l}
\textsuperscript{12} However, in other age groups, especially the 20–34 years age group, subjective class identification moved towards a lower class status, which is assumedly due to the recent and enduring economic stagnation and stagnation and continuous emergence of irregular employment in Japan.
\textsuperscript{13} Post-retirement employment is usually lower paid part-time employment.
\end{tabular}
Still, these interesting findings need further exploration: it has to be investigated how aged persons identify their subjective class and experience their position in regard to institutional access and its availability.

1.2.5 Periphery and urbanity

When studying ageing and the elderly in Japan, spatiality is a major dimension. Regional differences within Japan have a considerable effect on subjective dimensions and well-being, but also have less tacit components that manifest themselves in or around the individual, the social structure and the local politics of a municipality. In the case of Japan, the development of the past decades was that "rural areas tend to have higher concentrations of elderly residents, a pattern that is at least partly attributable to trends in urbanization" (cited from Kinsella, 2001; Vogelsang and Raymo, 2014, p. 156). This trend is not only tied to rurality, but concerns almost all peripheral places in Japan, i.e. those outside metropolitan centres (Mock, 2014; National Institute of Population and Social Security Research, 2014b). But not only is the outmigration of the young and apt a 'feature' of the periphery, rural–urban migration among the elderly is common as well, however, for different reasons. Instead of looking for a job or education, seniors look for care facilities with distinguishable patterns:

"The results show three migration patterns: (1) migration from central cities to suburbs, (2) migration from rural areas to suburbs, and (3) migration into core cities in each local area. The migration trend can be especially seen strongly in three metropolitan areas." (Kawase and Nakazawa, 2009, p. 9) (see also Godzik, 2008).

This rationale, though, might be questioned concerning the motivation to migrate, i.e. whether the elderly are in search of LTC facilities, presuming there are none in rural areas, or whether they are in search of security and support in a life phase of increasing frailty and experienced uncertainty, which they might find among their urban-dwelling children. Outmigration is a cue for the slow but steady decline of the periphery, which has been going on for decades now with the demise of manufacturing industries and transformation of agrarian production (e.g. George Mulgan, 2005). By pumping financial support into public works (see Estévez-Abe, 2008 for an elaborate argument on functional equivalents), the central government sustained the peripheral regions not only by establishing infrastructure, but also by providing for the economy and maintaining the local society. Si-
multaneously, a parallel structure for urbanity and the periphery was created, which only postponed the decline of the latter:

"Particularly, rural and remote areas with structural weaknesses as well as old industrial areas, dominated by an industrial mono-structure of sectors such as mining, metal manufacturing or shipbuilding that can no longer compete in the global economy, are mostly affected. Thanks to substantial governmental subsidies and assistance, the quantity and quality of public infrastructure services in such cities has been much better for a long-lasting time than one would expect. However, the situation has started to change dramatically as the central government has cut tax transfers and subsidies in the aftermath of the decentralization and regional policy reform." (Feldhoff, 2013, p. 101; cited from Machida, 2007)

The result of the Japanese efforts to invest in peripheral regions to keep disparity low, however, was that

"[i]n the course of building nearly 100 regional airports, 14,000 km of expressways, and more than 2600 dams, this 'construction state' has accumulated huge debts, often with little thought as to whether facilities were needed, while the real concerns of rural people went unheard." (Matanle, 2011, p. 830)

The "real concerns" (Matanle, 2011, p. 830) lie in the question of how to ensure economic and social livelihood in the periphery and how to maintain welfare and, in particular, care for the elderly. Remote and rural regions have been hit harder by the aforementioned changes as they are structurally more vulnerable.

Nevertheless, locality is particularly of interest if it comes down to elderly welfare, care and well-being. Recent studies point towards the connection between place and general health since "[c]ompositional place 'effects' reflect the tendency of similar individuals to live in a particular area and, consequently, to experience similar health outcomes" (cited from Cagney, 2006; cited from Macintyre et al., 2002; Vogelsang and Raymo, 2014, p. 157). Following this assumption, health and, by proxy, well-being and the availability of medical and care facilities for the elderly may be affected by a locality and its characteristics. As seen above, one assumption for the elderly’s migration away from the periphery is given in the presumed lack of health and care facilities. However, findings suggest that locality matters insofar as the local age structure might be an indicator of issues with health and ADL and experienced disadvantages:

"some characteristics of older individuals differ systematically between relatively older and younger areas in Japan. It also suggests that elderly living in relatively older places may have some disadvantage when it comes to the on-
The decentralisation reforms put peripheral regions in a tight spot. With the seizure of subsidies and assistance by the national government and the shift to fiscal self-reliance, peripheral and depopulating regions in Japan are also confronted with a decline in tax contributors and citizens to maintain infrastructure and facilities. Instead of an increase in local autonomy, the outcome of these reforms was an increase in regional disparity (Han, 2010). Spatial disparity manifests itself, for example, in the divergence of the costs of medical and elderly care. The ageing process is progressing faster in peripheral Japan than in urban areas, which in the near future will put 'rural prefectures' under stress as their elderly welfare expenses are likely to rise, and the regional divergence is expected to increase further. However, as ageing hits all regions in Japan, the difference between prefectures and regions will abate and elderly welfare expenses will converge again, i.e. hit a high level throughout the country (Nakata, 2012).

While social security expenses are one major obstacle that loom large and are expected to hit peripheral prefectures that have a high ageing ratio, the other key obstacle are persisting social norms and moral obligations of who should provide care. These become evident in the social organisation and interlocking of formal and informal institutional arrangements for elderly welfare. Changes in social organisation that might have occurred through the introduction of the LTCI, however, seem to be indistinguishable:

"Fifty years ago, before rapid industrialization and urbanization, most care for the aged was exclusively provided for by the family members, and rural areas of Japan have been noted in Western countries for the good care and respect towards elders by family and society (Hirayama & Miyazaki, 1996). Today, despite the dramatic postwar [sic] social transformation, social norms of care in rural areas resist changing, and any change is often slow (Tsutsumi, 2001)." (cited from Hirayama and Miyazaki, 1996; Tanaka and Iwasawa, 2010, p. 400; cited from Tsutsumi, 2001).

The ensuing assumption is that the family, as the main caretaker, is still the locus and pivot of elderly well-being and care in peripheral regions as social norms urge family members and kin to provide for them. In fact,

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14 Han argues that the aim was not in particular to increase local autonomy, but rather to adjust the national economy to be competitive with international competition.
such a set-up renders the elderly more exposed to experiencing social risk, presuming that elderly care facilities are lacking and social norms hinder the elderly from taking up LTC services.

"Thus, although rural nostalgia often depicts rural elders to be happier than urban elders surrounded by their family members, rural elders can be more socially vulnerable than urban elders, especially if they do not have siblings, spouses, or children." (Tanaka and Iwasawa, 2010, p. 399)

Although it is regularly taken for granted, the general notion is that locality matters in many respects. Whether it is the local infrastructure, the availability of care facilities, social organisation and social norms as well as nationwide reorientation in regional and welfare politics. Instead of public works, which for a considerable time were the basis for economic and social steadiness in rural and remote regions, now there seems to be investments in health and care for the elderly in the periphery, not only by the national government, but also through local initiatives and programmes, which on the other hand cause a restructuring of social institutions—which needs to be elaborated in the next chapters.

1.3 Hypotheses and research question

Examining institutional change of elderly care institutions and contributing to research on the welfare-mix in a post-industrial society from a social risk perspective is the major focus of this dissertation. The general perspective is on the individualisation of risk, a societal process in which economic risks are conveyed to individuals and risk responsibility shifts from the public to the private domain—but also, vice versa, which allows for more actualisation, autonomy and self-determination (Tilly, 1985). In this sense, the debate on the development of social welfare in Japan about whether inequality is rising or not has implicitly contributed to the discourses on risk and institutional change. However, the key factors for a change of welfare institutions lie in demographic, social and spatial structures and processes. It has, consequently, to be determined to what extent the elderly’s livelihood in different settings is impacted by demographic developments and recent changes in social policy. Furthermore, these alterations induced institutional change beyond the provision of livelihood support, influencing how social obligations and social practice are perceived and valued. Therefore, the following hypotheses guide my research:
1.3 Hypotheses and research question

- The rural elderly are socially better integrated through local communities and social organisations. In urban areas, the elderly rely to a higher degree on formal institutional support and care.
- The occupational and employment structure of Japan's rural areas promotes lower old-age pensions than in urban areas, forcing greater reliance on social institutions of local capacity building and self-help.
- Ageing, as an amplifier of inequality, reveals cumulative effects and results in greater advantages or disadvantages in the retirement phase, the so-called Matthew effect (Merton, 1968), which leads to differences between well-off and impoverished seniors—regardless of pension and welfare payments.
- Socio-economic variables (income, status, housing, education) lose their importance with rising age. In contrast, subjective and age-related variables and factors gain ground, i.e. social participation, social inclusion and their subjective perception, reliance on public and social institutions, and the subjective assessment of one's own health.

Based on the assumptions above and the projected notion that, through the introduction of long-term care insurance, there is now a reliable government institution source to which families can entrust the well-being of their parents and grandparents, the main research question is:

- Why and how has the implementation of the LTCI, in addressing the social risks of ageing, shifted the welfare mix between the state, the market and the family and reintroduced the role of the local community?

As was pointed out earlier (Ochiai, 2009, 2014a), the enactment of the LTCI law in Japan was a key event in Japanese social policy as it contributed greatly to a shift in the Japanese elderly care welfare mix (Figure 1-7) and had momentous effects on welfare provision and welfare creation in total, but, as indicated by the dotted lines, the outcome is not quite clear yet. Furthermore, it is assumed that the implementation of state-provided care for the elderly stimulated the market and communities to adapt and broaden their scope—and families to re-evaluate their capabilities and possibilities.
Institutional change and the emergence of social risks

Figure 1-7: Care for the elderly diamond in Japan before (left) and after enactment of the LTCI (right)


Note: The size of the circles represents each category’s contribution to the welfare mix.

The change of social institutions, however, that is a 'by-product' of formal institutional change of the LTCI law, creates uncertainty and poses social risks to the elderly and their families. The overarching issue, whether responsibilities for economic insecurity, social risk

and care for the elderly have shifted from the private to the public sphere, from welfare provided largely by the family and the local communities to welfare provided by the state and the market, vice versa, or as a blended combination among these care institutions, has to be addressed. The following sub-questions, thus, are:

– Why has the introduction of the LTCI changed the role of the state in care for the elderly?
– Why and how has the LTCI created a market for care and changed the nature of the market in the welfare system—at least for elderly care?
– How was local community support enhanced, while the familial basis of welfare provision remained?
– What influence does the regional and local context have in alleviating or undergirding the social risks of ageing?
These research questions offer wide-ranging opportunities to delve into and answer them. In order to comprehend the actual situation on the macro and micro levels, several techniques were utilised for analysis and during fieldwork.

1.4 Research design: mixed methods approach

The institutional and structural framework illustrated in the previous sub-chapters provided only a superficial glimpse of the social and economic status quo of the elderly in Japan. Many questions still remain unanswered, and threads entangled by relying on a single, specific method alone and in particular require qualitative data collection and analysis to grasp processes and dynamics on the individual. Nonetheless, this framework is crucial in understanding the necessity of a mixed methods approach with a focus on qualitative research. The cornerstone of ageing society research is the elderly, in the sense of a nexus of intertwining institutional layers and issues. It basically puts three perspectives into focus:

- **Top-down perspective:** an overview and analysis of policies and governing measures for the elderly introduced by local and national governments, which are designed and implemented in top-down processes. The general overview of national policies towards social security and in particular care for the elderly as well as the regional focus of social policies for the elderly is covered from this angle.

- **Bottom-up perspective:** irrespective of how well policies might be planned and implemented, the outcome for the individuals and groups targeted might deviate from the policies' intention. Taking up a view from the individual level provides valuable information on how social security measures secure and ensure livelihood and how these are dealt with by the environment of the respective individuals and groups.

- **Ageing perspective:** in contrast to the two above, the perspective on ageing provides insights into motivations, threats but also opportunities of the ageing process as such. Ageing is an amplifier of inequality as the cumulative impact comes into effect and reveals the dynamics of social change with numerous uncertainties for the ageing individual on a personal and individual level.

My research design strategy involved a mixed methods approach of secondary analysis, policy analysis and qualitative methods. Therefore, it was divided into three parts, of which the first was the analysis of social secu-
rity measures and policies, the second and the third part were temporally and locally divided fieldwork segments—in which policy and governance were evaluated and contrasted as well.

Qualitative data was gathered during fieldwork using participant observation and ethnographic interviewing in two fieldwork locations, one in the complex of Tokyo and one in rural Japan (see 1.4.1). An approach influenced by ethnography was considered essential for two reasons.

First, ethnography, especially participant observation and interviews, provides the direct and immediate access to the experiences of the elderly in their respective settings. Since their subjective experiences, perception of the surrounding institutional arrangements and risk assessment matter, it is not only the appropriate method of data gathering, but also the necessary one. Second, it was essential for the project to experience the institutional setting personally through excludedness, as a foreign and etic body, and includedness, as a participant or emic observer, to grasp how social security elements function, to survey social networks such as neighbourhood associations, and receive hands-on knowledge in elderly care facilities. These points, the social context, might be self-evident for locals, but in the study of social and cultural sciences they contain invaluable insights. This data cannot be acquired by policy, discourse or quantitative data analysis. One has to be aware of the interplay between these two roles—and different perspectives on the research topic—and the inclusion or exclusion that comes with them. Participating outsiders are enabled and allowed to "dive deep" into social circles which are not accessible to ordinary members of the society examined, but on the other hand, being an outsider might also obstruct the gathering of information (Herzfeld, 1983).

Why an in-depth account which is influenced by ethnography is needed for analysing the context in which social action takes places has been precisely formulated as the basal pillar of ethnography:

"Ethnography is the work of describing a culture. The essential core of this activity aims to understand another way of life from the native point of view. The goal of ethnography, as Malinowski put it, is 'to grasp the native's point of view, his relation to life, to realize his vision of his world' (1922:25) [emphasis in original]" (last passage cited from Malinowski, 1922; Spradley, 1979, p. 3).

15 On the emic-etic perspective, see also Morris et al. (1999) for an argument for integrating emic and etic approaches in qualitative research.
Ethnography, thus, provides the necessary context for social actions. Only then can sense be deduced from actions. Furthermore, it provides us with the social framework of values, beliefs and norms that guides social interaction and change. Furthermore and more precisely, a particular method of ethnographic research proves to be the go-to tool in qualitative research:

"The most complete form of the sociological datum, after all, is the form in which the participant observer gathers it: An observation of some social event, the events which precede and follow it, and the explanations of its meaning by participants and spectators, before, during, and after its occurrence" (Becker and Geer, 1957, p. 28).

Although the term "participant observation" indicates fully fledged participation in social groups, a researcher using this method levitates between different levels of social interaction. Ranging from "complete observer, observer as participant, participant as observer, and complete participant" (Atkinson and Hammersley, 1994, p. 248; cited from Gold, 1958; Junker, 1960), the hierarchical position of the observer is changing. This knowledge is a major point, as the "epistemology of participant observation rests on the principle of interaction and the 'reciprocity of perspectives' between social actors" (Atkinson and Hammersley, 1994, p. 256) and is rather an approach used by ethnographers to "use their 'literary' competence to reconstruct social action and social actors" (Atkinson and Hammersley, 1994, p. 256). Now, these insights are not new for constructivists, but comprise a basal cornerstone in ethnography-based approaches for they are filtered and abstracted echoes of experienced social interaction through and by the researchers.

However, participant observation is an invaluable contribution to the mixed methods approach as its utilisation, despite giving insights into social practice, contributes even further as:

"the goal for design of research using participant observation as a method is to develop a holistic understanding of the phenomena under study that is as objective and accurate as possible given the limitations of the method" (De-Walt and DeWalt, 2002, p. 92)

For this project, participant observation was largely conducted in care facilities for the elderly, especially in day-care centres. These are intermediary forms of elderly care, in which seniors still live at home but regularly visit these care facilities and, thus, bridge the gap between dependence and autonomy. Day-care facilities in particular offered a high chance of accessibility for research since volunteers for social activities with the elderly are lacking and volunteering scientists are, at first reluctantly, welcomed.
Gaining self-confidence in the different settings and also gaining the trust of the care staff and patients over time allowed me to conduct in-depth, ethnographic interviews with several patients (see appendix).

Besides that, I attended and visited local festivals (*matsuri*), community centres and outdoor sports activities to assess the elderly’s integration within local communities and local support measures and policies. Important insights were gathered by accompanying members of NGOs or NPOs, who engage in *machizukuri* activities, and local neighbourhood associations, which contribute to welfare creation for citizens and, in particular, the elderly. Yamashita (2013) argues that, in particular, welfare NPOs vary strongly in their configuration and might not allow their members to participate in decision-making processes, but the distribution of welfare services, however, is unproblematic and widespread.

Throughout the time span of the fieldwork, expert interviews with local government officials, managers and members of care institutions for the elderly, and NGOs and NPOs with civic engagement were conducted to investigate the impact of ageing and ageing policies within the institutional framework on seniors' lives, the provision of health and care for the elderly, the abilities of the elderly to cope, and local problem-solving measures, e.g. poverty alleviation initiatives. Further, these expert interviews provided deep insights into the organisation and significance, and variation and characteristics of care institutions for the elderly in urban and rural Japan, which allowed me to put the results into the greater context of Japan's regional divergence.

For the interviews with every respective target group, semi-structured and structured interview guides were prepared in Japanese (see appendix). These were proofread and commented on by academic, native-speaking linguists, and reassessed and restructured after the first pre-tests. Interviews with academic experts and, where possible, with administration experts were voice-recorded.

Interviews with patients and care staff were conducted differently, and the interviewing method of ethnographic interviews (Spradley, 1979) was applied. These semi-structured interviews aim not only at gathering verbally transmitted data, but also take into account the weighting that the interviewees give them—within their social context and its perception. In particular, in combination with participant observation, discrepancies between information given and observed behaviour and circumstances were able to be evaluated. Due to the nature of ethnographic interviewing, patient interviews usually could not be finished during one session, but in-
stead developed as in-depth exchanges with different patients over a period of several weeks and months due to their daily schedule. As trust was built, the initial guardedness and caution of the care staff as well as the reticence of some patients faded and more details in regard to their economic and social situations were shared with me. The interview data was noted down during breaks or after volunteering activities were over. In total, Interview data was gathered during fieldwork in (more details in the appendix):
- 2 interviews with academic experts,
- 15 interviews with administration experts,
- 7 interviews with care personnel,
- 49 interviews with patients.
Both segments of fieldwork also included secondary analysis of surveys, white papers, academic literature and data that was only available locally. It was necessary to investigate local in-depth data as it provided an increased understanding of local processes and developments; e.g. reports of local city's welfare departments are excellent data sources. Furthermore, literature and theory processing within the field promoted a deeper comprehension as a result of reflexive processes between these two. This reflexivity allowed an iterative process which oscillated between inductive and deductive approaches and "produces a theoretically driven ethnography, or what can be called 'theorygraphy', in which research activities aim to modify, exemplify and develop existing theories" (Tavory and Timmermans, 2009, p. 244). This combination of ethnography-oriented research and secondary literature analysis proved to be a useful method of verifying and reassessing evidence using a mixed methods approach and provided a thorough and concise image of the lives of elderly people in the different regional contexts.
"The biggest difference [...] may be not so much that participant observation provides the opportunity for avoiding the errors we have discussed, but that it does this by providing a rich experiential context which causes him [= the researcher] to become aware of incongruous or unexplained facts, makes him sensitive to their possible implications and connections with other observed facts, and thus pushes him continually to revise and adapt his theoretical orientation and specific problems in the directions of greater relevance to the phenomena under study" (Becker and Geer, 1957, p. 32)

In summary, this project's research was designed to provide a comprehensive, yet detailed account of the ageing society and institutional change by utilising triangulation of perspectives and methods.
1.4.1 Case studies

From the beginning of this doctoral project it was quite clear that one case study, in particular urban Japan, would not suffice to examine the multiplicity and complexity of ageing and institutional change in contemporary Japan. The reason is that in terms of its social composition there is not one location that could comprehensively contribute to research in order to make an abstracted and general argument. Despite the widespread belief that the sprawl of Tōkyō is representative of Japan's society as a whole, it is not. Even inner Tōkyō itself displays a great diversity and irregularity in its population, their age and its social structure, but also in its social policies. Thus, Tōkyō’s magnitude had to be examined from different angles, to provide a more detailed and refined picture of institutional change in Japan.

I decided early on that Tōkyō, as the cultural, social and political capital of Japan, was to be a case study location. The second location was a bit harder to select as it needed to be located in the Japanese periphery to juxtapose urbanity and rurality. Thus, after I had pondered for some time about locations with rather average and extreme conditions, such as the many genkai shūraku (限界集落, marginal village), villages with more than half of their population over the age of 65 years, I decided to focus on a rather "normal" small city, located in the Nagano prefecture.

Fieldwork in Tōkyō was divided into three separate periods of time (September 2012 until the end of December 2012, March 2013, and July 2013 and August 2013) and two regionally different settings—yamanote and shitamachi. I visited three care facilities for the elderly in Tōkyō on a daily basis, starting in the morning and ending in the late afternoon. All three were all-in-one care facilities for the elderly, their services ranging from day care to visiting care and institutional care, which had total capacities of up to fifty patients in day care alone. In all of the facilities, the activities I conducted were common tasks for volunteers, those of an "attentive listener" (傾聴, keichō) for elderly patients and supporting the care staff, e.g. handing out meals, cleaning tables and preparing afternoon activities. Besides these visits, I accompanied a care manager on her tour through downtown Tōkyō to visit her elderly customers in their homes and provide support and advice on issues that the elderly had.
The second fieldwork period (March 2013 until the end of July 2013) took place in Komagane, where in total seven care facilities for the elderly were visited. The same daily visiting pattern as in Tōkyō was applied here as well. Also, the activities I engaged in with the elderly and the support I offered to the care personnel were similar. The care facilities, however, differed in set-up as they were day-care-only facilities. Additionally, I attended neighbourhood association meetings.

1.4.1.1  Tōkyō-to: shitamachi and yamanote

Fieldwork in the urban case study was conducted in three of Tōkyō's 23 special wards (特別区, tokubetsu-ku): Minato-ku, Taitō-ku, and Katsushika-ku. In the three wards, fieldwork consisted of extensive participant observation and ethnographic interviews in old-age care facilities. Inquiries to several volunteer-seeking facilities providing day care and institutional care for the elderly were necessary as, to begin with, only one responded affirmatively. This facility, however, later functioned as a door-opener to other facilities as my experience in adopting the proper behaviour towards patients and my interaction with dementia patients increased, which was
acknowledged later on by other facilities. I visited the three care facilities for the elderly on a daily basis. These facilities were located in each of the three wards examined in order for me to grasp the spread of social diversity and social issues in different locations in Tōkyō. These facilities are partly public, non-profit corporations, established by the ward (kuritsu hōjin 区立法人) with the single purpose of providing cost-effective care, and also partly for-profit enterprises organized as a business association in the fields of healthcare and care for the elderly. These three old-age care organisations are located in the shitamachi and also in the yamanote districts of Tōkyō.

Tōkyō-to has one of the lowest ratios of aged persons throughout Japan and only 21.91 per cent of its citizens are 65 years and above, lower than the nation's average of 25.06 per cent\(^{16}\) (Ministry of Internal Affairs and Communications, 2015b). However, within Tōkyō-to the distribution of age differs significantly between the districts in Minato-ku and those in Taito-ku as well as Katsushika-ku.

1.4.1.2 Nagano prefecture: Komagane-shi

As a second field site in Japan, I visited rural Komagane-shi (駒ヶ根市) in the Nagano prefecture for data collection. It is located in central Japan, in a valley surrounded by the foothills of the Southern Alps and the Central Alps, and approximately 250 kilometres away from Tōkyō. Like many other rural cities, Komagane was founded in the 1950s as a result of administrative reform and the merger of hamlets and small settlements. In July 1954, Akaho, Miyata, Nakazawa and Ina were merged into Komagane-shi with 33,595 citizens in 12,168 households in 2011 (Komagane Shiyakusho, 2013).

Only connected to a highway and a local train, Komagane features a typical rural setting in terms of occupation and demographics. In 2011 over 26.2 per cent of all its citizens were over 65, which was above the nation's average of 23.3 at that time (Komagane Shiyakusho, 2013). The region’s primary industry experienced a steady decline with the result that the secondary (manufacturing, construction) and the tertiary sectors (food,

\(^{16}\) In Akita prefecture, 31.52 per cent of the population are 65 years old or over, the highest value throughout Japan, closely followed by Kochi prefecture with 31.14 per cent.

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convenience, and the so-called "service") occupations dominate the labour market in Komagane (Komagane Shiyakusho, 2013).

1.5 Theoretical foundation: welfare mix in an ageing society

Approaches to institutional change often embrace concepts of institutions that comprise elements of self-sustainment and equilibrium (Hall and Gingerich, 2004). A disequilibrium, caused by the endogenous change of institutions, or even one-sided institutional shortcomings, is superseded through other institutions (Aoki, 2001, pp. 329–330). Such concepts thus encompass the complementarity aspect of institutions, figuratively speaking of a scale in which equilibrium is present and is constantly constructed through self-perpetual change and adaptation. Such an equilibrated state, however, is bound by its environmental context and is not nurtured and stabilised by an influx of endless resources. On the contrary, available resources (human, financial, political) are limited and the societal and economic contexts constitute bounding factors which keep institutional arrangements in balance. This can also be said about the current state of the Japanese welfare regime and its preceding change.

While at first not incorporated into seminal accounts on welfare regimes (Esping-Andersen, 1990), Japan has been described as a peculiar case in many respects (Esping-Andersen, 1997) and even today remains "very difficult to clearly classify" (Ferragina et al., 2013, p. 800). Research on demographic and institutional change in ageing societies, however, needs to take welfare state theory into consideration as it provides the institutional framework in which the risks and opportunities of the elderly and their kin are negotiated. It is not of great importance here to clearly classify the Japanese welfare regime, as it is still ambiguous if looked at in more detail, or the degree of decommodification, as has already been tried elsewhere (e.g. Bonoli, 2012; Esping-Andersen, 1997; Estevez-Abe et al., 2001; Estévez-Abe, 2006, 2008). The weight here rather lies in the composition, the change and institutional dimensions of the Japanese welfare regime and its coordination—the Japanese welfare mix of care for the elderly. Welfare is not a static, monolithic object of investigation, but incorporates several dimensions that are simultaneously active in welfare creation.

For a long time, the expansion of welfare in Japan had a strong connection to the nation's economic growth throughout the post-war era (Maruo,
1986). In particular, corporate welfare through the market was evident in the welfare mix:

"A company/work unit acted like the family and the employees were loyal to their organisation and formed a strong identify [sic] around it. Japanese companies typically provided a range of occupational benefits from pensions and healthcare, to housing (direct provision and loans), and leisure facilities—although the scale and extent of such provision depended on the size of a company and occupational status of the workers" (Izuhara and Forrest, 2013, p. 524).

The market was and still is active in welfare creation, but is highly diversified—and so is welfare provision—due to its dual structure and the increase in irregular employment. Moreover, locality plays a fairly significant role as the numbers of self-employed citizens, such as farmers, and employees varies regionally and with it the welfare benefits (see also 1.2.1 and 1.2.5). Nevertheless, in regard to economic and social risk, the fallback level is provided by the family.

"Family support offered the means of survival when resources were scarce, and families have always filled a gap between the state and occupational provision. [...] In Japan, filial obligations are not legalized but the norm and practice still remain strong in social welfare. Thus families continue to provide the main source of support in many spheres of welfare, particularly in relation to care and accommodation" (Izuhara and Forrest, 2013, p. 524).

Therefore, family remains a dominant actor in the welfare mix in Japan, despite its changes and shifts. Nevertheless, the social cohesion of society and, in particular, family has undergone changes in post-war Japan, and with a declining population and trends towards core-families, the outlook is uncertain.

1.5.1 Individualisation of risks and the emergence of social risks

If we understand family as a fundamental social institution, its function, besides reducing economic and social risk, is the preparation of the individual for life in social contexts. This is transmitted by providing behavioural patterns and guidelines for dealing with various risky encounters in one's life, e.g. the code of conduct during social events, political preferences, health awareness and so forth. Generally subsumed under socialisation in the formative years of youth (see e.g. Hurrelmann, 2006, Chapter 3; Tillmann, 1989), the fundamental, but implicit, function of the family is...
to socialise young individuals and to provide acting security for situations in order for them to lead an independent and autonomous life in later life stages. However, after one enters adulthood and then reaches the last phase of one's life, in which health starts to deteriorate, everyday situations and activity become successively burdensome and less bearable due to one’s vanishing autonomy and loss of cognitive faculties. Reliance upon others, whether it is kin or care personnel, for personal security, care and often one’s whole livelihood increases with age and shifts responsibilities away from the individual.

Contemporary societies in Western and Central Europe, North America as well as Japan are experiencing vast changes to their demographic structure, with long-term and far-reaching effects on societal ageing and its concomitant processes towards modernity. The latter, which comprises individualisation processes through societally differing values and norms, sets new ideals and normative orientations for families, communities and life goals, i.e. an individual's lifestyle in general. Processes of individualisation are understood to be a causative factor for decreased social cohesion within society, and among generations and social groups:

"a process of individualization [emphasis in original] has taken place. [...] as a consequence people have lost their traditional support networks and have had to rely on themselves and their own individual (labor market) fate with all its attendant risks, opportunities and contradictions" (Beck, 1992, p. 92; cited from Berger et al., 1975; Touraine, 1983).

While Beck here also underlines the positive aspects of individualisation as prospects for individuation, the argument in his later publications is more pessimistic in regard to the opportunities, which do not appear as options anymore but rather as forms of coercion, stating that:

"Individualization [...] is a societal dynamic that is not based on the free choice of individuals. [...] One of the key characteristics of individualization processes is that it does not permit, but demands an active contribution by individuals" (Beck and Beck-Gernsheim, 1994, p. 14; own translation).

In Beck's notion of individualisation processes, three underlying dynamics become apparent, which society and individuals pace across (Friedrichs, 1998, p. 37) and which shape generational and individual life courses:

- de-institutionalisation,
- diversification—and biographical planning, and
- re-institutionalisation.

The process of de-institutionalisation involves the dissolution of traditional ties within and between social groups. It also entails the disengage-
ment of social action from its accordance with normative expectations of these groups. This detachment from traditional, informal institutions, which is concomitant with value change, will eventually lead to diversification of lifestyles by deviating from traditional pathways and allowing us to adopt "riskier" approaches to the more or less meticulous planning of biographies. Risk taking in biographical planning, however, has only emerged as a viable option through the establishment of proper social security and welfare systems as a safety net with which to control risky outcomes (Leisering, 1998). Eventually, these new institutional processes turn into elements that shape and model someone’s life course by stipulating trajectories and exercising risk management (Leisering, 2003; Leisering and Schumann, 2003)\(^1\). And while normative modelling through institutions (Leisering and Walker, 2008, pp. 433–434) is seen as risk mitigation in regard to individualisation, there is the emergence of individual risks, as individualisation also "means market dependency in all dimensions of living" (Beck, 1992, p. 132). Failure to comply with market rules would result in a disadvantageous position in the social hierarchy and social structure. Beck (1992, p. 119) remarks here on the vulnerability of individuals since traditional social ties have vanished and their reliance upon the labour market and "market institutions", arguably education and welfare, has become inevitable and a necessity. Care for the elderly falls into this category as well as it comprises an institution to rely upon and has undergone a major shift in institutional arrangement as a result of the formalisation of care for the elderly.

Individualisation in Japan, which is one of modernity’s processes, has led to "risk-aversive individualization" (Ochiai, 2011, pp. 227–229). However, instead of a stronger orientation towards individualism, the result, due to policies and reforms, has been a familialistic orientation of the government’s approach to social security and a familialistic notion in society. Despite having the state and market (through labour-based claims) as welfare providers, families have remained the most important social and economic units and risk-bearers. Risk-aversion in Japan is expressed through the institution of marriage, which renders the family as a place of safety and security. However, "when family relationships changed from being so-

\(^{1}\) Leisering and Schumann (2003, p. 200) have identified four key institutions in managing risks and regulating life courses which add up to a more or less tight arrangement in social life: education, family, the labour market and the welfare state.
cial resources to being risks during the economic crisis, risk-aversive individualization occurred to avoid the burden of a family" (Ochiai, 2011, p. 235). What is meant in particular with the term "burden of a family" is the burden of complying with preconfigured gender roles and the risk of assuming responsibility and care duties for family members in times of economic struggle and increasing irregular employment. The outcome of this development can be seen in a decrease in marriage rates, a rise in the mean age of marriage and extremely low total fertility rates (Chang and Song, 2010). Nevertheless, marriage as an institution of security continues to be intact and to promote the familialistic concept of a "modern family system, the system based on a division of labor between husbands and wives, in a mechanism that can be called the 'traditionalization of modernity'" (Ochiai, 2014b, p. 224). This, in particular, is of major relevance in understanding the welfare mix in Japan and its institutional dimensions.

1.5.2 The welfare mix in transition

The theoretical approach to welfare regimes is that of diverse actors, subsumed under dimensions, who provide pluralistic welfare measures and, thus, contribute to the so-called welfare mix (Rose, 1986). The established tripartite welfare model of the state, the family and the market as welfare providers (Esping-Andersen, 1990) contributed largely to the conceptualisation of welfare regimes, but had its issues in analysing welfare regimes with a more diverse set of welfare institutions, such as the Japanese welfare regime (Esping-Andersen, 1997; Seeleib-Kaiser, 2002). Consequently, 'welfare triangle' theorists were rightfully criticised for ignoring another large contributor in the welfare mix, the third sector (Evers and Laville, 2005; Jenson and Saint-Martin, 2003). This sector, consisting of mainly volunteering NPOs and NGOs, is present even in conservative welfare regimes with strong familialistic subsidiarity, but was ignored by welfare regime research for a long time (Bode and Evers, 2005; Fix and Fix, 2005). Yet, it is an essential dimension that bears a tremendous amount of the burden of welfare creation in a welfare regime.

Quadripartite (actually a quinquepartite) partitioning, therefore, allows for better distinction of the institutions responsible for providing welfare. These dimensions are the market, the state and the family (with a distinction into family and relatives) as well as the community. The third, voluntary sector of NGOs/NPOs and public–private partnerships is subsumed
under community, as for the most part it overlaps with local communities, and these in particular are significant welfare contributors and draw upon local institutions.

The welfare mix for care for the elderly is illustrated below (Figure 1-9) (Ochiai, 2009; 2014a) and comprises four institutional dimensions, which contribute to the welfare of the elderly. Before the introduction of the LTCI (left side), the overlapping of the market and the state was nonexistent; only after the year 2000 did the market increase. The overlapping is caused by governmental financial and tax incentives to create social welfare institutions for the elderly. While the liaisons between the market and the state remained unexplained, the community aspect remained comparatively small before and after the enactment of the LTCI, according to Ochiai (2009, 2014a)—which will be partially argued otherwise in due course.

Despite efforts to relieve families, and particularly women, of care work (Chan et al., 2011; Soma et al., 2011), the role of the family as provider has not changed and is still considered to be the most vital institution in providing care and ensuring livelihood, underlying the classification of Japan as a familialistic welfare regime (Leitner, 2003; Miyamoto, 2003; Ochiai et al., 2012; Peng, 2012; Yamashita et al., 2013). The basal pillar of care for the elderly is, however, still the institution of the family. "Japan is thus characterized by the major sector of care work being performed by the family in the narrow sense. Japan’s system can be described as ‘familialism’" (Ochiai, 2014a, p. 181).

It is indisputable that the Japanese welfare mix significantly consists of familialistic elements which are rooted in the past and contemporary social policy. Yet, the assessment by experts in regard to the constellation of the welfare mix largely omits an evaluation of interregional differences in Japan. And as has been stated earlier (paragraph 1.2.5), several indicators suggest that there are noteworthy differences in the welfare mix between urban and peripheral regions that are rooted in economic as well as social organisation. Care for the elderly is by far still provided by the family, even though values and expectations are changing.
1.5 Theoretical foundation: welfare mix in an ageing society

**Figure 1-9:** Care for the elderly diamond in Japan before (left) and after LTCI (right)


Note: The size of the circles represents each category’s contribution to the welfare mix.

The so-called "socialization of care" (Campbell and Ikegami, 2000, p. 27) with its nationwide implementation and tremendous flow of funds contributed largely to marketisation of the Japanese welfare regime, "shifting away from the state–family nexus by creating a 'quasi-market' where a wider range of providers (both for-profit and non-profit) now exists" (Izuhara and Forrest, 2013, p. 525). In formalised care for the elderly, the availability of funds attracted welfare providers and contributed to quick distribution of care facilities. However, while the policies aimed at the socialisation of care for the general public, the simultaneous process was that of the individualisation of risks for individuals.

On that note, the third sector became increasingly relevant in providing and contributing to old-age livelihood and care (Nakano, 2005). Hence, the community aspect in the welfare mix for care for the elderly, which overlaps with volunteering activities, gained and is still gaining significance—even more so in an interregional comparison between urbanity and the periphery.
1.5.3 Communities as an institutional buffer

Governmental social security systems are proclaimed to be dysfunctional in certain aspects of welfare provision; thus, the activation and mobilisation of community groups are regarded as future ways of reducing inequality (Ōsawa, 2011, 3, 173-178). The suggestion is to formalise, to some extent, community and family institutions and canalise already present altruism and benevolence into a gap-filler—to complement insufficient support from social security systems. Communities and their civic engagement are central actors in providing local and means-adjusted support to the needy. Communities are understood here as collectives with reciprocal interaction and transaction (Tönnies, 2005). This is partly given by the communities' mutual interest in economic and social cooperation in order to create common goods and commodities, which originates from the common historical background and geographical vicinity of a community’s individuals. Local governments are aware of the capacity of communities to ameliorate unfavourable conditions and try to harness the problem-solving capacity of communities and civic engagement through different means of social organisation and human capital coordination (Estévez-Abe, 2003; Pekkanen and Tsujinaka, 2008). The promotion of self-help and self-organisation is widespread and:

"Municipal governments often subsidize a grant for NAs' [= neighborhood associations; author's note] activities since NAs contribute to effective governance of their jurisdiction, providing various services for residents and working as intermediaries between the governments and residents. As such, the relation between local governments and NAs has been interdependent" (Hashimoto and Sato, 2008, p. 200).

However, variations in the presence of civic engagement and how it is socially organised exist and differ according to locality. The substantial difference in volunteering behaviour is conditioned by the societal 'field' in which activities are performed, in particular in terms of care for the elderly, and is largely determined by the support and coordination of civic groups, e.g. whether it is coordinated through an already formalised organisation, such as the Social Welfare Councils (社会福祉協議会 shakai fukushi kyōgikai), or less formal organisations with less institutional backing (Haddad, 2004).

But not all social groups are coordinated through public authorities and some are more informal than others. These social organisations “describe the collection of values, norms, processes, and behavior patterns within a
community that organize, facilitate, and constrain the interactions among community members” (Mancini et al., 2005, p. 319). Most of these groups are community and neighbourhood-based organisations, the *kumiai* (組合, Jap.: association), and are self-organised associations designed to coordinate between local support, needs and duties (e.g. community festivals or weeding). In addition to their organisational and motivational power and ability to mobilise resources, social pressure through peers plays another influence in goal-achievement strategies on the local level. This applies in particular to peripheral regions since hamlet and community inhabitants are highly pressured to display socially acceptable behaviour according to the principle of "hamlet solidarity" (Marshall, 1984, p. 69). Non-cooperative behaviour and the rejection of participation in community activities will otherwise and eventually result in a definite friend-or-foe relationship among citizens and complicate not only social but also economic relations (Marshall, 1984, pp. 67–69). Such strong feelings in "hamlet solidarity" are results of the past, in which survival was dependent on cooperation (e.g. for irrigation, harvesting, etc.) and social mechanisms enforced cooperative behaviour.

Furthermore, processes of decision-making and the expectations of locals permeate all levels and spheres of social organisation in local communities and can be even found in sports clubs, a hamlet's fire brigade and welfare clubs for the elderly—which consequently forces reciprocal behaviour within a local and rural community. Thus, even by exerting pressure to comply, the *kumiai*'s

"social and economic caretaking functions, to a large (but admittedly incomplete) extent replacing older kinship-based primary organizations, have been indicated. As an organization its services cross cut most interests within hamlets, even if they are only recreational" (Shupe, 1974, p. 355). What we see is that communities and their social organisation through common *kumiai* have a considerable impact on the well-being of individuals and families. In particular, *kumiai* with a commitment to welfare provision have an impact on elderly welfare and are a go-between, a connecting link, in the institutional interplay of welfare institutions. However, it has to be elaborated in how far their impact differs according to locality.

In this sense, what we have discerned so far is that the Japanese welfare mix is oriented by a distinct familialistic social policy that maintained its course despite several reforms and even the introduction of long-term care insurance. However, and this is key for further research, the welfare mix has changed since the enactment of the LTCI law. Not only did it expand...
the role of the state in the creation of welfare, but it has also influenced the quantitative and qualitative relationship between the welfare regime institutions. As the Japanese government took over a more influential position in care for the elderly with the LTCI, it also shifted the role of the market in the welfare mix by providing financial incentives to invest in social welfare, e.g. by creating tax exemptions for social welfare service corporations (社会福祉法人, shakai fukushi hōjin). No less meaningful is the influence of the LTCI law in the creation of community services, as financial support is provided to communities (via local governments) to ensure and enrich the livelihood of bedridden, frail and senior citizens. And, lastly, the family, basically the sole provider in current care for the elderly with a deep commitment to and involvement in informal care, was relieved of a certain degree of the care burden through the LTCI law. But more than that, the LTCI induced a change in the perception of responsibility within social institutions, such as the family and the community. As the benefit of the LTCI is provided in-kind, care institutions and organisations were tremendously influenced and the infrastructure of care expanded.

Figure 1-10: Balance of responsibility between public and social institutions before (left) and after the introduction of the LTCI in Japan (right)

Source: own representation.

All in all, the welfare mix in Japan has undergone fundamental shifts due to the LTCI law, being more than just the involvement of the state in care for the elderly. Like in a cobweb, the appearance of major actors led to the mild commotion in this net of interdependent welfare institutions.
In addition, I argue that the introduction of the LTCI in Japan has contributed to the individualisation of risk in Japanese society. That change, which hits social institutions and those for the elderly, is a major shift in risk responsibility in ageing Japan (Figure 1-10, above). It is rooted in the national government's effort to establish risk management procedures in society as a whole by shifting responsibility onto many actors. Interplay between public and social institutions in care for the elderly was established and corroborated more than the now heightened responsibility of the government. It is this interplay and intersection between institutions that entails the probability of the materialisation of new social risks, as the elderly seeking care are torn between their reliance on different institutions in a phase of high physical and social vulnerability. Simultaneously, generational and value conflicts, circling around the changes in values, create a playground for social conflict and "risky" outcomes of institutional support and the familial evasion of perceived care duties—which differ locally according to the availability of institutions and organisations that provide support.

Moreover, research indicates that spatial differences might have an impact on institutional arrangements and the accessibility of welfare measures, which leads us to the assumption that Japan may be one welfare state by social policy design, but has two welfare regimes according to locality: one for urban agglomerations with a higher availability and multitude of care organisations and one for the periphery with a stronger reliance on communal services and community.

The next chapter will give an overview of the development and status quo of care for the elderly in Japan and its formalisation and socialisation through the LTCI law. The later reforms, which gave LTC users a more active role in not only service selection but also premium contributions, are particularly important. Chapters 3 and 4 will provide accounts of the welfare mix institutions in action as meshes that the elderly and their families can fall back on. The former is set in rural Japan, while the latter is in Tōkyō. Despite the top-down implementation of the LTCI, local governments and care facilities have leeway in their care practice and provision, which will be depicted in the fifth chapter. Finally, the sixth and last chapter summarises the results of my extensive fieldwork and research, juxtaposing the socialisation of care and individualisation of risks, and provides an outlook for the future.

1.5 Theoretical foundation: welfare mix in an ageing society
The post-war period in Japan was a phase of persistent and pervasive social change, deeply rooted in a varying economic performance alongside an increase in flexible working conditions, shifting attitudes and values, as well as far-reaching demographic change. All these processes entailed modernisation and individualisation shifts through changes to traditional and religious paradigms, and eventually came to challenge the established inter-generational contract.

The problem of welfare for the frail and elderly, a long-standing societal and social question, was answered in Japan during the Meiji Restoration, the pre-war period, and the early post-war period by relying on widespread Confucian values. In particular, it was the reliance on the ie-system (家, literally: house, family), which provided guidance in organisation, composition and the division of labour in families, and formed the ideological cornerstone of social interaction. Specifically, intergenerational interaction was essential—mutual welfare and relief between grandparents, parents and children. While parents fostered their children until adulthood, a reversion occurred in old age with children taking care of their increasingly dependent parents. This mindset is still prevalent and a societal norm in almost all cultures as it involves universal reciprocal processes, regardless of cultural or religious backgrounds.

However, in the Japanese ie-system, family was understood as an authoritarian, patriarchal economic and social unit with rigid regulations concerning hierarchy, labour division and inheritance. Divided into main and sub-branches, the honke (本家) and bunke (分家), the ie-system was of major importance in securing and stabilising the socio-economic situation of families in the pre-war period, especially in rural areas (Fukutake, 1978, pp. 27–28). Nursing tasks for the frail and elderly in this system were almost exclusively assigned to female family members; principally, they were the domain of the eldest daughters and daughters-in-law. But through adaptations to the general constitution and law changes driven by the United States of America as the victorious power after World War II, in 1947 the ie-system was abolished by changes to the Civil Law (市民法, shiminhō) and the conjugal family system was established. All in all, these
steps, as well as the prosperous economic outlook of the post-war era, led
to a transformation of the family as an institution, changing family struc-
tures towards core families (核家族, kaku-kazoku) as well as initiating a
change of norms and values in the incipient post-industrialisation period in
the 1970s and 1980s—one generational cycle after the end of the Second
World War. Although the ie ideology still lingers as a set of values, it has
considerably lost its function (Tsutsumi et al., 2008, pp. 48–49).

2.1 Demographic change—increasing need for care for the elderly

Experiencing strong population growth in the immediate aftermath of the
Second World War, Japan faced profound demographic changes which
were soon mirrored in concerns that arose which evoked questions about
the economic outlook, expansion and financing of the welfare system, and
changing value orientations—similar to those in other developed states.
These single historical phases appear in retrospect in Japan's contempo-
rary demographic composition (Figure 2-1). The following are visible:
a) a strong population decline during the Second World War, i.e. among
the generation aged 70–75 today,
b) the first baby boom in the immediate aftermath of the war, which today
is represented by 60–70 year old seniors,
c) a drop in the birth rate to its "normal" value,
d) a drastic decline in births, sometimes labelled as "birth stop", due to
the "Year of the Fire-Horse" (丙午, hinoe-uma), a Chinese zodiac sign
associated with bad luck, and
e) a second baby boom, which was an aftershock of the first baby boom
 generation, which had occurred exactly one generation span earlier (30
years).
Just by taking a closer look at the distribution of the population according
to age and sex (Figure 2-1), one can clearly see the vast senescence of
Japanese society and its gradually diminishing younger ages groups. And
already at this point, figure 2-1 hints at the fundamental issue of gendered
life cycles, which results from the shifting sex ratio. The slight surplus of
men that exists at birth (105 men to 100 women) changes drastically with
rising age and reaches its peak towards the end of life with a 4:1 ratio of
women to men from the age of 90 years on (Ministry of Internal Affairs
and Communications, 2015a). The general worldwide trend of higher life
expectancy among women also appears quite blatantly in Japan: at birth
men are expected to live for 79.9 years, women for 86.4 years—defining their lifespan as being longer than in every other nation (Ministry of Health, Labour and Welfare, 2013a, p. 1).

Figure 2-1: Demographic distribution of the Japanese population by age and sex

Even for 90-year-old Japanese citizens a remaining life expectancy of 4.2 years for men and 5.5 years for women is calculated.

In the post-war period and during the phase of high economic growth, the baby boom generation formed an enormously young nation. The ageing of this large age group is responsible for Japan's senescence, which is indicated by the age dependency ratio, i.e. the proportion of the working-age population (15–65 years) to that of the aged population (≥ 65 years) (see Figure 2-2). Although not every aged person is a needy person but increasingly enjoys vitality and good health at an old age, the sheer numerical increase in the aged population indicates a high demand for old age welfare and nursing.

Source: Own representation, data Ministry of Internal Affairs and Communications, 2015a.

Note: Historical references a-e apply to both the male and female population. Age was not specified among 570,794 men and 405,629 women.

Even for 90-year-old Japanese citizens a remaining life expectancy of 4.2 years for men and 5.5 years for women is calculated.
2.1 Demographic change—increasing need for care for the elderly

Figure 2-2: Age dependency ratio, left

![Graph showing age dependency ratio from 1935 to 2011](image)

Source: Own representation, based on data from MIAC 2015c.

Note: *Calculation: (≥65 years) / (15-64 years) * 100. **1940 including Japanese military personnel and military.

Figure 2-3: Ageing index, right

![Graph showing ageing index from 1935 to 2011](image)

Source: Own representation, based on data from MIAC 2015c.

Note: *Calculation: (≥65 years) / (0-14 years) * 100. **1940 including Japanese military personnel and military.
Linked to the extensive population growth in the post-war era, the prosperous Japanese nation acquired young and capable labourers due to the first and second baby boom generations. But since the 1970s the age dependency ratio has grown immensely and is indicative of Japanese society’s growing burden of developing ways to handle issues of its ageing population (see Figure 2-3). In order to maintain the imperative and normative intergenerational contract and avoid cases of social hardship between parent and child generations, the arising long-term issues of the shrinking nation had to be tackled. It was feared that the implied intergenerational contract could not be complied with due to:

a) a labour shortage resulting from the incremental retirement of permanent personnel and insufficient recruiting—which also applies to care personnel,

b) rising deficits in the social security system since, according to age-relatedness, the number of people receiving a pension is rising while the number of contributors to the system is falling, and

c) a double financial, social and mental burden through informal care given by families and the simultaneous, and necessary, economic orientation towards double income households.

Although a stagnant or declining population is unproblematic, if the decrease occurs in all age groups or if international migration is not restricted, it definitely poses challenges to nations if the productive population is declining while the dependent one is growing. And Japan was and still is no exception. The demographic and social changes in post-war Japan have had many effects, e.g.:

- the development of the strong surge in number of the senior generation,
- shrinking family sizes and the tendency towards core families with only one child,
- the process of modernisation and value change with the increasing necessity and desire for women to pursue a career, and
- their resentment of their ascribed "traditional" role as the typical carers for children and seniors.

These social developments made a sociopolitical issue come into force anew: who cares for the aged, how should welfare for the ageing population be organised and what supporting mechanisms and systems should be created?
The rising demographic pressure finally made it inevitable to clarify the question of care for the elderly. But it was not only the changed population structure and a disequilibrium in social justice which became a necessity that had to be addressed. Also, matters of health and financial politics started to gain importance and could not be settled by the traditional approach any more, i.e. leaving care to the family. Although Japan had introduced several welfare mechanisms and programmes for those on a low income and the aged, they resembled a non-transparent patchwork of eligibility, jurisdictions and responsibilities. These arrangements, however, were not set up to handle an increasing elderly population, and manifold issues continued to pile up, causing shortages in adequate nursing and financing conditions. Eventually, at the turn of the century and close to similar developments in Germany in 1997, Japan introduced a comprehensive system of care for the elderly with universal coverage. However, prior to introducing the LTCI in Japan, the German Pflegeversicherung (translated as Care Insurance), which had been in operation since 1995, provided imperative input for the Japanese LTCI design to avoid certain decisions which were regarded as unfavourable, such as cash allowance for informal care (Campbell, 2002; Campbell et al., 2010).

The Pflegeversicherung did not only start earlier (in 1995, although discussions started as early as 1984 through private insurance companies, and the first draft bill on a federal level was introduced in 1990), but also has a slightly different policy design. Besides the form of financing (a pay-as-you-go system in Germany and Japan), basically three major differences can be distinguished in contrast to Japan. First, in Germany benefits in cash may be received as an alternative or addition to benefits in kind, leading to widespread informal care by kin in exchange for cash benefits. Furthermore, it contributes to exploitation of their labour as the in-cash-benefit levels are significantly lower than the benefits in cash and in kind for formal care. In Japan, in contrast, all those insured for care receive benefits in kind only. Second, the idea of day care and its provision is different in Germany as it is rather an exception but is also the norm in care usage, whereas in Japan the major pillar of care provision is day care as it allows for autonomy and cost-effectiveness. And third, while in Germany every citizen is eligible for care services, in Japan an age limit exists, starting at age 65 (or 40 for disabled persons), which is basically due to the financing structure of each LTCI: in Japan every citizen aged 40 and above has to
pay LTCI premiums; in Germany premiums have to be paid by basically every citizen with an income.

2.2.1 Historical developments of care for the elderly

After the Meiji Restoration, Japan found itself in a time of political and ideational turmoil with the emergence of political movements during the Taishō era (大正時代, *taishō jidai*, 1912–1926). During that time, often referred to as the Taishō democracy, the foundations of the modern Japanese welfare state were laid: in 1922 the Health Insurance Law was introduced to cover the medical costs of workers and then, in 1959, was transformed into the National Health Insurance (国民健康保険, *Kokumin Kenkō Hoken*) scheme, which was eventually enacted nationwide in 1961 and is still the obligatory general health insurance scheme. Every Japanese citizen is insured by their respective municipality, fees are levied based on annual income and medical costs are co-paid by those insured.

The post-war period was the cradle for fundamental social welfare laws and regulations. In 1959, the National Pension Law (通算年金通則法, *tsūsan nenkin tsūsoku hō*) was established and came into effect in 1961. In combination with the Welfare Law for the Elderly (老人福祉法, *rōjin fukushi hō*) in 1963, a broad social welfare bundle was crafted by the Japanese government. The Welfare Law for the Elderly focused on the livelihood of "[e]lderly persons [...] who have contributed to the development of society for many years and who have abundant knowledge and experience" and was intended to ensure them "healthy and comfortable lives that make living worthwhile" (Ministry of Justice, 1963, Article 2). However, such a broad aim did not correspond to reality. Although, following the law, care homes for the elderly and home care aid services were established, their range was limited and rather aimed at low-income seniors without caring family members since it reflected “prevailing beliefs [...] that family members should take care of their aging relatives” (Ihara, 2000, p. 8). Those beliefs were not questioned and were widely accepted as the elderly population in 1960 amounted to merely 5.7

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18 However, it was not in effect until 1927. But in 1938 it was expanded to cover agricultural workers as well.
per cent of Japan’s total population (Ministry of Internal Affairs and Communications, 2015c).

In contrast, prosperous periods for the Japanese nation at the end of the 1960s and the beginning of the 1970s and an elderly rate of 7.1 per cent even allowed for expansion of social welfare services for the aged to a sublime degree. In 1973, the Welfare Law for the Elderly underwent revision and from then on Japanese elderly people enjoyed medical treatment for all aged persons above the age of 70 years free of charge—instead of the co-payments of thirty per cent\(^\text{19}\) for the regular population (Campbell, 1984, p. 55). As an unanticipated consequence, the free of charge system developed unsolicited side effects in the 1980s and 1990s.

But healthcare expenses rose unexpectedly in the 1970s as two major world events, the oil price shock of 1973, a proclaimed oil embargo in which the Organisation of Arab Petroleum Exporting Countries (OAPEC) used its leverage on oil price mechanisms, and the energy crisis of 1979, due to the Iranian revolution and massive curtailing of oil production, had long-lasting effects on the Japanese economy, and adjustments had to be made to balance revenues and expenditure. Consequently, the Health and Medical Welfare Act was revised in 1982 and the co-payment system was changed by increasing the rate and setting the payment level equally for almost all those who were insured, even those who had been exempted before due to low income (Ikegami et al., 2011, p. 1108). Already at that time a co-payment rate of ten per cent was introduced for the elderly, but only in 1997 was it raised to twenty, and that rate was set at thirty per cent in 2003 (Ogawa and Matsukura, 2007, p. 208).

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\(^{19}\) Since the introduction of the National Health Insurance scheme, co-payment rates varied greatly according to municipalities and employee-based plans, but were lowered from 50 per cent to 30 per cent for everyone who was insured between 1961 and 1982 and remained at that level (Ikegami et al 2011: 1108).
Table 2-1: Major welfare reforms and regulations in Japan

<table>
<thead>
<tr>
<th>Year*</th>
<th>Major Laws and Regulations</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1922</td>
<td>Health Insurance Law</td>
<td>Basic coverage for employees</td>
</tr>
<tr>
<td>(1927)</td>
<td>Retirement Reserve and Retirement Allowance Law</td>
<td></td>
</tr>
<tr>
<td>1936</td>
<td>Old National Health Insurance Law</td>
<td></td>
</tr>
<tr>
<td>1938</td>
<td>Old Employees' Pensions Insurance Law</td>
<td>Basic health insurance for employees &amp; farmers</td>
</tr>
<tr>
<td>1944</td>
<td>Unemployment Insurance Law</td>
<td></td>
</tr>
<tr>
<td>1947</td>
<td>Worker's Accident Compensation Insurance Law</td>
<td></td>
</tr>
<tr>
<td>1947</td>
<td>Social Welfare Services Law</td>
<td>Established welfare services for children, the disabled, the elderly and single parents</td>
</tr>
<tr>
<td>1951</td>
<td>Employees' Pension Insurance Law</td>
<td></td>
</tr>
<tr>
<td>1954</td>
<td>National Pension Law</td>
<td>Comprehensive pensions</td>
</tr>
<tr>
<td>1959</td>
<td>National Health Insurance Law</td>
<td>Comprehensive health insurance available nationwide</td>
</tr>
<tr>
<td>(1961)</td>
<td>Act on Social Welfare for the Elderly</td>
<td>Medical and care cost coverage for the aged</td>
</tr>
<tr>
<td>1963</td>
<td>Farmer's Pension Fund Law</td>
<td>Guaranteed pension benefits for farmers</td>
</tr>
<tr>
<td>1970</td>
<td>Revision of the Welfare Law for the Elderly</td>
<td>Expansion of medical cost coverage and pensions</td>
</tr>
<tr>
<td>(1971)</td>
<td>Health and Medical Service Act</td>
<td>Medical cost coverage for persons ≥75 (also from 65–74 if disabled)</td>
</tr>
<tr>
<td>1982</td>
<td>Gold Plan</td>
<td>Promotion of health and welfare of the elderly by establishing infrastructure</td>
</tr>
<tr>
<td>(1983)</td>
<td>New Gold Plan</td>
<td></td>
</tr>
<tr>
<td>1994</td>
<td>Long-Term Care Insurance Act (LTCI)</td>
<td>Comprehensive old age nursing insurance</td>
</tr>
<tr>
<td>2003</td>
<td>Minor LTCI Revision</td>
<td>Benefits and fee adjustments</td>
</tr>
</tbody>
</table>
However, attitudes towards familial care for the elderly were gradually changing as the elderly population grew (12 per cent in 1990) and the demand for care facilities continued to rise. In an attempt to cope with these growing issues, in 1989 the "Ten-Year Strategy to Promote Health and Welfare for the Aged" (高齢者保健福祉推進十か年戦略, Kōreisha Hoken Fukushi Suishin Jūka-nen Senryaku)—or the so-called Gold Plan—was developed and established in order to drastically expand welfare and care for the elderly. Every municipality had to compile and formulate specific measures for their jurisdictions based on surveys (Ihara, 2000, p. 10) in order to prepare and ensure the availability and accessibility of the hitherto underdeveloped system of care for the elderly, i.e. "double the number of nursing home beds, triple the number of home helpers, and (from a small base) ten times the number of adult day-care centres" (Campbell and Ikegami, 2000, p. 28). Yet, since the economic outlook was anticlimactic after the implosion of the asset price bubble economy at the beginning of the 1990s, the original Gold Plan was revised in 1994 as the New Gold Plan to meet changed economic and demographic demands.

Although welfare programmes for the elderly were established in post-war Japan (see Table 2-1), the conception of care for the elderly at that time was still evoked and predefined through political slogans. The socially internalised idea of welfare and care provision through family and kinship and a simultaneously lower number of welfare institutions and rate of expenditure by the state resulted in the invocation of the so-called Japanese welfare regime by politicians in the early 1970s. It characterised Japan as a:

"'Japanese-type welfare society' in which – [...] founded on the self-help efforts of individuals and the solidarity of families and neighborhood communities that the Japanese possess—an efficient government guarantees appropriate public welfare according to priorities" (Campbell, 1992, p. 220).
Pointing out a mythical peculiarity of Japanese society and its welfare approach, the Japanese government clandestinely exploited traditions and traditional values, moral obligations and citizens’ good-will in order to curb expenditure and maintain the previously established economic standard:

“By promoting the slogan of a "Japanese-type welfare society" [...] during the 1980s, the government reduced social expenditures [sic] and instead called upon the population to recall the traditional virtue of caring for their aged in the family without public support.” (Lützeler, 2002, p. 283).

However, as the elderly population continued to grow and the birth rate plummeted, sustaining the myth of the said nihon-gata fukushi shakai became impossible, and comprehensive state-driven support for care for the elderly became more and more inevitable. Still, the Gold Plan turned out to be a key transition in Japanese welfare policy and an essential prearrangement for the Long-Term Care Insurance scheme. In this regard, it constituted the government's "new responsibility to provide long-term care to all frail older persons, not just the poor or those without families" (Campbell and Ikegami, 2000, p. 28).

The development of the Japanese welfare system illustrates how the Japanese government tried to make a virtue out of necessity, and thus successively initiated a transformation of the welfare system in Japan—away from a corporatist-centred and particularistic approach to a more comprehensive and universal model of care for the elderly.

2.2.2 Need for a change in elderly welfare: the LTCI is coming to Japan

The system of care for the elderly in Japan prior to the introduction of the Long-Term Care Insurance (LTCI) scheme was becoming increasingly complicated: fragmentations and differences between municipalities and jurisdictions with differing fees and eligibility systems proliferated. Eligibility for elderly welfare service usage even originated from the placement system for public assistance, making it ineffective for a large and ever growing population. Even worse, it focused on income and family support in caring for the elderly (Campbell and Ikegami, 2000, p. 29)—an increas-

20 The term nihon-gata fukushi shakai (日本型福祉社会) is translated as “Japanese-type welfare society”.

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Generiert durch IP '54.70.40.11', am 28.08.2020, 14:21:01. Das Erstellen und Weitergeben von Kopien dieses PDFs ist nicht zulässig.
ingly inadequate measure in a decade with rising income inequality, diverging values and norms, a growing number of seniors and a declining birth rate.

But the main dilemma of the welfare system for the elderly up to 2000 was the exploitation of medical services for geriatric care. Under the "Social Welfare for the Elderly" law and in the system since 1963, applicants who wanted to use care services for the elderly had to be declared eligible. The level of contributions, depending on their economic status and familial support, was evaluated by local governments. Regularly it turned out that the usage fee for care services for the elderly was higher than that for medical services, in particular for middle and upper-class households (Matsuda and Yamamoto, 2001, p. 4). Hence, it impelled the institutionalisation of the elderly in hospitals and de facto rendered medical facilities as geriatric care homes. Despite the hospital atmosphere, it was—at least economically—favourable for elderly patients to receive care in medical facilities. But local governments, health insurers and hospitals were dissatisfied and growlingly concerned about these unwanted side effects of welfare laws and regulations since 1963 (Yong and Saito, 2012, p. 3):

a) Costs of care for the elderly in medical facilities were borne by the health insurers and led to excessive encumbrance of health insurance funds. Since health insurance funds were also handled by local governments, health expenditure grew rapidly and placed several municipalities under tense financial conditions.

b) Hospitals were overcrowded\(^{21}\) and as beds were occupied long-term\(^{22}\), there was little room left for "real" medical patients. Besides that, personnel training and equipment for geriatric care needs were underdeveloped or unavailable and the personnel were overwhelmed by the excessive demand.

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21 In 2011, Japan had 13.4 hospital beds per 1,000 citizens, by far the most among all OECD countries, and only a minor decline since the introduction of the LTCI (14.7 beds in 2000). The number of beds is still particularly high if compared to Germany with 8.3 beds (Organization for Economic Cooperation and Development, 2013a).

22 The number of average days spent in hospitals was the highest in Japan among all OECD countries, with 24.7 days in 2000 right after the introduction of the LTCI. The average in all OECD countries was 9.2 days. Meanwhile, the number has fallen to 17.9 days in Japan and to 8.0 as the OECD average (Organization for Economic Cooperation and Development, 2013b).
Welfare care for the elderly and medical services were separate and uncoordinated systems, targeting low-income households or sick patients. This made application procedures rather intricate and, furthermore, socially stigmatised those who received welfare services.

For the sake of clarification of the de facto standard of medical facilities for nursing the elderly, in 1997 Japan spent approximately 60 per cent of its medical expenditure of 27 trillion yen on hospitals—and 46 per cent of hospital patients were over 65 years and stayed longer than six months using them as nursing homes (Matsuda and Yamamoto, 2001, p. 2). It was a direct and palatable result of the undeveloped system old age care and a misguided approach to a regulation of care for the elderly.

As early as in 1989, these key points led to a debate about the vitally needed reform of the welfare system for the elderly, but it was only in 1997 that the LTCI was enacted and eventually implemented on 1st April 2000. Despite the widely accepted vision of the Ministry of Health, Labour and Welfare to meet the requirements of the contemporary and prospective ageing society and its purpose "to provide benefits pertaining to necessary health and medical services and public aid services [...] to maintain dignity and an independent daily life routine according to each person's own level of abilities" (Ministry of Justice, 1997, Chapter 1, Article 1), there were also dissonant accounts concerning the outcome of the LTCI.

Groups of volunteers, NGOs and NPOs, such as the "Women's Association for a Better Aging Society"\(^{23}\), were quite vocal and well-heard during the approach towards the LTCI (Campbell and Ikegami, 2000, p. 30; Coulmas, 2007, pp. 70–71). These groups claimed that the introduction of comprehensive care for the elderly was a big step en route to gender equality by relieving women of giving full-time familial care and opening up paths into employment and career building (e.g. Körei shakai wo yoku suru josei no kai, 1997). Women's interest organisations are also credited for preventing cash allowances for family care. They argued that efforts in gender equality would be endangered since cash allowances, despite the financial support for families providing informal care, would pressure women anew into family care and traditional role models (Campbell and Ikegami, 2000, pp. 30–31).

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23 This group's Japanese name is 高齢社会を良くする女性の会 (Kōrei shakai wo yoku suru josei no kai).
2.3 The structure of the LTCI

Implemented in 2000, the Long-Term Care Insurance scheme is a relatively new social insurance scheme, but now comprises a key part of welfare for the elderly in Japan and offers comprehensive old age insurance. It covers care and age-related medical and nursing services for aged persons by combining parts of the health insurance and the welfare systems, which, prior to the LTCI, were autonomous parts and caused complications in application for those taking up the service, budget burdens and load management between the different applicable systems. The aim of the LTCI, as a social insurance scheme, was also the socialisation of the costs of care for the elderly among all citizens and also between local and national administrations in order to curb financial burdens for care services receiving families, but also local governments and municipalities.

2.3.1 Administrative foundations: insurers and financing

Municipalities\textsuperscript{24} are insurers of the LTCI. The financing of care for the elderly, however, is not merely tied to municipalities, but relies on the multi-level distribution of taxes between local, trans-local and national governments, as well as premiums. Based on the principles of social insurance, the LTCI as pay-as-you-go system draws its financing from different financial sources (Figure 2-4) which are divided by half into premiums and tax revenue (Ministry of Health, Labour and Welfare, 2011a). If broken down further, the premiums of those insured, which comprise 50 per cent of the LTCI funds, are split as follows:

\textsuperscript{24} Or special wards in metropolitan areas such as Tokyo (-to) and Osaka and Kyoto (-fu) and hereby later referred to as municipality only.
Figure 2-4: Financing structure of the Japanese Long-Term Care Insurance scheme

LTCI funds

<table>
<thead>
<tr>
<th>Premiums (50%)</th>
<th>Taxes (50%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>National government (25%)</td>
<td>Prefectural government (12.5%)</td>
</tr>
<tr>
<td>Prefectural government (12.5%)</td>
<td>Municipality (12.5%)</td>
</tr>
<tr>
<td>Premiums 40-64 Years (30%)</td>
<td>National government (25%)</td>
</tr>
<tr>
<td>Premiums 65+ Years (20%)</td>
<td></td>
</tr>
</tbody>
</table>

Source: Own representation, data IPSS 2014; MHLW 2013.

- 20 per cent\(^{25}\) are deducted from pensions of those insured who are aged 65 years and above,
- 30 per cent are paid as obligatory premiums by every citizen between the ages of 40 and 64 years.

LTCI premiums become compulsory when age 40 is reached\(^{26}\) and are calculated on the basis of the municipal tax (住民税, jūminzei). Furthermore, municipalities have discretion in setting "multipliers" to premium levels\(^{27}\),

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25 The ratio was incrementally altered, starting with 17 per cent for seniors and 33 per cent for 40–64 year olds, then adjusted to 18 and 32 per cent etc. Since 2010 the percentage has been set at 20 and 30 per cent in order to resemble the country's population ageing. However, local governments have discretion to alter the ratio according to their population ratio.

26 Recent discussions in Japan convey the argument of including lower age groups and providing LTC services to people in need but outside the designated age bracket of 40 and above.

27 See appendix for a detailed list.
thus unburdening low-income households or imposing a stricter payments on high-income households. Although the premiums vary, the average was circa 3,000 yen per month for aged users (cited from Gleckmann, 2007; Yong and Saito, 2012, p. 8). The remaining half of the funding is drawn from multilevel governmental budgets:

- 25 per cent from the national government,
- 12.5 per cent from prefectural governments, and
- 12.5 per cent from municipalities.

Such ratio distribution between the different governing levels indicates that the funding of the LTCI is constructed in a way which generally does not take regional differences into account. Hence, it constitutes a gradual burden for prefectures and municipalities with a higher age-dependency ratio, which is often the case for rural prefectures and remote municipalities with elevated ageing. Regions with a growing elderly population, and consequently a higher ratio of low LTCI premium contributors—20 instead of 30 per cent—and simultaneously a higher number of LTCI service users, face financial risks and often fiscal deficits. Local governments as LTCI insurers are pressured any time expenditure exceeds revenue. Five per cent of the system's total revenue is used to decrease regional disparities (Ministry of Health, Labour and Welfare, 2002b); nevertheless, there is a discrepancy in LTCI usage between urban and rural areas, and it is likely to rise as rural regions tend to age faster than urban regions (Mitchell et al., 2008).

However, the aforementioned budgetary foundations of the LTCI only cover approx. 90 per cent of LTCI expenses. The remaining ten per cent of LTCI expenses are borne by the co-payment rate, introduced in 2002, which LTCI users pay for services they take up. Additionally, since 2005 so-called hotel costs, e.g. for meals, diapers, water, gas and electricity, have to be paid by users receiving outpatient care in order to stabilise troubled LTCI system expenditure.

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28 National and prefectural governments may alter their contributory ratio to 20 and 17.5 per cent respectively in order to benefit infrastructural expansion, e.g. of facilities (Ministry of Health, Labour and Welfare, 2011a, p. 12).

29 Although the co-payment rate is set at ten per cent, municipalities can remit these payments for low-income seniors.
2.3.2 Eligibility and benefits

Those insured under the LTCI scheme are eligible for service usage if they apply at the local city hall (市役所, shiyakusho) or district hall (区役所, kuyakusho) by completing a questionnaire, being visited at home by an assessor and, finally, by being examined by physicians. Applicants are then assigned a care manager\(^30\) in order to develop a care plan in correspondence with the applicant and her/his family to cater the care to their medical requirements and social needs. Furthermore, eligibility is only given if certain criteria are met by the applicants. One criterion is age, creating two categories of applicants (Ministry of Health, Labour and Welfare, 2011a, p. 12):

- Primary insured persons, or Category 1, are seniors of 65 years or over. Approximately 28.4 million citizens are eligible for service uptake.
- Secondary insured persons, or Category 2, are citizens between 40 and 64 years, i.e. those who are obliged to make LTCI premium payments. Although circa 42.4 million citizens would fall into this category, the second mandatory criterion for this age group is a disability which hinders a self-determined life, which reduces the number of eligible persons drastically.

A further criterion is the amount of care required, which is determined in an assessment process in which the ability to partake in activities of daily living and the amount of nursing required are evaluated, which then determines the level of care benefits assigned. These benefits are provided as services or in kind, while benefits in cash were considered inappropriate in discussions prior to the LTCI’s introduction\(^31\). The care levels assigned depend on the applicant’s ability to participate in daily life autonomously, e.g. performing basic hygiene activities, receiving sufficient dietary intake, and adequate mobility.

The mandatory 85-item questionnaire asks 73 questions concerning the applicant’s mental health and 12 about their medical status, with the result

\(^{30}\) The role of care managers as gatekeepers for patients, since they can refer them to certain care facilities and care specialists and consequently profit themselves but also place higher burdens on social security budgets, is discussed by Sugawara and Nakamura (2015).

\(^{31}\) In comparison with the German LTCI, the "Pflegeversicherung", benefits in cash turned out to be the most popular benefit, leading to a situation in which more than half of care for the elderly is provided informally by the family.
that a computer-assisted process provides a tentative assessment of an applicant’s required level of care. Eventually, the initial assessment is re-evaluated in order to be adjusted to the applicant’s actual needs:

"The Nursing Care Needs Certification Board, consisting of physicians, nurses, and other experts in health and social services appointed by a mayor, determines whether the initial assessment is appropriate, considering the applicant's primary care physician's statement and notes written by the assessor during the home visit. If necessary, the board reassigns the needs level. Most commonly, the board upgrades the need [sic] level to accommodate special needs not captured in the computer-based assessment. For example, the assessor may mention that the applicant's abilities fluctuate although the computer output indicates that the person is ‘independent’. Or the assessor's note may indicate needs for institutional services because the applicant lives in a rural area without grocery stores or lives with a violent alcoholic spouse." (Tsutsui and Muramatsu, 2005, p. 524).

Home visits by assessors, who quite often are also care managers, aim at ascertaining the physical and social surroundings of applicants in order to create an ample overview of the services they require. Taking part in one of these visits in Tōkyō, I was quite astonished to experience that they are conducted in the same way someone would host their neighbour: drinking tea, eating senbei rice crackers and chatting about family and daily life. However, this apparent informality is used to ease the examination atmosphere and detect signs of mental health decline. Since the assessor also acts as a care manager to this applicant, a neighbour-like relationship is regularly established, rendering the assessor/care manager the pivotal point in the organisation of care for seniors. The care manager then provides an overview of available services and creates a plan according to the level of care that has been determined and the financial limit that has been approved.

For those insured under the LTCI scheme, the application process is quite straightforward as they need only inquire about care assistance at the municipal welfare office (保健福祉課, hoken fukushi-ka, or 高齢福祉課, kōrei fukushi-ka), which is usually located within the city hall. The background processes, however, are quite extensive (Fig. A-1, appendix) and result in the applicant being placed in one of the two support levels or five care levels—according to the severity of care needed. Preventive care levels (要支援, yōshien) are assigned to seniors who are still mobile and active, but are on the brink of needing assistance and support, while care levels (要介護, yōkaigo) are assigned to those who need a significant amount of assistance during their daily life throughout the day and/or night. Sup-
port Level 2 and Care Level 1 are partly interlocked to provide a continuous and seamless transition between prevention and care. As an indicator, the support and care levels are divided by the MHLW according to care needs in terms of time and burdensome or non-executable activities (Table 2-2), but are still object to the individual and specific medical assessment of the applicant's social surroundings and nursing needs.

Table 2-2: Support and care levels with corresponding time, activities and benefits

<table>
<thead>
<tr>
<th>Level</th>
<th>Minutes</th>
<th>Problematic activities*</th>
<th>Financial benefit (yen/month)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Support Level 1</td>
<td>25–31</td>
<td>Standing (on one &amp; two legs), sitting</td>
<td>49,700</td>
</tr>
<tr>
<td>Support Level 2</td>
<td>32–49</td>
<td>Walking, body care, counting money</td>
<td>100,400</td>
</tr>
<tr>
<td>Care Level 1</td>
<td>50–69</td>
<td>Dressing, making daily life decisions</td>
<td>165,800</td>
</tr>
<tr>
<td>Care Level 2</td>
<td>70–89</td>
<td>Face washing, urination, defecation, proper sitting</td>
<td>267,500</td>
</tr>
<tr>
<td>Care Level 4</td>
<td>90–109</td>
<td>Eating, expressing wishes</td>
<td>306,000</td>
</tr>
<tr>
<td>Care Level 5</td>
<td>≥ 110</td>
<td>Swallowing, remembering</td>
<td>358,300</td>
</tr>
</tbody>
</table>


Note: Higher financial benefits are provided for institutional care. *Higher care levels include problematic activities from the previous level.

2.4 Live long and prosper: the institution of day care

Prior to the introduction of the LTCI scheme, care for the elderly was a delicate issue, and two all-or-nothing options were available for seniors to receive care: institutional care in public facilities or private care by the family. The former was either expensive or only available to people on a low income through public assistance, and it usually placed families under the stigma of abandoning their parents and putting seniors in a heteronomous, totalitarian system of old care homes with strict rules and
2.4 Live long and prosper: the institution of day care

schedules. Family care, on the other hand, placed families and particularly the main caregivers, women, under high mental and physical stress due to them having to provide care, a well-managed household and, if possible, a second income. The elderly were simultaneously experiencing similar stress through uneducated care procedures conducted by family members and interpersonal discrepancies—which occasionally led to abusive behaviour.

Nevertheless, due to fiscal, organisational, structural and sociopolitical reasons, in 2000 a new form of care was established and became quickly the most important and most used benefit among all long-term care services: day care (Figure 2-5). Although tsūsho sābisu (通所サービス) is the official hypernym to a range of care services under the LTCI, literally meaning "outpatient services", it is rather rare in everyday conversation and care workers and patients refer mostly to day care (デイケア, dei keā), even though day care means outpatient care with medical massages and rehabilitation training and is regularly confused and used synonymously with day service (デイサービス, dei sābisu), which is ambulant care only without those physical measures.

Day care as a care service for the elderly is located at an in-between position within the LTCI scheme and, thus, comprises an intermediary between the two other, rather antagonistic care possibilities:

- home care nursing services (訪問介護, hōmon kaigo) for the elderly in the habitual, accustomed environment of their own household with support through informal family care, and
- institutionalised care in geriatric homes for the elderly (施設介護, shisetsu kaigo), embracing all facets of social life and interaction in a non-private environment.

The intermediary function of day care is achieved by offering outpatient treatment during daytime in specially equipped facilities and stays at home at night. It allows both the provision of medical and nursing treatment at the day care facility and harvests the social environment of family, neighbours and habitual place. From initial and occasional home help and use of day care one day a week for low-level certified patients, it offers the elderly a smooth transition to more weekdays and additional home care ser-

33 The term 通所介護 (tsūsho kaigo, outpatient care) is often used as well, but implies a much narrower understanding of care services than 通所サービス. The latter includes services that are not directly related to care for the elderly, but also those of preventive measures and social activities.
services, until they become high-level patients who need to be completely nursed in an institutional care home—or remain in day care if desired.

Furthermore, these three categories—home care, day care and institutional care—match the gradual decrease in the level of the autonomy and the increase in external intrusion into the elderly’s privacy and daily lives. A greater degree of frailty, expressed in the care level, leads to a higher classification within the LTCI system and an elevated necessity and usage of more nursing measures which intrude into seniors’ privacy but are more supportive. Low-level classified care users use less intrusive care services, such as home and day care, more frequently than institutional care to, at least partly, retain their autonomy and vice versa (Figure 2-6).

Whereas it is certainly debatable whether home visits by external care professionals intrude more into the elderly’s privacy than day-care centre attendance with e.g. its group bathing, institutional care definitely exhibits the utmost intrusion into an aged individual's life by not providing any opportunity for them to retreat into the widespread private rooms that house multiple patients.

*Figure 2-5: Distribution of LTC service usage*

![Distribution of LTC service usage](https://doi.org/10.5771/9783845285948)

Source: own representation, based on Ministry of Health, Labour and Welfare, 2015a. Note: Day care includes short stays in geriatric homes of up to two weeks and rehabilitation services.
2.4 Live long and prosper: the institution of day care

Figure 2-6: LTC service usage by level of severity


Note: Day care includes short stays in geriatric homes of up to two weeks and rehabilitation.

Despite tight and strict schedules, day care constitutes a bouquet of nursing and social activities and a relief for the elderly and their co-residing families. Day-care centres aim to create a convivial atmosphere and convey the impression of a social gathering by serving tea and cookies, sanitary facilities that resemble public baths and joint lunches. Hence, they exercise a socialising function besides performing actual nursing activities. They also allow seniors to expand their accustomed social sphere by meeting old neighbours, since day-care centres are usually community-based, and making new acquaintances—all in all, therefore enhancing the social life of frail seniors while simultaneously providing nursing care.

2.4.1 Scheduling day care

Aiming to provide a pleasant ageing process, both day care and home care facilitate far-reaching discretion for seniors by selecting services within
the granted financial limit of their respective care level. Care managers (ケア・マネージャー, kea manējā)34 specialised in compiling, scrutinising and re-examining weekly schedules draft a care plan in coordination with seniors and their families. The combination of home-based and outpatient-based services is widespread and usually suggested since day care is not a service used on a daily basis, but every other day (Table 2-3). If higher frequency of care is required though, institutional care is advised. However, a typical care plan fills half a week with a full-time day care programme including nursing, medical and social activities to cater to the seniors' needs, as well as days in between at home to relax, do household chores, maintain social ties, force and reactivate self-reliance—and, of course, conserve personal and municipal budgets.

Table 2-3: Care plan of an LTCI care level 3 patient

<table>
<thead>
<tr>
<th></th>
<th>Mon</th>
<th>Tue</th>
<th>Wed</th>
<th>Thu</th>
<th>Fri</th>
<th>Sat</th>
<th>Sun</th>
</tr>
</thead>
<tbody>
<tr>
<td>AM</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Home help</td>
<td>Visiting Nurse</td>
<td>Home help</td>
<td></td>
<td></td>
</tr>
<tr>
<td>PM</td>
<td></td>
<td>Day Care</td>
<td>Day Care</td>
<td>Day Care</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Evening</td>
<td>Home help</td>
<td>Home help</td>
<td>Home help</td>
<td>Home help</td>
<td>Home help</td>
<td>Home help</td>
<td></td>
</tr>
<tr>
<td>Night</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rented tools</td>
<td>e.g. wheelchairs, nursing beds, bathing equipment, wheeled walkers, canes</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Source: Own representation, adapted from Ono, 2011.

Despite the discretion elderly patients and their families possess in planning care activities, the day-care schedule itself is highly organised and leaves only little to no leeway for patients during their time in day care for mostly structural, organisational and financial reasons. Designed as an intermediary care option, day care is structurally limited since its bedrock is

34 The official term is 介護支援専門員, kaigo shien senmon-in or "expert in care support".
bound to that of nursing facilities and not leisure organisations—even though this image is often conveyed by the MHLW and marketing conducted by care facilities for the elderly. Thus, care personnel are strict in executing the seniors’ daily schedule and their designated tasks at a certain time in order to guarantee and fulfil the institution's nursing function to every patient (Table 2-4). Furthermore, financial constraints due to fixed payments per patient from insurers, consequently, limit personnel capacity and dictate tight stipulations in terms of time, and put individual nursing and dedicated daily schedules out of reach. Once chosen, seniors in day care have some scope to skip certain activities, e.g. recreational activities—however, they usually cannot neglect other elementary activities, such as eating, washing or rehabilitation.

Table 2-4: Typical daily schedule in a day-care facility

<table>
<thead>
<tr>
<th>Time</th>
<th>Activity</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>07:30 – 09:00</td>
<td>Pick-up</td>
<td>Patient pick-up at their residence by care workers in wheelchair-lift equipped transport buses</td>
</tr>
<tr>
<td>08:30 – 09:30</td>
<td>Medical examination</td>
<td>Simple medical check-up, including heart rate monitoring, blood pressure check and a consultation concerning health condition and medication</td>
</tr>
<tr>
<td>10:00 – 10:30</td>
<td>Physical exercises</td>
<td>Easy, sedentary gymnastics, stretching exercises and, if necessary, massages</td>
</tr>
<tr>
<td>10:30 – 12:00</td>
<td>Bathing</td>
<td>Usually group bathing, assisted by nursing staff and the use of lifts or stretchers for physically immobile patients</td>
</tr>
<tr>
<td>12:00 – 12:45</td>
<td>Lunch</td>
<td>Meals, adjusted to dietary needs (diabetes, lactose intolerance), are prepared and served</td>
</tr>
<tr>
<td>13:00 – 14.00</td>
<td>Afternoon nap*</td>
<td>All patients rest after lunch</td>
</tr>
<tr>
<td>14:00 – 16:00</td>
<td>Recreation &amp; hobby activities</td>
<td>The priority here lies on socialising and cultural activities, often conducted by volunteers and care workers together</td>
</tr>
<tr>
<td>16:00 – 17:30</td>
<td>Returning</td>
<td>Patients are taken back home door-to-door by care workers</td>
</tr>
</tbody>
</table>

Source: Data collected in several day-care facilities.

Note: *Several facilities omit afternoon naps due to a shortage of space for (futon) beds and due to a high number of patients that cannot be handled within the time frame. Instead, recreational activities are performed.
2.5 Reforms of the LTCI: curtailing expenses, fostering civic engagement

The LTCI was initially organised in a five-year cycle for policy revision. In its already fifteen years of existence, it has undergone more than the scheduled reforms as readjustments to demographic, financial and nursing related requirements were needed. Two major reforms, in 2005 and 2011, resulted in elementary changes to the LTCI, and while counted as minor reforms, refits in 2003 and 2014 became necessary before the scheduled revision date and brought pervasive changes.

2.5.1 Surprised by popularity: unscheduled reform in 2003

The rapid growth and rising popularity of the LTCI caused dwindling funds. Due to an elevated demand for institution-based services, premature modifications to the reimbursement system became obligatory. These adjustments followed the 1997 outline of the LTCI in order to promote preventive and high-age autonomy enabling measures of community and home-based services to avoid institutionalisation and hospitalisation and, hence, curb relatively high expenses. It was achieved by fine-tuning benefit levels:

"Specifically, the LTCI fee schedules were lowered on average, especially for institutional services, but were increased for care management, home-helper services, and in-home and facility-based rehabilitation services." (Tsutsui and Muramatsu, 2005, p. 526).

By making institution-based services more unattractive, even at this early revision stage of the LTCI scheme, the policy orientation of future reforms shone through. But it also reflected the LTCI’s basic agenda of containing cost-intensive institution-based services while fostering the simultaneous and interlocked usage of community-based services and social capital.

Minor changes to the 2003 reform were the readjustment of the computer-based needs-assessment and care level placement. Patients suffering from dementia and those who were mentally ill had been solely assessed and treated by required "direct care provision" up to this point (Tsutsui and Muramatsu, 2005, p. 526), which proved to be inadequate for mental health related conditions. Consequently, a dementia-aware control mechanism for the assessors and doctors was established, which led to care level increases for patients severely affected by dementia (Tsutsui and Muramatsu, 2005, p. 526; Yong and Saito, 2012, p. 8).
2.5 Reforms of the LTCI: curtailing expenses, fostering civic engagement

2.5.2 On-time prevention: reform of 2006

Following the first ample modification of the LTCI law, the next scheduled review in 2005 brought far-reaching changes and adjustments on insurance and community levels. The first innovation was the introduction of so-called "hotel costs"\(^\text{35}\), and the second one was a further orientation towards and the introduction of new preventive measures. Hotel costs (滞在費, taizai-hi, lit.: subsistence expenses) are paid by institutionalised residents in geriatric homes to cover their consumption, i.e. electricity, gas, water, diapers and meal preparation. Hotel costs are, however, means-tested and capped for low-income individuals. These additional payments were mainly introduced for two reasons:

a) to further discourage the elderly from using long-term institution-based services in geriatric homes and relying to a higher degree on outpatient care home-based assistance, and

b) to refinance the heavily strained budget due to the high rate of institutionalisation and hospitalisation of seniors.

Driving seniors out of nursing homes was the foremost aim of this reform since institutionalisation caused threefold expenses within the LTCI funds in 2006 compared to community-based services (Tsutsui and Muramatsu, 2007, p. 1459). The difference between these two forms was significant, the per capita spending at that time for institution-based services was 308,446 yen per month and for community-based care only 100,669 yen per month (Ministry of Health, Labour and Welfare, 2006c). Control mechanisms seemed to be necessary as a disequilibrium of financial contributions, care access and social justice occurred over time, since

"seniors have had economic incentives to enter LTC facilities. [...] A monthly copayment [sic] of a resident at a 'special nursing home for older people' in 2005 ranged from $509/month (shared room) to $736 (private room)\(^\text{36}\) for which the resident received food, living quarters, around-the-clock care and safety. This copayment [sic] amount was lower than the rent and utilities for most apartments in Japan. Residents of community-based settings, such as group homes for people with cognitive problems and assisted living facilities, would have to pay $1,000/month to $1,725/month\(^\text{37}\) out of pocket for various

\(^{35}\) Hotel costs are also called "board costs" or "boarding costs" in the Anglo-Saxon literature on this subject.

\(^{36}\) Author's note: In Japanese currency the average amount was between 55,000 to 82,000 yen per month, considering the yen–dollar conversion rate in 2006.

\(^{37}\) Author's note: Accordingly, the amount is 110,000 to 190,000 yen per month.
fees, food and LTCI copayments [sic]. Entering a facility is more affordable than remaining in the community." (Tsutsui and Muramatsu, 2007, p. 1459).

Here a flaw in the LTCI act had to be dealt with in order to uphold budgets and keep social justice in balance. The flaw had led to a similar set of problems as in the pre-LTCI period: then, seniors not being able to afford nursing sought geriatric care in medical hospitals since it offered economic incentives. Now, seniors sought—partly low-level—geriatric care in geriatric homes to excess, even overrunning the rising supply of nursing homes by far.

And this is where the second major reform building block was placed. Community-based prevention measures were initiated in 2006 to further reduce the financial pressure on municipalities as insurers due to an ever growing number of receivers. The subsequent steps were the introduction of additional care prevention levels within the assessment system, which are now Support Level 1 and 2, and preventive community-based support programmes and centres. These local services offer guidance and counselling in nutrition, exercising, health and old age support related concerns to the still autonomous but fraily-prone elderly and often function as a socialising link between the community, neighbourhood and seniors. Also, trying to benefit from the precautionary aspect of maintaining the physical and mental condition of aged persons led to the incorporation of sport-oriented services, such as muscle training, into the "long-term care prevention allowance" (Shimizutani and Inakura, 2007, p. 27). Since preventive services are designed "in tandem with local government health screening schemes for older Japanese adults to promote early intervention so as to prevent costly health expenditures" (Yong and Saito, 2012, p. 278), the 2005 reform not only constituted a substantial shift towards community and prevention-based orientation of the LTCI, but also towards a system of local integration, binding local residents more closely to their respective communities and municipalities.

By realising and intensifying the already available home and community-based programmes, e.g. home care and day care, a closer interlock between formal and informal care was achieved. Nevertheless, since the aim of the 2005 reform was to lower the number of seniors in institutional care facilities, the initial shift of care duties and responsibilities towards state provided formal care was undertaken. Furthermore, a more complex, but autonomy and social interaction-oriented concept of care for the elderly was envisioned by the MHLW—simultaneously demanding and relying again on families to a higher degree in contrast to the 1997 draft of the LT-
2.5 Reforms of the LTCI: curtailing expenses, fostering civic engagement

CI law. All in all, this reform constituted a key factor in changing local social organisation and establishing stronger interaction between the agents involved.

2.5.3 Care and community: reform of 2012

Targeting the next step of prevention oriented long-term care to avoid institutionalised and intensive nursing, the reform bill of the LTCI law, passed in 2011, constructs the idea of an "Integrated Community Care System" (地域包括ケアシステム, chiiki hōkatsu kea shisutemu; Ministry of Health, Labour and Welfare, 2012, pp. 21–23) and has been in effect since 2013, i.e. the start of its review processes and implementation, and should finally be implemented in 2015\(^\text{38}\). Despite the usual minor adjustments, such as fees and benefit levels for the different care forms and care levels, the new approach aims at a more flexible, needs-adjusted and community-oriented configuration of LTC as well as interlocking it with healthcare (Ministry of Health, Labour and Welfare, 2011a, 2011c). The first major step towards forming a system of integrated community care is a process of creating cooperation and collaboration between multilevel actors, i.e. better functional and work process coordination between hospitals, inpatient geriatric homes and outpatient care centres, as well as welfare services and public assistance, seniors and their families, and municipalities. Regardless of it being an enormous process of reorganisation, regional characteristics and the needs of municipalities should also receive attention in order to provide flexibility and a region-specific response to nursing demands and necessary support measures. Thus, each local government has to conduct surveys on care service usage and evaluate the demands of all elderly age groups and genders for certain services, such as community buses or grocery shopping assistance. Pilot studies conducted throughout Japan showed the feasibility of this approach and its reactivating effect on seniors with declining health and social interaction (Ono, 2011, pp. 44–47).

\(^{38}\) Due to the Great East Japan Earthquake in March 2011, and the resulting nuclear and social disaster in Tōhoku, the ensuing reconstruction procedures consumed and still consume an enormous amount of the national budget and capacity in infrastructural organisation, slightly delaying the execution of LTCI reform efforts.
Linking livelihood supporting systems more closely is indicated by the 2012 reform in terms of medical care, nursing care and the use of supportive systems and social capital in order to integrate the "spheres of daily life" (Ministry of Health, Labour and Welfare, 2011a, p. 18) into a comprehensive system to ensure the safety and livelihood of seniors and their families, although the MHLW already understands the LTCI's role partly as a creator of spheres of daily life.

Yet, deeper linkage of the aforementioned spheres in order to craft more flexible, status-dependent care for the elderly appears to be faced with possible problems. For instance, it calls for the participation of active, outgoing and healthy seniors to establish, assess and select the variety of services provided, although care managers and families act as remedial assistance. Still, it connotes this possibility only to those with a low level of support or care level assessment since their social networks and community ties are intended to provide a measure preventing further care. More important seems to be the willingness of the community, i.e. the neighbourhood, to provide support. Public and formal care facilities and institutions, as well as their employees, receive financial remuneration for their continuous and often physically and mentally exhaustive work, while informal care by the family in Japan is not remunerated, nor is preventive support given by volunteers and neighbours. In fact, informal care has its downsides not only because it is not recognised as a profession, which is a stressor itself, but also because it ties up human resources. In particular, informal care curbs the regular labour participation of women and leads to citizens rearranging their life courses around institutions and policies\textsuperscript{39} (Estevez-Abe and Hobson, 2015; Rhee \textit{et al.}, 2015; Schneider \textit{et al.}, 2013; Shire, 2015; van Houtven \textit{et al.}, 2013).

Volunteering and community support measures are already visible, e.g. the preparation and delivery of meals, cursory health condition checks and grocery shopping by neighbours and volunteers who visit occasionally. Formalisation of these activities has proved to be valuable, in particular in areas of the Japanese countryside with remote and scattered hamlets and houses. Evidence illustrates that the NPO law, which was enacted in 2000, fostered the materialisation of social and community entrepreneurship in Japan's rural regions (Defourny and Kim, 2011) as formal "legitimation

\textsuperscript{39} Unlike in Germany, informal care given by the family does not benefit from cash allowances in Japan. This, however, is a heavily criticized incentive for women to abandon their careers and retain the "traditional" role of a nurturer and carer.
may be the [emphasis in original] key resource for new groups" (Pekkanen, 2003, p. 119). While this certainly is true, it also marks a development in democracy and a consideration by a conscious civil society that allows for civic participation. The law "was a negotiated process whose outcome depends on political culture, value preferences and attitudes of those involved. Citizens have increased public awareness and become active in areas neglected by the state and the market" (Hein, 2011, p. 528).

In this regard, the comprehensive community care, as intended by the latest reform, promoting and encouraging collaboration with local communities in order ensure the elderly’s livelihood might mark a smart move by the MHLW since:

"Japanese neighborhood associations are effective in the provision of social capital. Their organizational infrastructure and networks provide a bulwark that mitigates enfeeblement and loneliness. Together, these factors ameliorate the effects of the ageing society. In this context at least, NHAs are effective 'problem-solves' [sic] for the state" (Pekkanen and Tsujinaka, 2008, p. 718).

More than that, volunteer work in Japan is a highly community-based activity and local support of one's own community through volunteering is the main reason for the majority of volunteers to engage in these activities40 (Zenkoku Shakai Fukushi Kyōgikai, 2010, p. 225).

Yet, on the other hand, it also illustrates that volunteer work is not in particular deemed as a gap-filler for the social security systems, nor as a moral obligation. Volunteering is "seen as an individual choice, a reflection of personal principles, rather than a function of bonds of duty or obligation" (Nakano, 2005, p. 14). As such, volunteer work is a lifestyle decision that, judging from my own fieldwork experience in care for the elderly, is deliberately made by housewives and retirees. Nevertheless, by trying to harvest the yield of an active civil society by trying to engage the community in care activities, the acceptance of such an intrusion into matters that might be considered private has to be considered since the "deci-

40 One thousand volunteers were asked, and in multiple answer questions 36.3 per cent replied that "地域社会とのつながりをつくることができた" (chiiki-shakai to no tsunagari wo tsukuru koto ga dekita), which translates as they "could establish a link to their regional community". The other top-ranking replies are "I made many friends" (多くの仲間ができた, ōku no nakama ga dekita) with 31.1 per cent and "the activities are fun" (活動自体が楽しい, katsudō jittai ga tanoshī) with 31.0 per cent.
As regards the recent completion of the latest reform, the outcome of both the 2005 and the 2012 reforms has an ambivalent assessment: the process of municipal implementation needs elaboration and their results are complex (Hayashi, 2015; Tsutsui, 2014). A neighbourhood watch for social and health issues had, despite broad acceptance by municipalities, many issues on the interpersonal level, which resulted in "both embarrassment and stigma experienced by recipients of this model for cost-free neighbourhood visiting and support by volunteers" (Hayashi, 2015, p. 19). However, the mobilisation of volunteers with a "reward scheme" has attracted many (aged) volunteers to conduct activities with their frailer peers to supplement LTC services—which they would have conducted even if there were no rewards (Hayashi, 2015, pp. 18–19).

Despite that, this reform, like that of 2005, constitutes an important step away from passivity towards activity. Started as a rather passive system, in which the assessment of patients is awaited and then they are placed into nursing facilities, the LTC scheme has been transformed through reforms into a proactive arrangement of several cogwheels to enable the elderly’s livelihood, prevent age-related medical and social issues, and enhance healthy ageing in a familial environment while curtailing expenses. Approaching and embracing the already strong civic engagement in Japan could turn out to be an ingenious approach to safeguarding the elderly’s livelihood, especially in rural Japan, or be regarded as cynical exploitation of unpaid, benevolent and philanthropic labour, once again evoking a link to the creation of a nihon-gata fukushi shakai.

2.6 Consequences of the LTCI and the effects of day care

Judging the outcome of the LTCI scheme more than a decade after its initiation, we can discern a rather ambiguous picture, which becomes clearer if the various angles of medical, political or social impact are considered.

First of all, the main political and financial purpose of setting up and providing opportunities for formal care, expelling geriatric patients seeking care from hospitals and stemming exploding social insurance expenditure was met. Hence, as a direct consequence of this supportive measure, families and seniors were and are largely relieved of the familial dilemma of being caregivers and caretakers. Inter and intra-generational disputes
2.6 Consequences of the LTCI and the effects of day care

and conflicts arising from the crucial question of who actually should take care of aged family members were curtailed as well. This topic, which comes up among the children, especially often in controversial discussions among siblings, and self-evidently also the spouse and remote relatives, concerning the hierarchy of care and their individual contributions has, however, one simple answer: women (Figure 2-7 and Figure 2-8). Eldest daughters and daughters-in-law are the main caregivers for their parents’ generation and wives the main caregivers for their coeval generation. It indicates the continuous propagation of values and norms of the pre-war ie-system, the societal normative of gender disequilibrium and the persisting notion of women as nurturers and caregivers and men as breadwinners. Recent studies, however, indicate a decline in filial care obligations (Tsutsui et al., 2014). Despite this vast gender gap in societal and familial caretaking responsibilities, regularly placed on career-oriented women, the LTCI seems to provide:

– opportunities for families to mitigate care burdens by outsourcing health and nursing responsibilities to public institutional set-ups,
– options for seniors to temporarily leave and interact outside their old, established and, quite possibly, socially restricted environment, and also
– opportunities for the elderly to evade familial conflicts arising from differing moral concepts of filial duties between parent–child–grand-child generations, such as financial, social and nursing support as well as a sense of guilt for burdening the family.

41 Quite frequently, it is also combined with the issue of inheritance and succession, especially in rural areas, see e.g. Tsutsumi (2001).
42 A study among old people with disabilities (n = 5,938) revealed that approx. one third (34.2 per cent) of the informal caregivers were depressed. The reasons for depression among those caregivers could be broken down to the characteristics of "female, income inadequacy, longer hours spent caregiving, worse subjective health, and co-residence with the care recipient" (Arai et al., 2014, p. 81).
Figure 2-7: Main caregivers in Japan, left

In this regard, the LTCI and day care especially constitute an enormous leap towards self-determination and autonomy for the elderly and their families by providing a choice of desired services and applicable nursing, and unfolding their positive effects on social life and interpersonal interaction.

Besides the advantage of LTC services within the social environment, the results of medical benefits are fuzzier. Several research projects have assessed the prolongation of life and the promotion of functional bodily and mental improvements using care programmes and activities. Elaborating in more detail on the distinguished LTCI branch of day care, it turns out that, from a medical viewpoint, an assessment of its effects provides conflicting study results, although the general tendency seems to underline a positive outcome.

The beneficial effects of day care are indicated on various levels of daily life and with an impact on patients’ physical and mental health. Day-care visits are revealed to have a direct medical influence on the users’ di-
etary balance, the enhancement of nutritional performance and more balanced blood levels (Nishiwaki et al., 2007, pp. 19–20). Furthermore, study results show a decrease in depression, functional improvements in daily life activities (ADL) and a strong reduction in mortality rates among the users of day care for the elderly (Kuzuya et al., 2006, pp. 1368–1369). Furthermore, the findings reveal that this decrease in mortality rates is especially strong among younger elderly people (65 to 74 years) and less accentuated among higher age groups of 75 years and above. However, the positive effect of day care usage is likely to affect younger seniors to a higher degree since their first contact with LTC and day-care services was established early on in their senescence, while their mental and physical health is still on an elevated level and higher compared to those of older groups who make use of day care. Therefore, day care’s beneficial effects may continue to last for elderly people aged 65–74 years while they age as their health status will still allow for remediation in contrast to frailer, older groups.

Contrastingly, more recent comparative approaches between two major branches of the LTCI, day care and home help, indicate that day care has no significant advantage in improving ADL or actually lowering mortality rate levels (Ishibashi and Ikegami, 2010). On the contrary, home help services seem to provide better results concerning ADL, hinting that seniors fare better when receiving care from an external influence in familiar physical and social surroundings.

Although results for medical and functional improvements produced by the LTCI appear to be mixed (Tamiya et al., 2011, pp. 1186–1187) or not convincing enough as the benefits of certain care forms are debatable (Ishibashi and Ikegami, 2010), the general tendency of old-age welfare research points towards expansion of quality of life, prevention and containment of age-related diseases as well as maintenance of the actual level of livelihood and mobility (Kono et al., 2012, pp. 307–308; Stuck et al., 2002, p. 1027; Tsutsui and Muramatsu, 2007, p. 1462; Ukawa et al., 2012, p. 561; Yamada and Ikegami, 2003, p. 241). Besides this, since long-term hospitalisation and institutionalisation of the frail elderly are largely avoided, the social risks of isolation and social deprivation are also tackled (Tomita et al., 2010, p. 346).

Furthermore, as long-term medical treatment and institutionalised care in nursing homes are responsible for vast expenditure in the healthcare and LTCI budgets, preventive measures, such as home visits and day care offered by the LTCI, not only enable functionality, mobility and indepen-
dence among the elderly, but also curb expenses in intensive medical treatment and care home usage (Kono et al., 2013, pp. 579–580). Not surprisingly, this was one of the main policy goals of the LTCI reform in 2005, which aimed at both the prolongation and maintenance of the individual’s self-reliance in a self-controlled environment and containing rising care-related expenses, thus killing two birds with one stone.

Nevertheless, while an enormous range of literature focuses on analyses of old-age welfare systems and the assessment of medical, financial and political outcomes, two crucial subjects are rarely brought up. One is the effect of lighter LTC services, such as home and day-care visits, enhancing and enriching the social environment of frail seniors, which is gradually deteriorating due to the ageing process. By providing new geographical and social surroundings, fresh acquaintances, sensitive contact persons and entertaining activities, LTC services give seniors the opportunity to engage in social interaction, recreate their self-perception and design their own last phase of life. This social and individual aspect of LTC is pivotal in enabling the livelihood and well-being of seniors and their families, and enhancing their subjective perception of social life. Secondly, regional differences of welfare institutions for the elderly did not find their way into literature until recently, i.e. spatial differences between the availability of, access to, execution of and eventually interlocking between direct care and peripheral, supportive care and aid institutions for the elderly. Although the LTCI is stipulated nationwide, local governments exercise adjustments within their scope of discretion and create community projects with differing degrees of success. Deriving from conducted qualitative research, both issues, spatial disparities between care institutions and social interaction between patients and welfare institutions—a major interest of the elderly who are lacking familial and social network support—do matter and will be covered in the following chapters.
3 Ageing in peripheral Japan: flowers, care and social meshes

Blooming cherry trees lined the busy Sumida River, and the first *hanami* festivals had been celebrated cheerfully in the mild weather of the upcoming spring when I left the eastern part of inner Tōkyō for the city of Komagane in the Nagano prefecture (駒ヶ根市, *komagane-shi*). I had compared Komagane with other smaller cities beforehand and eventually selected it as an ideal representative of Japanese rurality. Since rural areas are regularly perceived as antitheses of the superior infrastructure of metropolitan areas, resulting in greater mobility as well as greater accessibility to care facilities for the elderly, Komagane turned out to be a far more interesting city than expected in my pre-fieldwork research.

3.1 *The city between the two Alps: Welcome to Komagane*

Geographically located in the rural south of the mountainous Nagano prefecture in central Japan, Komagane lies in a valley surrounded by foothills of the Southern Alps and the Central Alps. Situated in the middle between the former capital, Kyoto, and the current one, Tōkyō, Komagane has a geographical and administrative size of 8.1 km from north to south and 25 km from west to east, encompassing a perimeter of 75.8 km and an expanse of 163.53 km². In 2013, this vast area was populated by only 32,980 citizens (Komagane Shiyakusho, 2014).

Komagane gained its city status on 1st July 1954, when the surrounding villages Akaho-machi (赤穂町), Ina-mura (伊那村), Miyada-mura (宮田村) and Nakazawa-mura (中沢村) were merged by virtue of reforms towards administrational convergence and economic reconstruction plans following the Second World War\(^43\). Although amalgamated half a century ago, today’s geographical and infrastructural borders between the areas are still perceptible as ‘big green patches’ among agglomerations of residential and commercial districts.

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\(^{43}\) Miyada-mura was phased out and became independent again on 30th September 1956 after protesting against the merger and loss of administrative responsibility.
Like many rural and peripheral cities in Japan, Komagane has its downsides when it comes to transregional public transit, which is particularly tangible when you are trying to reach the city via public transportation only. A bullet train connection, the *shinkansen* (新幹線), associated by rural areas with an economic upturn or at least as having trans-local importance, does not exist. Whereas an hourly operated local train runs throughout the whole Nagano prefecture from Nagano City (長野市) in the north to the southern city of Toyohashi (豊橋市) and comprises the rather deserted one out of two options for public transportation users. The other one is the usually jammed highway bus (高速バス, *kōsoku basu*), operating between major cities and Komagane. The bus, despite heavy traffic in the metropolitan areas, reaches Komagane in 3.5 hours, while the train option, a stop-over connection with a *shinkansen* and a local train, requires a little more than 4 hours.

Arriving at Japan Railways Komagane Station or the close-by Highway Bus Station, a passenger who is not familiar with the city is confronted with two issues—surprisingly chilly temperatures and the nearly non-existence of short-range public transportation. Although a local bus line existed (駒ちゃん, Komachan), the frequency and service area was vastly limited. With a cycle time of once to twice an hour at the most, only serving major parts of the geographically widespread city while omitting less populated districts, the bus was educating commuters in patience. Actually, this service was discontinued one month after my arrival due to huge financial deficits through non-usage. Simultaneously, an on-demand bus service was established to more appropriately serve remote districts and meet the needs of the major bus users, the elderly. Although it was mainly aimed at the mobility needs of the senior population and those without a driving licence by providing a flexible on-demand departure schedule, limited resources and availability hindered its satisfactory execution. A female pre-day care user (Patient #18, 17.05.2013) explained that she once

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Regional, public infrastructure in general is well established. Due to "substantial governmental subsidies and assistance, the quantity and quality of public infrastructure services in such cities has been much better for a long-lasting [sic] time than one would expect" (Feldhoff, 2013, p. 101; see also Matanle, 2011, p. 830), but has already started to deteriorate "dramatically as the central government has cut tax transfers and subsidies in the aftermath of the decentralization and regional policy reform" (Feldhoff, 2013, p. 101, citing Machida 2007). Actual figures underline the fact that subsidisation by the national government is declining while income through communal tax is increasing (Tobita, 2015, p. 31).
relied on the on-demand bus service for a quick city visit to shop for groceries, but then had to wait one hour for its arrival—and in the meantime, after taking a nap and doing some gardening, completely forgot about her appointment and had to rush when the bus driver called on her in her driveway. Other, mostly female, seniors reported their reluctance to contact a previously unknown service, while some seniors rather expressed curiosity and willingness to try it out. However, this is an exemplary case of seniors' mobility in rural places, especially of the frail and those without a driving licence for cars.

The strong reliance on vehicles in Komagane cannot be only understood as an expression of luxury and joie de vivre, but also as a necessity to take part in daily life. It leads to circumstances in which families possess four or five vehicles per household, or one for each family member\textsuperscript{45}. But it also shows that the elderly, required to take a driving capability examination from the age of 75 on, are at a disadvantage in a widespread rural environment that requires mobility.

The meagre provision of public transportation is an obstacle for elderly people in their daily activities. Especially in regard to the typical element of areas considered rural, in which the agglomeration of services which fulfil daily needs, i.e. restaurants, supermarkets, cleaning services etc., tends to be located alongside heavily frequented roads and are not within a central complex such as train stations, as is the case in many Japanese urban spaces. Komagane has three main roads with a high volume of traffic during the daytime. Two of these three busy roads are "highways" (with an inner-city speed limit of 40 to 50 km/h) running in a north–south direction and connecting regional cities, with the remaining one crossing both and linking them to the Inter City Express Way (Komagane IC) towards Tōkyō and Kyoto. It also leads to the tourist area of Komagane Kōgen, the Highlands and its peak mountain Komagatake, which both allow for skiing in winter and hiking during summer. These three major roads are lined with the majority of shops, restaurants and service facilities. Apart from these tourist-oriented and highly commercial areas, the rest of Komagane is rather residential.

Secondary and tertiary sector occupations have dominated the recent labour market situation in Komagane, whereas the primary industries of

\textsuperscript{45} Vehicles for personal transportation in Komagane amount to 26,726 cars and 1,941 motorbikes (Komagane Shiyakusho, 2014, p. 50).
agriculture and forestry experienced a steady decline after the Second World War. Since tourism is an important source of income for the whole region today, areas closer to the Japanese Alps and main roads, and thus tourist customers, are highly coveted. In order to raise the region’s tourist value, a local "tradition" was invented in 1993—sōsu katsudon day on April 27th. On this day, which takes place close to the Golden Week, the local speciality sōsu katsudon (ソースカツ丼), an escalope in a bowl of rice covered with Worcester sauce, is sold at a bargain price to attract customers.

The 'street image' of Komagane is determined by scattered elderly individuals with crooked spines slowly strolling the deserted shotengai (商店街), the shopping promenades of the inner city. These, however, should be called "shatta-gai" (Matanle and Sato, 2010, p. 203) in order to describe the atmosphere more precisely as former pottery shops, mom-and-pop grocery stores, old-fashioned electrical stores still advertising "Color TV" by Mitsubishi, and tiny restaurants and izakaya (居酒屋), Japanese-style pubs, have been shut down and have literally closed their shutters (shatta). Komagane in this regard emanates an atmosphere that is more modern than Dore's precisely depicted rural village, but still leaves things from the past alive, especially the scramble crossing with its children’s song, where, theoretically, people could cross the street to and from every direction (Dore, 1978, p. 17)—if there were any pedestrians around. Only in the evenings does the downtown area of Komagane radiate dense activity as the remaining pubs and restaurants open up and eagerly await the working population ending their shifts. Although I was accommodated in the midtown area, my initial and sobering impression upon arrival was that of a ghost town since it coincided with the local day of rest.

3.1.1 Getting older: demographics of Komagane

When one compares and analyses the population and household development since the first statistical surveys in Komagane in 1935 (Figure 3-1), ageing and depopulation become apparent in this small city. Following the

46 The local narrative is that the taste, which is mostly based on the sauce, is different in each restaurant since long inherited recipes are used.
47 The traditional Japanese era name and calendar names the year 1935 of the Gregorian calendar as Shōwa 10 (昭和 10).
nationwide trend, demographic change took place rapidly in Komagane, first with rapid growth and even a small baby boom, which then slows and eventually results in a gradual decline in the population and households, which is conjoined with a low birth rate. The latter becomes particularly tangible in local elementary schools with classes of fewer than fifteen pupils\textsuperscript{48}. Although rather statistical and demography-based, this data expresses changes in social institutions, entailing shifting patterns of family structures, changing cohabitation as well as alterations in the reliance upon the family—or, more generally, the transformation of social cohesion and social organisation. With an ever growing aged population, the city had and still has to develop welfare and care programmes to cater to the needs of the elderly and also cope with seniors residing more and more in single-person households, who incrementally face immobility and hence the risk of social exclusion.

Figure 3-1: Population and households per year in Komagane

\begin{figure}
\centering
\includegraphics[width=\textwidth]{pop_households.png}
\caption{Population and households per year in Komagane}
\end{figure}


\textsuperscript{48} Nakazawa Elementary School, in a remote district of Komagane, copes with the burden of having small classes. One of the classes I visited consists of only two boys and ten girls.
Walking the deserted streets and visiting public spaces in Komagane, such as the well visited city library, busy departments of the city’s administration or the manifold but quite hidden parks, temples and shrines as well as the locations more rooted in daily life, e.g. mom-n-pop shops and bigger supermarkets chains, show that senescence is already a major issue in the city and will likely gain even more importance soon. Demographic statistics outline Komagane as a fast ageing city with its inhabitants enjoying high longevity—thus, it is a typical rural setting in Japan. In recent years, in fact, the Nagano prefecture proudly featured the highest life expectancy throughout Japan (Nagano Prefectural Government, 2015). This longevity is praised as a result of hard labour, fairly untouched and healthy natural environments, and salubrious nutrition. But it also poses challenges to a small but scattered city with a gradually deteriorating population and declining economy in coping with the problems of care, support and financing.
Table 3-1: Population of Komagane according to district and age

<table>
<thead>
<tr>
<th>District</th>
<th>Population</th>
<th>Ratio</th>
<th>Aged Population</th>
<th>Ratio</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Men</td>
<td>Women</td>
<td>Total</td>
<td>Men</td>
</tr>
<tr>
<td>Minami-wari</td>
<td>576</td>
<td>597</td>
<td>1,173</td>
<td>49.1%</td>
</tr>
<tr>
<td>Naka-wari</td>
<td>673</td>
<td>693</td>
<td>1,366</td>
<td>49.3%</td>
</tr>
<tr>
<td>Kita-wari 1-ku</td>
<td>1,566</td>
<td>1,580</td>
<td>3,146</td>
<td>49.8%</td>
</tr>
<tr>
<td>Kita-wari 2-ku</td>
<td>1,080</td>
<td>1,080</td>
<td>2,160</td>
<td>50.0%</td>
</tr>
<tr>
<td>Komachiya-ku</td>
<td>1,186</td>
<td>1,202</td>
<td>2,388</td>
<td>49.7%</td>
</tr>
<tr>
<td>Fukuoka-ku</td>
<td>1,959</td>
<td>2,006</td>
<td>3,965</td>
<td>49.4%</td>
</tr>
<tr>
<td>Ichiba-wari-ku</td>
<td>902</td>
<td>947</td>
<td>1,849</td>
<td>48.8%</td>
</tr>
<tr>
<td>Uwabu-akazu-ku</td>
<td>421</td>
<td>510</td>
<td>931</td>
<td>45.2%</td>
</tr>
<tr>
<td>Shimodaira-ku</td>
<td>765</td>
<td>788</td>
<td>1,553</td>
<td>49.3%</td>
</tr>
<tr>
<td>Machi 1-ku</td>
<td>543</td>
<td>595</td>
<td>1,138</td>
<td>47.7%</td>
</tr>
<tr>
<td>Machi 2-ku</td>
<td>1,744</td>
<td>1,757</td>
<td>3,501</td>
<td>49.8%</td>
</tr>
<tr>
<td>Machi 3-ku</td>
<td>802</td>
<td>850</td>
<td>1,652</td>
<td>48.5%</td>
</tr>
<tr>
<td>Machi 4-ku</td>
<td>1,036</td>
<td>1,036</td>
<td>2,072</td>
<td>50.0%</td>
</tr>
<tr>
<td>Uwabu</td>
<td>1,010</td>
<td>1,037</td>
<td>2,047</td>
<td>49.3%</td>
</tr>
<tr>
<td>Nakazawa</td>
<td>1,380</td>
<td>1,498</td>
<td>2,878</td>
<td>47.9%</td>
</tr>
<tr>
<td>Higashi-Ina</td>
<td>967</td>
<td>1,024</td>
<td>1,991</td>
<td>48.6%</td>
</tr>
</tbody>
</table>

Sum (Average)       | 16,610 | 17,200 | 33,810 | 4,041 | 4,629 | 8,670 | 26.1% |

% of Total Population | 49.1%   | 50.9%   | 100.0%          | 12.0%   | 13.7%   | 25.6%   |
The impression of an ageing city is mirrored in Komagane's demographic statistics as they feature a rear-heavy age distribution (Figure 3-2) with an average age of 45.5 years. In 2013, 27.2 per cent of the city's population were already beyond the retirement age, exceeding the national average of 23.3 per cent in the same year. Furthermore, ageing in Komagane is district-based with senescence being visible or vivid to varying degrees in the respective parts of the city. If we break down the age ratio, the various local districts exhibit a wide range of aged persons from 18 to almost 36 per cent (Table 3-1), which renders ageing issues problems of local and social organisation.

3.1.2 Still in the field: working seniors

Reaching the age of or being older than 65 years usually defines Japanese citizens as *taishoku-sha* (退職者, retirees) or, more generally, as an elderly person (*お年寄り, o-toshyori, or 高齢者, kōreisha) as the mandatory retirement age has been set at 65 years. Compared to those in the post-war period, today's elderly often experience enough financial and health leeway to enjoy a fulfilling retirement after life-long participation in the labour force. But being retired in Japan does not necessarily result in 'real' retirement, which usually evokes images of vacationing, hat wearing and camera-packed seniors travelling the world. The actual retirement age is 69.1 years for men and 67.2 for women (Organization for Economic Co-operation and Development, 2013c, p. 129).49 After mandatory retirement the elderly engage in post-retirement employment, often re-employed at the same firm with less attractive conditions (Kajitani, 2006), or community work in the local vicinity—usually as a means of earning additional income, of improving the community or as mere pastimes. Farming offers many seniors the opportunity to kill several birds with one stone: earning additional income, giving them a recreational purpose, enabling them to

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49 For the sake of comparison, the actual retirement age in Germany is 61.8 years for men and 60.5 for women with an official retirement age of 65 (depending on the year of birth), in the United States it is 65.5 and 64.8 respectively with an official age of 65 (which depends on the year of birth as well). Japan is only surpassed in its high retirement age by Iceland, South Korea and Mexico.
participate in local organisations and community projects, and maintaining their health.

Table 3-2: Post-retirement occupation ratio of Japan's and Komagane's population

<table>
<thead>
<tr>
<th></th>
<th>All industries</th>
<th>Agricultural</th>
<th>Non-Agricultural</th>
</tr>
</thead>
<tbody>
<tr>
<td>Japan</td>
<td>10.23 %</td>
<td>48.20 %</td>
<td>8.84 %</td>
</tr>
<tr>
<td>Komagane</td>
<td>13.10 %</td>
<td>57.65 %</td>
<td>9.46 %</td>
</tr>
</tbody>
</table>

Source: Own calculation, data by Komagane Shiyakusho, 2014; Ministry of Internal Affairs and Communications, 2013.

Note: Forestry and fisheries not included in the categories "agricultural" and "non-agricultural". Calculation = working population ≥65 years / working population ≥15 years

Agricultural activities are highly 'aged professions' and a sector of immense post-retirement activities. Rural areas and paddy field rich regions, such as Komagane, feature a high ratio of post-retirement occupations and exhibit a considerable number of seniors working in the agricultural sector (Table 3-1). Although the long-standing agricultural history in Komagane is slowly fading, while the tourist sector is gaining in importance, the elderly and—more rarely—the young still work in farming. More as a supplementary rather than as a main source of income and rather as a recreational pursuit, the cultivation of vegetables and fruit is mostly done for self-sufficiency, but also characterises the rural landscape with rubber-booted, suntanned and bent-over seniors in paddy fields.

It is further rooted in the local idea of a good life and ideal death. Called pinpin korori, it can be summarised as living a vigorous and healthy life and experiencing a sudden death—preferably in the rice fields and without being a burden to someone else.

3.1.3 Well distributed: infrastructure of care for the elderly

Known for its tourist value, which Komagane entirely draws from its mountainous environment, attracting tourists and locals to group weddings on a plateau below the peak of Mount Komagatake (駒ケ岳), the more densely populated inner part of Komagane cannot be exactly described as neat or spruce, but rather as functional and inconspicuous. Besides that, tours of rural exploration per pedes, or later by bike, conveying the im-
pression of an outcast in this vehicle-centred rurality, portrayed a picture of Komagane as a city with a dense network of welfare facilities for the elderly, whose focus is in particular the core area of the city but also features scattered facilities in the outer districts. These facilities function as hubs of care for the elderly, either a) inpatient care, where seniors are admitted to and cared for in a home, or b) outpatient care, which is provided in the patient's home, or patients gather for several hours and provided with care activities. Thus, isolated and remotely located facilities do not necessarily mean that care for the elderly does not reach seniors who live even more remotely. Furthermore, almost all outpatient care facilities provide pick-up services for every patient, while they regularly struggle with Komagane's remoteness.

Remoteness is one of the typical problems of care facilities in rural areas as it decreases the time available for care duties (e.g. bathing, medical check-ups) as well as financial resources (gasoline, increased material wear of used vehicles) due to longer fetching times. Riding alongside Nakajō-san (中城), a trained medical nurse and coordinator of the city's own care prevention measure for the elderly, Honobono Club Mini Day Care (ほのぼの倶楽部ミニ・デイケア), it took us approx. 45 minutes on a regular basis to pick up and drop off four to six patients every day. This is also the time needed for transportation for a maximum of two bedridden (寝たきり, netakiri) or three wheelchair patients in conventional, integrated day-care centres, such as Ėderu Komagane (エーデルこまがね). The rather obvious explanation, given by the two accompanying day-care workers of Ėderu Komagane, Izuhara-san (厳原) and Yoshida-san (吉田), is the time that is spent on operating automated ramps as well as overcoming doorsteps and gravel driveways with wheelchairs and stretchers.

The locally quite balanced distribution of care for the elderly in the residential areas of Komagane is illustrated in Figure 3-3. A basic principle is that these facilities gather and cater to seniors in their vicinity to avoid further stress for patients and placing a greater burden on resources. However, due to capacity limits and seniors' preference for certain care facilities, patients from faraway districts being transported across the city cannot be avoided. On the other hand, several patients (e.g. female pre-day-care patients #18, #19, 13.05.2013) mentioned a welcomed sightseeing tour through their city—which has significantly changed since the 1950s.
However, a few of Komagane's local non-profit care facilities for the elderly pursue a different concept to other day-care facilities because they are financially incapable of providing pick-up services to all patients, i.e. they lack the vehicles and personnel. Instead, they rely on the patients’ families to bring their frail parents to the institution. The welfare NPO Komanetto Nashi-no-Ki (こまネット梨の木) is one of them, located in a former two-storey private house. While Komanetto strongly relies on the support of families, it is struggling with a recent development in a few patients' families. When the task of transporting the elderly was handed over to families, some of them learned to use this 'loophole' in their favour and exploit care hours, as the leader of the facility, Takeuchi-san (竹内), ex-
plained, by disregarding the official operating hours and putting staff and family members under increased stress.

3.2 Inclusionary meshing: the institutional set-up for rural elderly welfare

Located between foothills with its underdeveloped but typical public transportation infrastructure, this rural city at first conveys the impression its organisation of care for the elderly is not balanced or even outstanding. My pre-fieldwork investigations, a prerequisite to gaining early access to field sites, professional contacts, patients and an accepting landlord, had revealed only few useful results and left me rather concerned, mainly due to the absence of responses from the care institutions I had contacted—a quite different experience than that in Tōkyō\(^5\) Nonetheless, during the first week after my arrival, extensive and intensive door-to-door canvassing resulted in meetings with several care facility coordinators, on which this research project is based, and led to promising and fruitful access to resources and facilities. It was only much later that the full scheme of the organisation of care for the elderly began to emerge as a surprisingly well developed system of entangled meshes of elderly welfare. Beginning at the level of informal and social institutions, these meshes merge intergradually with levels of more highly formalised institutional arrangements—while struggling with resources and finances.

What exactly are these meshes and what is their *modus operandi*? With the introduction of the LTCI, a gradated system was put in place to meet the requirements, special circumstances and health status of the elderly seeking care. This system was enhanced over time and currently spans seven levels of care, divided into supportive measures and actual care (see last chapter for a detailed description). However, these are not just discrete layers, but exhibit an interlocking effect and transition smoothly into higher levels of care and dependency as patients’ physical and mental health decline. These transitions within the LTCI system are legislatively for-

\(^5\) Only later did several care management and staff members mention in informal conversations that they were concerned about or even uncertain what to think of or what to do with a foreigner in their very own care facility among all the frail and demented elderly patients. I encountered this uncertainty regularly during my entire fieldwork in rural and urban care facilities for the elderly.
malised and are meanwhile socially accepted\textsuperscript{51} parts of a bigger social security net.

\textit{Figure 3-4: Meshes of elderly welfare with Komagane's own and LTCI programmes}

\begin{itemize}
\item \textbf{Community Projects} (Komagane)\hspace{1cm} Neighborhood watch \hspace{1cm} ocha-nomikai \hspace{1cm} saron
\item \textbf{Preventive Measures} (Komagane)\hspace{1cm} Mobility services \hspace{1cm} Living support \hspace{1cm} Elderly Re-activation
\item \textbf{Preventive} (LTCI)\hspace{1cm} Health awareness \hspace{1cm} Nutrition Counselling \hspace{1cm} Gymnastics
\item \textbf{Day Care} (LTCI)\hspace{1cm} Rehabilitation \hspace{1cm} Light care \hspace{1cm} Social interaction
\item \textbf{Institutional Care} (LTCI)\hspace{1cm} Total care \hspace{1cm} Medical treatment
\end{itemize}

Source: Own representation.

These meshes constitute the fundamental framework of prevention and elderly care in Komagane. The subsequent parts of this study will depict the respective meshes, focusing on the city's own approach, the everyday experiences of the elderly and the gradual transfer from one mesh to another as seniors’ capabilities decline, by revealing the underlying social organisation of the community and the city's efforts to foster and establish civic engagement and support.

\textsuperscript{51} Utilising social welfare and elderly care welfare was considered a social stigma in the post-war period up to the late 1980s and only recently became socially accepted (see also Yong and Saito, 2012).
3.2 Inclusionary meshing: the institutional set-up for rural elderly welfare

3.2.1 Centralised: organisation of care

The guidelines and specifications for welfare for the aged are set on the national level and implemented top-down to the level of municipalities, but nonetheless grant local governments certain discretion in policy execution. This discretion comprises an efficient instrument for communities in handling 'unusual realities', such as locally extraordinarily high ageing, infrastructural inferiority, the remoteness of hamlets and budgetary bottlenecks. Addressing and trying to overcome those 'unusual realities', rural and small municipalities frequently pursue progressive and experimental approaches, often exceeding the pre-specified scope of laws, regulations and political agendas with self-developed and situation-adjusted programmes.

Welfare for the elderly in Komagane is centrally coordinated by the Citizens' Welfare Department of Komagane's city hall (駒ケ根市役所民生部, Komagane shiyakusho minsei-bu), which was recently relocated in a newly edified modern building opposite the grey concrete town hall, and now also houses the examination committee for LTC applicants. The general welfare programme for the elderly follows a model designed to enable livelihood and is aimed at revitalising and activating the elderly and enhancing their mobility. Pivotal pillars in these programmes and initiatives, their execution and (re-)assessment are the so-called Welfare Plans. Currently in its fifth iteration, the triennial Komagane Welfare Plan for the Aged (駒ケ根市老人福祉計画, Komagane-shi rōjin fukushi keikaku) denotes agendas and actions based on surveys conducted on elderly households as well as aged citizens. These surveys explore certain aspects of living circumstances of aged persons, e.g. activities of daily living (ADL), financial status, means of transportation and use of care services for the elderly. The effort that Komagane's Citizen's Welfare Department puts into compiling a representative survey is quite astonishing\(^{52}\).

Following the mission statement by the national government (Ministry of Health, Labour and Welfare, 2002a) with the aim of creating an inclusive and cohesive society beyond all generational bounds, the Komagane Welfare Plan, an in media res publication, pursues a twofold aim:

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\(^{52}\) For the current Welfare Plan, 953 elderly citizens were surveyed, comprising approx. 10.4 per cent of all 9,123 aged citizens in Komagane.
– improvements to transregional and local administrative structures and processes of service provision and service interlocking
– the enhancement and establishment of supportive measures for the elderly, i.e. prevention and care.

The necessity of a consistent and comprehensive framework for the elderly’s livelihood is elucidated by the currently 33 of 56 welfare facilities in Komagane which are particularly oriented towards the needs of the elderly. This point is further stressed by the fact that 23 of all care facilities for the elderly were established at a high frequency in or after 2000, with the enactment of the LTCI law (see Appendix). Although the legal implementation of care for the elderly has increased and secured the flow of finances, the vehemence of senescence in Komagane is indicative of the needs in an ageing society.

These 33 facilities for the elderly are already established institutions within the given legal framework of care for the elderly. However, the major points of action in the welfare plan make clear that besides the continued operation and expansion of these facilities, the city’s administration is also focusing on other aspects (Komagane Minsei-bu Hoshō, 2012, pp. 1–5):

1. Provision of a worthwhile life in old age and stimulation of social participation
2. Health maintenance and care prophylaxis
3. Support for seniors’ independent living
4. Assistance for demented seniors
5. Aid provision for in-home care
6. Estimation of the needed amount of LTC services and measures to secure access to LTC services
7. Guarantee of proper access to LTC services and administration of the LTCI

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53 高齢者の生きがいづくり、社会参加の推進 (Kōreisha no ikigai-dsukuri)
54 健康づくり・介護予防事業の充実 (Kenkō-dsukuri / kaigo yobō jigyō no jūjisusu)
55 高齢者の自立支援 (Kōreisha no jiritsu-shien)
56 認知症高齢者の支援 (Ninchishō kōreisha no shien)
57 居宅における介護者の支援 (Kyotaku ni okeru kaigosha no shien)
58 介護保険対象サービスの利用見込みと供給量の確保策 (Kaigo hoken taishō sâbisu no riyōnikomi to kyōkyūrō no kakuhosaku)
59 円滑な介護サービスの提供・介護保険の運営 (Enkatsu-na kaigo sâbisu no teikyō / Kaigo hoken no unei)
3.2 Inclusionary meshing: the institutional set-up for rural elderly welfare

An integral part of the fourth to the seventh aim is the implementation and guaranteeing of strictly legal terms of the LTCI law, while the second aim is tailored towards the preventive orientation of the last two LTCI law reforms. These aspire to curb age-related diseases by initiating and putting a focus on preventive measures. Ideally, later life phases will be less burdensome for the elderly as health can be maintained longer through preventive action, but the ulterior motive is fiscal policy as care-related expenses are always rising. In Komagane, LTCI expenditure has overtaken developments on the national level by approximately twenty per cent and are expected to even grow further (Figure 3-5 and Figure 3-6).

Figure 3-5: Long-term care insurance expenses per user (in yen)

From the viewpoint of prophylaxis as later-life relief and cost containment, the broad approach (but also less measurable outcome) of the first and third aims is noteworthy. The intricate living circumstances in the many remotely located hamlets and scattered houses as well as the increasing number of single-person households in Komagane leads to the respective citizens being left exposed, which renders supportive measures


Note: Care services at home and outpatient care are subsumed under ambulant care.
absolutely necessary but also hard to implement. In many cases, these measures have to take effect, even before the eligibility of the LTCI law has been reached, in order to ensure the livelihood of those seniors. Furthermore, from a budgetary perspective, preventive measures are necessary in order to contain above-average social security spending in a below-average tax income situation due to the high number of retirees in rural areas.

Figure 3-6: Number of users per 100 of those insured and per LTCI category


Note: Care services at home and outpatient care are subsumed under ambulant care.

Seniors in single-person households especially encounter several issues in their daily life, often experience a lack of reliance onto their family and, consequently, they feel insecure. Of all the seniors in Komagane who live alone, 22.1 per cent stated that they do not have any family members within a perimeter of thirty minutes, who could provide assistance or help in
The greatest fear of those seniors is a domestic accident in general, but 44 per cent said that they particularly feared stumbling and falling. Furthermore, a sudden decline in health decline and proneness to illnesses, with 35.2 per cent, underline the deep uncertainty they experience by living alone (Komagane Minsei-bu Hoshō, 2012, Part 3: 17-18).

Consequently, the necessity of initiating supportive measures is clear as the seniors affected are not yet eligible to utilise LTC services, but on the other hand require support as their livelihood might be endangered through the risks of living alone. 'Mobility' especially constitutes a main area for improvement as seniors with 56.3 per cent and 31.0 per cent stating they are highly reliant on automobiles as drivers and passengers respectively during their time outside home (外出時, gaishutsuji), while 40.5 per cent rely on walking (徒歩, toho) (Komagane Minsei-bu Hoshō, 2012, Part 3: 5).

The competent authority for the Welfare for the Aged sub-department of the Welfare Department, Sakai Hiromichi (酒井 宏道, 31.05.2013) stated in an interview that although Komagane receives funding from the national and prefectural government for the LTC services for the elderly, it established additional prophylaxis and mobility services on its own by using the city's tax revenue. These services are primarily intended to support elderly households in general and single-person households in particular. The number of elderly persons living alone is surprisingly high and problems are indicated in this area. In a citywide survey conducted in 2010 among Komagane citizens of 65 years and above, 10.9 per cent stated they lived in single-person households, 32.7 per cent in an elderly-couple only household, and 55.6 per cent continued to live with their family (Komagane Minsei-bu Hoshō, 2012, Part 3: 5).

Multiple-choice replies were possible in response to the question of "日常生活においての心配ごとについて" (Nichijō seikatsu ni oite no shinpai koto ni tsuite) [What are your concerns about everyday life?] and "健康がすぐれなかったり病気がちである" (Kenkō ga sugure nakattari byōki gachi de aru) [I will suddenly lose my health and become ill often] and "外出時や部屋の中で転倒や事故" (Gaishutsu-ji ya heya no naka de tentō ya jiko) [I will trip and have an accident while being outside or in the room].

Multiple-choice answers were possible.

60 The original question was "30 分以内に駆けつけができる親族" (30-pun inai ni toketsuke ga dekiru shinzoku) [Are there relatives that could come over within 30 minutes] with the reply "いない" (Inai) [No].

61 Multiple-choice replies were possible in response to the question of "日常生活においての心配ごとについて" (Nichijō seikatsu ni oite no shinpai koto ni tsuite) [What are your concerns about everyday life?] and "健康がすぐれなかったり病気がちである" (Kenkō ga sugure nakattari byōki gachi de aru) [I will suddenly lose my health and become ill often] and "外出時や部屋の中で転倒や事故" (Gaishutsu-ji ya heya no naka de tentō ya jiko) [I will trip and have an accident while being outside or in the room].

62 Multiple-choice answers were possible.
gane Minsei-bu Hoshō, 2012, Part 2, 3). However, Komagane is trying to promote self-reliance and independence among the elderly.

In this regard, Komagane has initiated two meshes in support of the elderly’s livelihood that are located before the actual up-take of LTC services and are aimed at supporting seniors with ADL. The entry-level mesh strongly utilises informal components as supplemental elements of the elderly’s livelihood, while it tries to (re-)establish social networks within communities and neighbourhoods and foster mutual support if necessary. Social ties within neighbourhoods cannot be taken for granted and 13.2 per cent of the elderly in Komagane have no contact to their neighbours (Komagane Minsei-bu Hoshō, 2012, Part 3: 18).

The core aim of the second mesh is to enable social participation by providing activities oriented towards inclusive life phase organisation, i.e. supporting access to mobility services and to activities that foster social interaction with peers.

However, as a model of inclusionary programmes and activities, the main purpose of the LTCI and local preventive programmes is to curb the extraordinary levels of ever rising elderly welfare expenses—on both a national and local level. For Komagane, a typical representative of local and bottom-level administration, welfare expenses per person and pro rata recipients recently reached and outpaced the national development (Figure 3-5 and Figure 3-6). The underlying result is that although innovative and experimental approaches to welfare for the elderly exhibit the effect of continuously integrating and activating seniors, and often enabling their livelihood, at their core these measures are publicly disguised examples of cost containment and countermeasures against the expected shortage of care labour. The latter, exposed by the versatility of care workers required daily in task execution, is partly overcome by heavy reliance on volunteer helpers for a multitude of supportive tasks (talking, driving, cooking and feeding).

63 The answer to the question "近所の方とのつき合いについて" (Kinjō no kata tono tsukiai ni tsuite) [Do you have a relationship with your neighbours?] was "つき合いはない" (Tsukiai ha nai) [I don't have any relationship].

64 Care workers (ケアワーカー, kea wâkâ) are actually Certified Care Workers (介護福祉士, kaigo fukushi-shi) and have to be distinguished from medical nurses (看護士, kango-shi). While the latter undergo a more thorough examination and apply medical treatment to patients, care workers are assigned care-related tasks, whether in pediatric, handicapped or geriatric care. So, not only do they have less responsibility compared to a nurse, but also a lower salary.
3.2.2 ... but outsourced: the interlocking of Shakyo and the city's Welfare Office

The first and by far most intensive involvement in elderly welfare in Komagane was quite unexpected at the time I began my fieldwork, but less surprising in retrospect. A serendipitous stroll led to the Fureai Center (ふれあいセンター), a host facility for recreational activities for seniors, located centrally by a major road and established to foster contact, exchange and mutuality—an idea on which its name is based, literally a "centre for connectedness". This very centre is run by the Komagane-shi Shakai Fukushi Kyōgikai (駒ヶ根市社会福祉協議会), the local social welfare council, commonly abbreviated as shakyo.

As non-governmental organisations, welfare councils have a special standing within the administrative and hierarchical structure of both the Japanese welfare system and that of local governments. As well as other forms of civic interest groups, such as the ubiquitous neighbourhood (隣組 tonarigumi, 町内会 chōnaikai) and influential agricultural associations (農業協同組合, nōgyōkyōdōkumiai, short: 農協, nōkyō), social welfare groups constitute a tremendous body of support for ministries and local governments through their organisation of social capital and the mechanisms they employ to reach individuals (Pekkanen, 2006, Chapter 4).

Groups which focus on civic engagement represent a basic foundation of social organisation towards well-being:

"Four groups stand out as key postwar partners of the Japanese state in the field of social welfare: welfare commissioners (minsei iin), social welfare councils (shakai fukushi kyōgikai), social welfare corporations (shakai fukushi hōjin), and seniors' clubs (rōjin kurabu)" (Estévez-Abe, 2003, p. 158).

As one of the civil society groups, "social welfare councils were organized in a top-down manner so the government could 'represent' citizens in local- and national-level deliberative councils that allocate public resources" (Estévez-Abe, 2003, p. 159) and thus by law have to

"include as members the majority of social welfare providers in the locality, government officials, welfare commissioners, and medical personnel and other specialists, with no group to exceed 10 percent of the total membership" (Tsujinaka 1989: 170-72, cited from Estévez-Abe, 2003, p. 159).

De jure, social welfare councils are an instrument of local welfare implementation and resource allocation in accordance with local governments and third-party welfare providers, ideally functioning as a feedback-loop
between top and bottom and distanced from political party agendas. To put it more concisely, local *shakyo* organisations act as policy implementers and outcome indicators. Thus, social welfare councils are representatives of local needs for adjustments in welfare policy.

However, *de facto*, social welfare councils, closely interwoven with the local administration, operate as prolonged and executing semi-autonomous arms of local governments and engage in service provision with their own facilities and services. Furthermore, besides the fact that nationwide *shakyo* runs their own welfare facilities, their services are regarded as providing cost-effective pillars of the Japanese welfare regime (Estévez-Abe, 2003, p. 161).

In Komagane, the *shakyo* is closely tied to the local administration authorities by even having an office with four employees within the Welfare Department of the city hall to enhance collaboration. The main elderly welfare engagement of the local *shakyo* besides care prevention and actual care provision, lies in several activities and programmes with community involvement aimed at reciprocal social exchange and social cohesion. Community and district level projects use the strong links of the citizens to their natural surroundings as starting ground since the citizens' livelihood as farmers depended and still partly depends on it. Utilising their long-standing agricultural knowledge and also the urge to craft and preserve the natural surroundings, *shakyo* offers activities aimed at beautifying neighbourhoods, i.e. excavating and planting flower beds by incentivising the elderly with photographic documentaries as well as gardening competitions between neighbourhoods. These activities attract many seniors who compete with each other by comparing the participation rate and the number of children who help out. Another similar event, for example, is the annual *kusatori* (草取, weeding) in mid-summer, after which a joint picnic is held in front of the *Fureai Center*.

The vast majority of the city's own long-term care prevention initiatives are carried out by the local *shakyo*. These encompass programmes such as nutrition consultation, general cooking classes in the *Fureai Center* and special cooking classes for divorced or widowed men. Furthermore, exercises for the elderly are offered at the municipal gymnasium, but are mainly only attended by women as men tend to avoid mere 'gymnastics', and a meal delivery service for frail citizens was initiated with the underlying main purpose of checking the health of the recipients of the meals. Moreover, *shakyo* runs services such as the Honobono Club, a care prevention initiative.
In addition to that, four out of the 33 care facilities for the elderly in Komagane that operate under the LTCI law are run by shakyo: two day-care centres and two group homes for dementia patients.

This overview exemplifies the strong partnership between the local government and this NGO. As the social welfare council consists by law of several governmental and non-governmental experts as well as medical specialists and welfare institution leaders, it basically provides close collaboration between these actors to circumvent problems of overcapacity or insufficient provision of care services. For the local government, it acts as antennae at the operative level of elderly welfare and care so that negative developments are diagnosed early on and countermeasures might be implemented, even on a political–administrative level.

### 3.3 Let's have fun together: community projects, preventive measures and day care

In addition to the services already provided by the LTCI system, Komagane has initiated elderly support and care prevention programmes in order to further support the elderly’s livelihood. Elucidating their function and impact on seniors in Komagane, the next paragraphs will illustrate the transition from the initial mesh of voluntary pastime activities and light assistance to higher levels of support and dependency, moving from Komagane's own community projects to preventive measures, and will then shift into the LTC services of Preventive Care and Day Care (Figure 3-7).

While all four lower levels of ADL assistance and actual care are illustrated here, the most care-intensive mesh of institutional care is omitted in this chapter. This was a deliberate decision as institutional care is utmost dependent on formal care and public institutional settings with little to no leeway in autonomy, and is perceived by many seniors as "social death".

#### 3.3.1 Drinking tea: saron & ochanomikai

Community and district-based programmes constitute an essential element of preventive public health measures for local governments. After social security and public health expenditure rose vastly at the beginning of the 21st century, more and more local governments decided to address the causes rather than the symptoms and initiated public health-oriented
projects in order to raise awareness about unwholesome behaviour, intervene on the earliest possible level and eventually set up countermeasures.

**Figure 3-7: Meshes of elderly welfare in Komagane**

[Diagram showing levels of dependency with categories: Community Projects (Komagane), Preventive Measures (Komagane), Preventive (LTCI), Day Care (LTCI), Institutional Care (LTCI).]

Source: Own representation.

The focus of community projects typically lies on health and ageing-related issues, e.g. mobility and motor skills (Barnett *et al.*, 2003; Pang *et al.*, 2005) or widespread depression issues and their resulting suicidal tendencies (Motohashi *et al.*, 2004; Oyama *et al.*, 2006). Assessments of community projects exhibit high success rates and, subsequently, a decrease in problematic cases (WHO, 2013), which renders them *en vogue* showcase projects for local governments to display their progressiveness. Furthermore, as a major part of social expenditure is still consumed by the use of intensive and institutional care due to partly avoidable age-related issues, financially struggling rural and local governments, but also the Japanese national government, hope to find another means of cost containment.

The remoteness of districts and insufficient infrastructure are considerable concerns in Komagane with its expanse of 8 kilometres from north to south and 25 kilometres from west to east and 33,000 inhabitants. Meanwhile, it constitutes a promising matrix for community projects. Even though the majority of community and district projects directly target public health questions, in 2012 Komagane initiated a subtle approach to age-related problems by trying to establish *chiiki nettowāku* (地域ネットワーク), community networking. These networking projects are designed to in-
terlock into common neighbourhood association meetings and basically pursue a threefold aim:
- provision and distribution of health-related information,
- introduction of relevant contact persons and services,
- social participation through get-togethers and the renewal of neighbourhood ties.

During the twenty-minute ride to the *Kise* community, Miyazaki-san (宮崎, 26.07.2013), a trained physiotherapist in his late fifties and currently in charge of the community project at *shakyo* with another colleague, elucidates the interlocking mechanism between local associations and the city's networking project while we cross the river valley. *Kise*, although only ten kilometres away from Komagane's centre, features neither supermarkets nor any other commercial infrastructure. Instead we drive on tiny roads between paddy fields and do not encounter any person on this hot and humid summer day until we reach the community centre. The local neighbourhood welfare association (*地区福祉団体, chiku fukushi dantai*), organises monthly conventions within each community for its residents with personnel and the organisational support of *shakyo*, Miyazaki-san explains. However, *shakyo* only has the status of a guest as they are officially invited by the neighbouring welfare association to join the meeting. These procedures are necessary to preserve the rather informal set-up of common neighbourhood meetings, i.e. without a strong official or administrative influence on the general agenda or the topics of the meeting. These gatherings are thus labelled *ochanomikai* (御茶飲会, lit. tea-drinking gatherings) or *saron* (サロン, salon) and are open to every community member—but only elderly women attend, one in the company of her daughter and her newborn baby. So, the first third of the meeting is reserved for the guests, while the remaining part is for the community only, without officials or external representatives.

For this particular meeting, Miyazaki-san as a representative of *shakyo* was requested to provide information concerning the prevention of age-related issues and care measures, walking aids and household tools for the elderly, as well as health information for the hot and humid days in summer. With his colleague Shimizu-san from the *shakyo* office in the city's welfare department, Miyazaki-san informed the attendees about the support programmes initiated and provided contacts for further livelihood support consultation, after which his colleague then stressed the impor-
tance of a sufficient intake of liquids during the summer\textsuperscript{65}. A local provider of equipment for the aged was invited by Miyazaki-san as an expert to explain prices, subscription models, LTCI coverage and the handling of the tools presented, i.e. canes, bathtub seats and walkers. After this brief one hour presentation of support initiatives, we left the community centre and the group had its tea.

This collaboration between neighbourhood associations and shakyo, which \textit{de facto} represents the local government’s welfare ambitions, coincides with earlier accounts which speculate about the fact that "neighborhood associations are promoted by the government" (Pekkanen, 2003, p. 133). The process represents utilisation of the widespread neighbourhood associations in Komagane to gain access to well-branched social networks. The expected effect is the distribution of information within the neighbourhood networks, so that it even reaches those who are not yet affected by measures of prevention or care, and also those who lack the mobility or skills to obtain this data on their own. Simultaneously, the information provided and the knowledge of contact persons on the available support network may reduce uncertainty among elderly citizens. It is furthermore a process of binding and attracting concerned citizens by giving administrative and bureaucratic processes a face, namely that of the people in charge.

On the other hand, this exchange is reciprocal as shakyo keeps local communities up to date with welfare developments in Komagane and locally implemented measures as well as ideas and concerns raised between different communities, which contributes to the interconnectedness between districts. In fact, welfare representatives in each district, who have been elected, are in close contact with shakyo, exchanging data on activities, issues and meetings.

Knowing about available support programmes, elderly citizens can utilise them to enhance their livelihood by replacing their incapability with publicly provided services. Word-of-mouth recommendations are an integral part of these informational and informal campaigns, reaching seniors who are not involved in associations and committees, such as Yamada-san.

\textsuperscript{65} Insufficient intake of liquids is one of the major causes of heatstroke and death among the elderly during the commonly hot and humid Japanese summer (Kondo \textit{et al.}, 2013; The Japan Times, 2015c; Japan Today, 2015). Live tickers usually provide continuous information about heatstroke cases in prefectures and major cities during television programmes throughout the day.
in the next paragraph. She learned from a neighbour that there is something she could use that she might find worthwhile.

3.3.2 Moped grannies: elderly widows in rural Japan

When Yamada-san (patient #15) entered the Honobono Club (ほのぼの倶楽部, lit.: Heartwarming Club) with a handful of other obāchan, she looked like the other grannies—as they literally call themselves. They all changed their street shoes into more comfortable indoor shoes after they were dropped off by one of the care workers, and with obviously painful steps wobbled from the genkan (玄関), the typical Japanese foyer, to the so-called cafeteria room (食堂, shokudō), in which the daily programme of activities takes place. Yamada-san, however, unlike the others, used an oshigurama (押し車, wheeled walker) to stagger the short distance of approximately thirty metres. While walker users are not uncommon in care facilities for the elderly as roughly one fifth of the seniors who attend such a facility use them to assist their mobility, Yamada-san had a secret in her daily life, which she disclosed over the course of several meetings—to the utter astonishment of me and the care personnel. Yamada-san rode a motorcycle. Or to put it more precisely: she rode a Honda scooter, primarily not for joyous jaunts, but for necessary errands—and sometimes even covering distances of over 25 kilometres.

With her children living several hours drive away in the Kansai area of Japan, she experienced a substantial loss with her husband's passing. Not only did her lifelong companion vanish, but it also exposed her to the individual risks of ageing. Now that she is residing alone, Yamada-san is in good company in Komagane as 9.1 per cent of the elderly live in a single-person household (Komagane Shi yakusho, 2014, p. 36). Her house in western Komagane is detached and spacious with surrounding paddy fields, which are enclosed by further paddy fields and some uncultivated land. Although her house is located close to the more densely populated areas in Komagane, she experiences phases and characteristics of isolation. They are rooted in her decline in mobility, despite her autonomous and normal performance of ADL. Yamada-san never had a driving licence for cars, since it was uncommon for women at that time, as she said (#15, 20.05.2013). Nevertheless, she is used to driving her scooter and is increasingly dependent on its functionality. Walking, however, constitutes a persistent problem for Yamada-san due to her curved spine. And the next
bus stop on the usually busy Motor Road 75, connecting the tourist area of Komagane Mesa (駒ヶ根高原) with the inner city, is one kilometre from her home—and it takes her over half an hour of tool-assisted and painful walking to reach it. So, Yamada-san used her scooter and some preventive services, which she knew of through her neighbour due to the saron held in her community, to overcome this problem.

Since her mobility was restricted, she chose services offered to seniors citywide which supported her in this regard, i.e. the Welfare Taxi (福祉タクシー, fukushi takushi) if she is not in the mood to use her scooter or the weather is unsettled, home-delivered meals every other day (配食サービス, haishoku sābisu) as well as renting an oshiguruma. But since her husband passed away, she has been bothered by another issue: "okiina ie de chotto samishi desu ne... [I feel lonely in my big house...]

(66) (#15, 20.05.2013). It led to her attending the Honobono Club weekly, where other women in her group share the same desire for social interaction.

The club was initiated by the city's Welfare Department in cooperation with shakyo and functions as a hub for the promotion of mobility and dementia prophylaxis, thus curbing dementia and age-related diseases as well as enhancing the social support network for Komagane's elderly. Despite its name, the Honobono Club is a public–private service with up to 280 members per year (Komagane Minsei-bu Hoshō, 2012, Part 1: 27), regularly reaching its capacity limit with only three full-time employees and one part-time. This high demand is a result of the attractiveness of the activities it offers, such as hanami (花見, viewing cherry blossom), cooking the local delicacy goheimochi (五平餅, baked rice on a stick with a sauce made from local herbs) or having yakiniku (焼肉, Japanese barbecue), and the colloquial, often district-based gatherings and ensuing conversations. The club divides districts by weekdays, and on days when the club opens seniors with mobility issues congregate with their neighbours, spend time together and chat about common interests, such as the ubiquitous topic of local flowers, which one can encounter in every elderly welfare facility. Yamada-san joins in the club activities every Monday for the usual participation fee of 1,300 yen(67) and enjoys a full day of fun, as she says.

66 「大きな家で寂しいですね」．
67 This fee includes 500 yen for lunch, 500 yen for administration and salaries, and 300 yen for sweets, tea, drawing materials and handicraft supplies.
Picking up Yamada-san one sunny morning with the newly leased shakyo minivan, she had already been waiting beside her house and had asked for a photograph with the gajin no ojisan in front of her blooming suisen (水仙, daffodils) and suzuran (鈴蘭, lily of the valley) and was very eager to learn the requirements in order to access LTC services during our ride back to the care facility. As she revealed shortly after, she was involved in an accident which was no fault of her own; she was hit by a car when she was shopping for groceries on her scooter. While she did not suffer any physical harm, her scooter was damaged and she had to find new means to ensure her livelihood—wondering if she was already able to attend a 'real' day-care centre—as she had enjoyed the social gatherings she had had.

For widowed seniors like Yamada-san, these preventive and supportive measures contribute largely to their livelihood and enhance their well-being by widening the scope of actions they can perform. Furthermore, they extend and renew their social networks, while containing mental decline caused by isolation. Despite that, this situation laid bare the dilemma of senescence in remote areas, not by endangering seniors socio-economically, but by putting them under the strain of insufficient social exchange due to a lack of mobility.

However, Yamada-san was not yet eligible for LTC services and remained in the preventive programme of the Honobono Club in the Fureai Center. Instead, she will receive a home helper, coined 'Helper-san' (ヘルパーさん) by shakyo, who will assist her in getting cooking supplies and doing household chores for 200 yen per hour. Even though Yamada-san’s mobility has decreased even further, as has her ability to engage in social interaction, she receives assistance with ADL and her livelihood is secured by local support measures.

However, another of Yamada-san’s peers, a physically healthy and energetic woman who was eager to do the dishes and serve tea during the club gatherings, jokingly competing with my main volunteering duties and proudly sharing her moving past in which she raised her baby sister, feeding her goat milk while she was at school, and lifted several trays of dishes while carrying six bottles of beer during the time she ran a restaurant, smoothly transitioned into the next higher form of care for the elder-

68 "Yagigyū da-yo!" [I tell you, it was goat milk!] caused lively discussions about how poor the valley was in the pre-war era, the sour taste of the milk and the baby’s tolerance of it.
ly. As she gradually showed more intense traits of dementia during the time of my fieldwork, her doctor, with her agreement, decided to place her into the weekly, more frequent care prevention programme of the local day-care centre and informed the leader of the Honobono Club, Nakajosan, that this transition had taken place.

3.3.3 "Uchi de warau koto nai sa"—social isolation of the elderly

Being a foreign volunteer in care institutions for the elderly among yama no naka folks always involved the perk of meeting people who were eager to converse and share their life stories and past experiences, especially if they considered them entertaining to others, such as their fellow seniors, as well. Occasionally and quite suddenly, however, the conversation drifted towards grave and sad topics.

A female volunteer at Komagane's preventive day care organisation, the Honobono Club, herself in her late sixties, brought in the newly published book "An shite" mukashi rabu rabu ima kaigo and read out loud an anecdotal and humorous account on issues of ageing written by the Japanese medical doctor and author Hinohara Shigeaki (日野原 重明), who himself surpassed the age of one hundred in 2011. The anecdote depicted a senior striking out wildly with his walking cane and burdening his environment, while feeling like the blind but virtuoso samurai Zatōichi with his sword. While everybody enjoyed the story and dried their tears of laughter, one female octogenarian patient (preventive day-dare patient, #19, 17.05.2013) fell silent and said "uchi de warau koto nai sa... kochi, itsumo hanashitari, warattari..." [there's nothing to laugh about at home... here, we always chat and laugh...], expressing her dissatisfaction with her everyday life. Although 85 years old, she is still in good health and even works in her own hatake (畑, rice field), clearing it of weeds and

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69 Literally yama no naka translates as "in the mountains", describing the locations Komagane's seniors live in. But its actual and frequent usage by the seniors themselves is done so with an ironic smirk about being an odd hillbilly, who never left their hometown and never saw the world.

70 The Japanese book title 「アーンして」むかしラブラブいま介護」 translates as "Say Ah! Then lovey-dovey, now care", but employs a double connotation in an as it can also be understood as 'wailing'.

71 「家で笑うことがないさ。。。  こち 、いつも 話したり 、笑ったり。。。」
pulling small debris from the irrigation channels. Still sprightly and in robust shape, underlined by her red cheeks, she was born and raised in Nakazawa, the eastern and hilly part of Komagane which is dominated by steep hills and slopes with gradients of up to thirty per cent, where she now lives a solitary life. Despite her son and his wife sharing the same property with her, they live in separate houses. She also has the feeling of being separated from the outside world without a driving licence and even the next supermarket in her neighbourhood, operated by the Japan Agricultural Cooperatives chain JA Coop, is an almost unwalkable distance of one kilometre away. For this elderly woman, a godsend in her daily life is her close proximity to her son's residence and the feeling of reliance and security that it subsequently provides. Without him, she says, she cannot image how she would organise buying groceries or visits to the doctor.

Such a strong feeling of dejection and forlornness is not uncommon among the female elderly due to significant changes in their daily routine as result of ageing processes. A decline in physical strength diminishes their opportunities to experience contact to people outside their homes, while their contact to people at home fades if their husbands pass away and children establish independent households. Melancholia and depression are common 'by-products' of ageing processes, especially among persons with functional limitations (Tiedt, 2013, p. 452). However, this issue is not a solely age-related condition, but a multilevel outcome of other dependent variables, such as access to social support, quality of social interaction and mobility. In this context, depression and, subsequently, psychosomatic disorders and suicidal tendencies are significantly associated with seniors who live alone in rural Japan (Fukunaga et al., 2012).

I encountered similar trains of thought in care facilities for patients with a more severe physical and mental decline. While I was involved in a conversation between a physically disabled hundred year old woman (#30, 29.05.2013), who expressed her dissatisfaction with her inability to walk and move her arm freely due to osteoarthritis, and an overly active nonagenarian female day-care patient (#32, 29.05.2013) with signs of dementia and an infectious laugh, the topic of 'becoming a cucumber', which Long (2003) trenchantly coined, came up. While the hundred year old woman stated that she can only handle minor households tasks, such as folding the laundry, which she also did in the day-care centre with the daily washed towels, uniforms and washing mitts, her nonagenarian counterpart nonchalantly uttered her opinion on this subject: "nanmo dekinakute,
ikiru wake ga nai" 72 [If you can't do nothin', there's no way to live]. After a short pause and the response that there is nothing one can do about it ("shōganai"), the nonagenarian reacted with "atashi ha jibun de jisatsu suru kamorshiren..." 73 [I, myself, would possibly commit suicide...] and giggled, which left her interlocutor speechless.

Although this occurrence clearly is an over-the-top example of the fear of a life with gradually declining abilities, in which seniors have to cope with physical and mental handicaps and the inability to manage daily needs, it illustrates the helplessness the elderly encounter. Despite the lacking knowledge of available relief options, which in this case would be additional care benefits under the LTCI system organised by the authorised care manager, the uncertainty experienced is also a reflection of changing intergenerational behaviour and values and the difficulty of living alone. Many of the patients I interviewed uttered they had a complicated or almost non-existent relationship with their children (#23, #24, #30) or that they were residing in a single-household with less frequent opportunities for contact with others (#15, #17, #21, #26, #32).

The complicated relationship with their families results from intergenerational value differences or mere interpersonal conflicts, as this nonagenarian preventive day-care patient expressed in her discontent about her son's behaviour: "musuko ga iru-noni, nandemo tetsudai-tanondakedo, nanmo yaranakatta..." 74 [I have a son, but although I begged him to help me, he didn't do anythin']. And so she concludes that her experience of feeling isolated and need for the chance to convene with others was a result of that by stating that "uchi de samishii ne. hitori de suwattete, okyaku matteru ne... otonari-san ga amari kuranai ne" 75 [It's lonely at home. I am sittin' there alone, waitin' for visitors to come... my neighbours don't come that often] (#24, 23.05.2013). While this is a comprehensible statement of disappointment by this elderly woman who lives alone, it implies a deeper underlying dissatisfaction with intergenerational value change and the holding of the traditional belief that one has to care for one’s parents. This vexation further spreads among those seniors who enjoy regular contact

72 「何もできなくて、生きる訳がない。」Another possible translation could be "If you can't do nothin', there's no reason to live" as wake offers both possibilities.
73 「あたしは自分で自殺するかもしれん。。。」
74 「息子がいるのに、何でも手伝い頼んだけど、何もやらなかった。。。」
75 「家で寂しいね。一人で座ってて、お客待ってるね。。。お隣さんがあまり来らないね。」
with their children, as this vigorous octogenarian stated "hitori de umarete ne, hitori de nakunatte ne. shouganai" [We're born alone, we die alone. There's nothing we can do about it] (#25, 27.06.2013).

All these seniors are in an awkward predicament when they are in need of spontaneous or even regular assistance for their ADL from their families and, furthermore, cannot expect or demand such support due to their complicated relationships or separate households. But, while seniors who live alone can usually rely on moral and advisory support from their children, i.e. in administrative processes such as applying for LTC, those with below-average familial contact cannot. At least in one case, the hundred year old handicapped female day-care patient (#30) insinuated that her relationship to her children may have suffered from their incapacity or unwillingness to take on care tasks and responsibilities. On the other hand, she was happy she had the possibility of formal care that gives her the opportunity to continue living in her home with assistance, taking part in outpatient care, meeting her peers and receiving care in a senior-friendly environment.

As a matter of fact, most of Komagane's elderly citizens (63%) prefer such a typical arrangement of day care, and for even more (86%) this is the reason to choose day care as their main form of care (Komagane Minsei-bu Hoshō, 2012, Part 3: 8). Nonetheless, the motivation behind choosing formal care over informal care is not solely based on personal preferences, but also on the family as a social unit and interpersonal relations within families. If being a care burden to their family can be avoided, 61 per cent of the local elderly would rather consider institutionalisation in foster homes (Komagane Minsei-bu Hoshō, 2012, Part 3: 8).

76 「一人で生まれてね一人でなくなってね。しょうがない。」
77 「できる限り自宅に住みながら介護サービスを利用したい」(Dekiru kagiri jitaku ni suminagara kaigo sabisu wo riyō shita) [If possible, I will remain living at home and use care services].
78 「住み慣れた自宅で生活を続けたいから」(Sumi-nareta jitaku de seikatsu wo tsudsuketai-kara) [I would like to continue living in my accustomed home].
79 「家族に迷惑をかけたくないから」(Kazoku ni meiwaku wo kaketakunai-kara) [I do not want to burden my family].
3.4 Where it's at: an interim conclusion

What can be concluded here is the emergence of the two issues of social relationships and care provision. First, a value transition is perceptible between parent and child generations, but also within the generation of today’s retirees. The current working-age generation is struggling with the insecurity of labour conditions and the demands for higher flexibility even in low-paid occupations. In this regard, the importance of double-income households is increasing, which nevertheless has a long standing tradition in rural and agricultural regions. The Nagano prefecture, in which Komagane lies, not only ranks in Japan’s top ten with 63.4 per cent double-income households (Ministry of Internal Affairs and Communications, 2014d), but, due to its high ageing, signifies that care for the elderly and economic participation are not easily reconciled. Furthermore, it is crucial in intergenerational social interaction in order to maintain familial and social equilibrium, that the elderly incur the reproach of merely soliciting for care tasks. Such a feeling evokes a hierarchical relationship, which is often rejected by seniors as they still insist on their superiority within the familial hierarchy, and causes family quarrels. However, such experiences do not occur in formal care relationships as professional carers treat seniors as legally entitled receivers and paying customers rather than as patients or even supplicants, and care personnel engage with them in conversation, entertaining activities and actual care tasks.

Furthermore, there is a growing acceptance of public and formal institutions as providers of livelihood, well-being and care among the elderly. Leaving their past image and stigma of service recipients behind, seniors in Komagane, especially women, deliberately choose services they consider beneficial. The local government supports this ideational shift by providing programmes and measures to support families and seniors—and shields its budget at the same time.

Secondly, and this is closely connected to the paragraph above, there is the gradual transfer of care responsibilities in rural areas from private to public and vice versa. Elderly people in Komagane rely to a higher degree on social ties, such as family and neighbourhoods, if they need only minor assistance, such as with shopping. Despite this, the general notion is not to burden one’s own surroundings and endure life under the principle of pin-pinkorori, a local notion of a vigorous life even in old age and a sudden

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death, the equivalent of a good death\textsuperscript{80}. Living autonomously and healthily without being a burden is the quintessential concept and is reflected increasingly in above-average LTC service usage rates among the elderly (Figure 3-5 and Figure 3-6). Relying on social ties, e.g. family or neighbours, places a strain on others that one would rather avoid. But entrusting one’s own livelihood to public institutional arrangements, which one is legally entitled to and which has already been paid for by taxes and premiums\textsuperscript{81}, is considered less rude towards family members and neighbours than demanding care and nursing and less intrusive into the lives of children and siblings.

Nevertheless, in Komagane the initiative by the local government, in line with the reforms of the LTCI, sets out to establish grassroots civic engagement in care for the elderly. The meshing that is produced through the organisation of welfare tries to branch into the social sphere of communities and neighbourhoods and use their capacities and capability of social organisation to improve the livelihood of the elderly and lessen the burdens of an ageing society on each individual actor—the working-age population, the senior generation, local and national governments and their respective fiscal budgets. Involvement and commitment, however, is required by every actor.

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\textsuperscript{80} Long (2003) and Woss (1993) have both focused on the topic of a "good death" in Japan and have both come to the conclusion that it is a sudden, unexpected passing in a homely and familiar atmosphere. The opposite of a good death is a painful, insidious disease in a medical and sterile environment. Woss in particular has examined pokkuri temples at which Japanese citizens pray for a sudden death.

\textsuperscript{81} Although a co-payment rate still applies.
The 19th century writer Charles Dickens conceptualised his well-known novel, "A Tale of Two Cities", as contemporary social commentary on the discrepancy between the peasantry and aristocracy in France. While he depicts circumstances of ongoing exploitation due to aristocratic lifestyles and the eruption of the mob's anger causing society's upheaval and eventually leading to the French Revolution, Dickens uses an entangled duality in his work. The duality leitmotif concerning the 'two cities' is his comparison between Paris and London as well as the more interesting juxtaposition of and distinction between the "rich" and "poor" within each city, their respective lifestyles and social environments.

In the non-fictional 20th century, societies have changed since Dickens' literary depiction of aristocrats and peasants. Welfare regimes were established and social security systems and mechanisms were introduced as balancing and equalising measures. The dichotomy between well-off and less well-off districts in major cities, however, is still conspicuous and often demarcated by inner-city and suburban districts. The metropolis of Tōkyō features such traits. Tōkyō-to is not just one city but an agglomeration of 23 special wards (区, ku)\(^{82}\), each with its own distinct atmosphere, characteristics and historical background. Regardless of the distinctions, Tōkyō metropolis and its inner part especially, served by the famous circular subway line Yamanote (山手線, Yamanote-sen), are historically, geographically and culturally divided into two bigger areas: yamanote and shitamachi.

This divide developed over time during the Edo period as a side effect of the feudalistic estate-based society in Japan of the Tokugawa era (1603–1867), basically sorting the population according to their profession

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\(^{82}\) Tokyo-to was established in 1943 by merging the former city of Tokyo (東京市, Tōkyō-shi) and the now integrated prefecture of Tokyo (東京都, Tōkyō-fu), which had existed since the Meiji Restoration (明治維新, Meiji Isshin) in 1868, ending the reign of the Tokugawa shogunate since 1603, then known as Edo, the former name of Tokyo.
into four estates. Japanese civil and military aristocrats, the latter were samurai, resided and eventually settled in the western hilly area of Tōkyō, also in order for them to cushion the effects of the hot and humid summers, which over time was coined as yamanote, literally "foot hills" (山の手) (Seidensticker, 1991, pp. 8–9). The population with a lower social standing due to their professions as artisans or even merchants, the "official" bottom rung on the social ladder, lived in the so-called shitamachi (下町) districts, literally the "lower city", which geographically were the flat and swampy quarters in eastern Tōkyō between the Sumida (隅田川) and Arakawa (荒川) rivers—a hub of commerce and trade in early Tōkyō.

Although almost 150 years have passed since the abolition of the estate-based system through the Meiji Restoration reforms, which were ignited by the pressure of the arrival of the black ships of the US Navy under the command of Commodore Matthew Perry, the everyday divide between yamanote and shitamachi is not as clear-cut as it used to be. Nevertheless, it is still perceptible in contemporary Tōkyō and could be related to an early process of gentrification. It manifests itself in the nature and visibility of employment among the respective local dwellers and their social class, the type of housing, the streetscape and accordingly its restaurants, izakaya (居酒屋, bars), recreational facilities such as karaoke bars, pachinko (パチンコ, arcade game machines) and the rare green spots in Tōkyō, tiny parks which often serve as optical indicators of the economic and social status of districts through the number of the homeless seeking shelter in public washrooms.

The geographical division between estates of the past is still mirrored in contemporary dynamics of social life and a distinction between blue-collar and white-collar workers in Tōkyō:

"Yamanote soon comes to stand for the values of the Westernizing, modernizing, internationalizing elite, and shitamachi for a set of largely retrospective values celebrating an urban culture that was in decline, if it had not already disappeared. Alternatively, shitamachi and yamanote can be seen to stand

83 The so-called shinōkōshō system (士農工商) divided society strictly into military aristocrats (士, shi), peasants (農, nō), artisans (工, kō) and merchants (商, shō) with limited social mobility between them (see Hall, 1974; Hall, 1984, Chapter 10.5 and 10.6 for a discussion of social organisation during the Edo period).

84 Although the shinōkōshō system consisted of four classes of citizens, there were also 'underclasses' of pariahs, called heinin, eta and burakumin, which gained their status from living in slums, engaging in 'unclean' professions (leather processing, prison wardens, etc.) or being physically or mentally handicapped.
more broadly for the way of life and values of small shopkeepers and industrialists, on the one hand, and of the salaried and professional classes, on the other." (Waley, 2011, pp. 96–97)

Although this nowadays rather ideological distinction is in decline due to mechanisms of gentrification, the characteristics of yamanote and shittamachi have been culturally regenerated and incorporated through community development, or the Japanese equivalent machizukuri (まちづくり), and an encompassing process in which younger residents are "being subordinated by the older residents, through the rituals and practices that are marked as 'traditional'" (Slater, 2011, p. 110). Some may therefore assume that such a setting of direct social class juxtaposition and confrontation apparently entails flashpoints of class struggle. This, however, is not the case. Residents perceive shittamachi and yamanote elements to be "complementary" rather than opposed to each other; hence, they even subsequently "reduce the likelihood of antagonistic class conflicts and actually promote community cohesion" (Slater, 2011, pp. 110–111).

Despite the diversification in social class or aesthetic scenery, another level of disparity exists between the shittamachi and yamanote districts. Being rooted in differences of demography and local administration, the preconditions and strategies of ensuring the elderly’s livelihood, by utilising a liaison between public and social institutional support, vary considerably between the wards of Tōkyō. The next paragraphs will thus elucidate the administrational, demographic, infrastructural and actual care situation in three Tōkyō districts, one in yamanote and two in shittamachi.

4.1 Young with older spots: demography of Tōkyō-to

Witnessing the hanami festivities (花見), the traditional cherry blossom viewing in spring which is celebrated nationwide, an alcohol-heavy mass picnic defined by tipsy and gleeful participants and the omnipresent blue tarpaulins used as picnic rugs, one may wonder where the elderly in superannuated Japan are. Strolling through tourist-riddled and densely populated districts that are rich in pop culture, such as Shinjuku, Shibuya, Roppongi or Minato, which are often considered to be typical representatives of Japanese society, will also not result in the impression of a hyper-ageing nation. Even participating in the shakaijin's (社会人) daily routine, an expression for full-grown members of society, will not necessarily bring a middle-aged person into regular contact with the elderly in Tōkyō as they
have their own time schedule, usually trying to avoid the typically peak hours in transportation usage and grocery shopping. In brief conclusion, one wonders what the fuss is all about.

Table 4-1: Distribution of population according to age in the 23 wards of Tōkyō-to

<table>
<thead>
<tr>
<th>Ward</th>
<th>Population</th>
<th>0-14</th>
<th>15-64</th>
<th>65-</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chiyoda-ku</td>
<td>54,160</td>
<td>11.74%</td>
<td>69.52%</td>
<td>18.74%</td>
</tr>
<tr>
<td>Chūō-ku</td>
<td>132,610</td>
<td>11.61%</td>
<td>72.09%</td>
<td>16.30%</td>
</tr>
<tr>
<td>Minato-ku</td>
<td>235,337</td>
<td>11.95%</td>
<td>70.87%</td>
<td>17.18%</td>
</tr>
<tr>
<td>Shinjuku-ku</td>
<td>324,082</td>
<td>8.55%</td>
<td>71.71%</td>
<td>19.74%</td>
</tr>
<tr>
<td>Bunkyo-ku</td>
<td>204,258</td>
<td>11.28%</td>
<td>68.90%</td>
<td>19.82%</td>
</tr>
<tr>
<td>Taitō-ku</td>
<td>187,792</td>
<td>9.20%</td>
<td>67.35%</td>
<td>23.45%</td>
</tr>
<tr>
<td>Sumida-ku</td>
<td>254,627</td>
<td>10.54%</td>
<td>67.09%</td>
<td>22.37%</td>
</tr>
<tr>
<td>Kōtō-ku</td>
<td>487,142</td>
<td>12.52%</td>
<td>66.89%</td>
<td>20.58%</td>
</tr>
<tr>
<td>Shinagawa-ku</td>
<td>368,761</td>
<td>10.83%</td>
<td>68.52%</td>
<td>20.65%</td>
</tr>
<tr>
<td>Meguro-ku</td>
<td>267,379</td>
<td>10.30%</td>
<td>70.09%</td>
<td>19.61%</td>
</tr>
<tr>
<td>Ōta-ku</td>
<td>701,416</td>
<td>11.20%</td>
<td>66.91%</td>
<td>21.88%</td>
</tr>
<tr>
<td>Setagaya-ku</td>
<td>867,552</td>
<td>11.54%</td>
<td>68.92%</td>
<td>19.55%</td>
</tr>
<tr>
<td>Shibuya-ku</td>
<td>214,665</td>
<td>9.35%</td>
<td>71.72%</td>
<td>18.92%</td>
</tr>
<tr>
<td>Nakano-ku</td>
<td>313,665</td>
<td>8.54%</td>
<td>70.85%</td>
<td>20.61%</td>
</tr>
<tr>
<td>Suginami-ku</td>
<td>542,956</td>
<td>9.96%</td>
<td>69.40%</td>
<td>20.64%</td>
</tr>
<tr>
<td>Toshima-ku</td>
<td>271,643</td>
<td>8.61%</td>
<td>71.24%</td>
<td>20.15%</td>
</tr>
<tr>
<td>Kita-ku</td>
<td>334,723</td>
<td>9.92%</td>
<td>65.01%</td>
<td>25.07%</td>
</tr>
<tr>
<td>Arakawa-ku</td>
<td>207,635</td>
<td>11.44%</td>
<td>65.88%</td>
<td>22.68%</td>
</tr>
<tr>
<td>Itabashi-ku</td>
<td>540,040</td>
<td>11.15%</td>
<td>66.87%</td>
<td>21.98%</td>
</tr>
<tr>
<td>Nerima-ku</td>
<td>711,212</td>
<td>12.45%</td>
<td>66.71%</td>
<td>20.84%</td>
</tr>
<tr>
<td>Adachi-ku</td>
<td>670,385</td>
<td>12.37%</td>
<td>64.09%</td>
<td>23.54%</td>
</tr>
<tr>
<td>Katsushika-ku</td>
<td>448,186</td>
<td>12.02%</td>
<td>64.55%</td>
<td>23.43%</td>
</tr>
<tr>
<td>Edogawa-ku</td>
<td>676,116</td>
<td>13.91%</td>
<td>66.33%</td>
<td>19.76%</td>
</tr>
</tbody>
</table>

Source: own representation and calculations, based on Tōkyō-to Sōmukyoku Tōkei-bu, 2014.

Note: Wards with care facilities for the elderly that I visited are marked in dark grey.

In fact, population-wise Tōkyō is a relatively young metropolis in Japan with an elderly population of only one fifth of the city’s total inhabitants (Tōkyō 21.3 per cent, Japan 24.2 per cent; Ministry of Internal Affairs and Communications, 2014a) and a continuous influx of a young population,
which contributed to a population growth of 4.6 per cent between 2005 and 2010 (Ministry of Internal Affairs and Communications, 2014b). As an intellectual and economic centre, Japan’s capital attracts young citizens seeking work and education by simultaneously draining social capital from smaller cities and the countryside. The downside for rural and remote regions which are affected by this efflux is that this internal migration is one factor leading to comparatively high aged populations and faster ageing processes in those regions. However, Tōkyō benefits from social capital gains not only with a below-average aged population and thus fewer social security recipients, but also from their economic capacity in spending capacity and consumption.

Despite its overall fairly low but diverse ratio of aged citizens, the still apparent geographical distinction between Tōkyō’s *yamanote* and *shitamachi* is indicative of institutional and social differences. And, indeed, areas of the metropolis are rendered as ‘older wards’ and ‘younger wards’—of which one is regularly reminded when traversing the different districts by foot and outside the *shakaijin’s* work schedule. Then, one can witness dressed-up but also sloppily attired aged persons intensively checking fruit in the supermarket, assiduously sweeping the streets, patiently waiting in line at the bus stop or running various kinds of other errands.

The different demographic situations in the respective wards and districts are reflected by local policies on the elderly’s livelihood, which buttress the demands of differing degrees of urgency for the establishment of supportive institutional arrangements for seniors. Policies on securing the elderly’s livelihood vary in the metropolis of Tōkyō as every ward constitutes an autonomous administrative unit. Thus, an imbalance between the various wards concerning pressing issues related to care for the elderly arises, and results in both diverse approaches towards public care for the elderly by the local ward governments and also differing requirements put on social organisation in order to support the elderly.

The distribution of seniors within inner Tōkyō is quite astonishing, which becomes geographically apparent in the widely perceived distinction between *yamanote-shitamachi* (Table 4-1). Considered to be typical *yamanote* representatives, the lowest ratios of aged persons are found in the wards of Chiyoda, Minato, Shinjuku, Shibuya and Chuō, which has the lowest proportion of seniors among the population with 16.3 per cent. On the other hand, areas characterised as *shitamachi*, e.g. the wards of Taitō, Sumida, Adachi and Katsushika, exhibit the highest ratios of elderly inhabitants in Tōkyō—climaxing with 25.1 per cent in Kita ward. The gap
in ratios of elderly citizens among the different wards is explained by their varying degrees of different characteristics and their attraction to certain age and social groups. *Yamanote* areas are often characterised by big organised, high-performance corporations, which attract a younger, well educated workforce, and an affluent population, whereas *shitamachi* areas are typified by rather small and medium-sized enterprises, often rooted in traditional manufacturing and craftsmanship occupations and a less well-off population.

Notwithstanding the cultural diversity of the sprawling megalopolis of Tōkyō and its straggling and exuberantly strung-together architecture, Tōkyō is an extremely close-knit network of clear-cut administrative units in close proximity. Geographically, however, it proves to have seamless transitions between districts, although each one features its own distinctive characteristics, such as Kabuki-cho, the lively nightlife district, which also houses care facilities for the elderly, and is close to one I visited. Starting in the centre of Tōkyō and gradually moving to the outer wards, the following paragraphs will illustrate and compare the age structure, demographics and social composition of the three wards in which my research took place.

4.1.1 Modern *yamanote*: Minato ward

While the Japanese nation is ageing at a tremendous pace, Tōkyō-to keeps its ratio of a relatively low number of elderly citizens stable and remains a young urban agglomeration (Table 4-1). But even within Tōkyō, local spots of below-average senescence are present, and Minato ward is such a spot. It has the impressive second-lowest elderly population ratio within Tōkyō with only 17.2 per cent (Tōkyō-to Sōmukyoku Tōkei-bu, 2014; see Table 4-1) and an average age of 42.1 years (Minato Kuyakusho, 2012c). Due to consecutive population growth in the last few years, Minato-ku alone reached a population of 208,397 citizens in 2012 (Minato Kuyakusho, 2012a, pp. 12–13). Of the 17.2 per cent seniors in Minato ward, approx. only one fifth (19.5 per cent) use care services for the elderly (Minato Kuyakusho, 2012a, 12, 15).
4 A tale of two cities: diversity in a metropolis

Figure 4-1: Age distribution in Minato Ward (Tōkyō)

Source: Minato Kuyakusho, 2012c.

Figure 4-2: Age distribution in Katsushika Ward (Tōkyō)

Source: Katsushika Kuyakusho, 2013a, p. 5.

Figure 4-3: Age distribution in Taitō Ward (Tōkyō)

Minato-ku resembles a representative of the sophistication of urban lifestyle and post-industrialisation in Tōkyō, which is often associated with yamanote districts and their ascribed status of future orientation through the presence of big white-collar enterprises which provide many jobs and gentrified neighbourhoods. Yamanote areas are symbols of Japan’s ‘cool’ pop culture image (Kondo, 1990, pp. 57–59; Waley, 2002), setting trends with their avant-garde fashion and a creative media mash-up scene, which determines the visual and normative lifestyle of many young Japanese. Minato ward is known for its posh, upper-class setting with expensive housing, luxurious hotels with elegant and thick-carpeted top-floor panorama wedding lounges, as the location of the nationwide TV channels TBS and TV Asahi, the famous concert hall, Suntory Hall, as well as the location of Crown Prince Naruhito and Crown Princess Masako’s residence. And, to underline its gentrified character, foreign consular services are also located in Minato, e.g. the embassies of the United States of America and Germany. Overall, Minato ward conveys the image of classy living, expensive dining and service sector employment.

4.1.2 Traditional shitamachi: Taitō ward & Katsushika ward

If we assume the yamanote districts are Tōkyō’s vanity cases, the ostensibly adversary shitamachi areas are its handy toolboxes that are getting long in the tooth. Taitō and Katsushika wards are parts of Tōkyō’s so-called lower city, which was historically populated by artisans and merchants, a fact which is still mirrored in its population and architecture. This impression is conveyed by the many mom-and-pop shops that are spread around the first floor of densely collocated pale grey and dull beige buildings. Aligned in quondam shopping promenades (商店街, shōtengai), which are nowadays being locally and preponderantly closed down, these tiny and cluttered shops owned by seniors sell an enormous—and often odd—variety of daily goods, hardware, pottery and groceries. The hurrying passers-by in the early morning are manual and service labourers, distinguished by their professional attire of the blue or light green jumpsuits of manufacturing employees and the hachimaki (鉢巻, headbands) and knickerbockers (ニッカーボッカー) of construction workers. The apparent difference is made more palpable by the visibility and plasticity of senescence, which is expressed by slow pacing obāchan and ofīchan, abruptly stopping to take a curious look around before continuing their
stroll. Traditional cultural activities are rooted historically in the lower city; hence, sumō (相撲) or the nō theatre (能楽堂, nō-kakudō) as well as famous religious sites and temples are located in these districts and still attract many visitors.

Compared to Minato ward, Katsushika-ku’s and Taitō-ku’s population statistics reveal a significant difference in the size of their aged populations, with 23.4 and 23.5 per cent respectively over the age of 65 years (Tōkyō-to Sōmukyoku Tōkei-bu, 2014). In Katsushika ward 14.8 per cent of the elderly use LTC services (Katsushika Kuyakusho, 2012, p. 67), while in Taitō ward it is 18.8 per cent (Taitō Kuyakusho, 2012, p. 18).

What hints at the latent existence of social, ageing-related issues (e.g. mobility, social isolation and pauperisation) is the relatively high rate of single-person households among the local elderly. In Taitō ward, 18.9 per cent (7,755 seniors) of the elderly live alone, whereas in Katsushika the amount is slightly lower at 15.7 per cent (15,319 seniors) (Katsushika Kuyakusho, 2012, p. 18; Taitō Kuyakusho, 2012, p. 16).

If we compare the distribution of population ageing among the wards, the diversity in Tōkyō-to becomes clear, but also hints at the different measures and administrative strategies required to cope with the varying dimensions of the social and economic needs of the elderly.

4.2 Urban care institutions

Striding through Tōkyō's ward, one experiences the lively and energetic atmosphere that is created throughout the day by young white-collar and blue-collar employees. Rushing to work in the morning, they hurriedly eat lunch in tiny restaurants and even tinier snack bars85, afterwards rushing to one of the myriads of convenience stores (コンビニ, konbini) to buy snacks and soft drinks. At the same time, their senior colleagues enjoy a cigarette and a cup of coffee in the various heavily air-conditioned coffee bar chains. Such strolls usually do not reveal the entirety of a ward's welfare infrastructure, which remains mostly invisible due to the complexity of the cityscape with its multi-storey buildings with multiple neon signs, smaller houses tightly packed next to each other, surrounding modern

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85 Not to be confused with nightlife ‘snack bars’ (スナックバー, sunakku bā), derivates of hostess clubs throughout Japan.
skyscrapers, and the somewhat anachronistic and chaotic bundle of power lines above ground. Yet, they indicate the growing necessity of turning any available space into accessible and well distributed pieces of elderly care infrastructure throughout the ward.

When walking by inconspicuous pale grey multi-storey buildings, one may occasionally encounter the sign "訪問介護" (hōmon kaigo) on the window next to a stylised depiction of smiling seniors, indicating a visiting care facility. As these outpatient care facilities require only little space, hōmon kaigo services can be found even in the smallest of buildings. Visiting care provides basic domestic support with a strict time schedule, such as assistance with household chores from care staff as well personal hygiene and medication provided for by medical staff, and thus basically requires only a small centre for administrative tasks.

On the other hand, the space requirement of the other two buttresses of the Japanese system of care for the elderly, day care (デイケア or デイサービス, dei kea or dei sābisu) and even more for institutional care facilities (施設介護, shisetsu kaigo), is eminently higher due to the space required for the workflows of patient care, medical treatment and administration. Even though centres that provide only day care are widely distributed across Tōkyō's wards and suburbs, and sometimes even exhibit creative usage of available real estate, enormous integrated multi-storey care facilities are quite common.

These all-in-one facilities provide a wide array of services, often ranging from visiting care, day care, institutional care and sometimes even child care. The need to combine different care and medical services in one facility stems from the scarcity of geographical space, but also the necessity of providing highly sophisticated, task-divided and cost-effective care for the elderly. These facilities are organised in units and facilitate synergic effects among the respective supportive subunits, i.e. kitchen, medical staff. On a side note, many of these facilities foster and encourage mutual visits between elderly patients of the respective care forms (e.g. day care and institutional care), but also between childcare and care units for the elderly.

Within the wards, the care facilities for the elderly are evenly distributed and approximately half of them are within close walking distance to the

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86 Long abandoned real estate is regularly transformed into small day-care facilities for the elderly. The unused properties were formally used as bathhouses, cinemas, etc.
numerous Japan Railways (JR) train stations. In contrast to the agglomeration of businesses and services alongside highly frequented roads in the countryside, in Tōkyō’s metropolis commercial life is amassed around the densely distributed train and subway stations due to their function as major hubs of social and public life. Care institutions being located close to public transportation stations entail the advantage for patients that family members can easily visit their institutionalised relatives, often combining their visits with other daily necessities, such as shopping or commuting. Hence, the lack of incentive to visit their elderly relatives, which apparently exists among the generations of children and grandchildren, is reduced theoretically. Nevertheless, the location of elderly care facilities is by no means determined by infrastructural and geographical side factors, but rather by the availability and usability of a given property.

A distinction between the organisation and combination of services among care institutions for the elderly between shitamachi and yamanote wards exists, according to an interview with the Volunteering Coordinator, Fukushima Hiroko (福島 弘子, 09.08.2013), a staff member in an all-in-one care facility for the elderly in Minato ward, which I visited regularly. Shitamachi and suburban districts especially contain a high rate of small day-care-only facilities with a small number of patients of between ten and twenty. In turn, machi no naka (町の中, inner-city) institutions tend to be conglomerated institutions of care services as depicted above. Since economic and cultural progression has driven out traditional businesses in shitamachi areas (wig makers, senbei bakeries, mom-and-pop-shops), new ones, such as the shitamachi day-care services, adapt to their surroundings by reusing abandoned public and private real estate. One popular example is a now established day-care facility which is housed in a former sentō (洗湯), one of the traditional public baths in Japan. This facility is reported to offer its patients a formidable bathing service (入浴, nyūyoku), a typical form of day care treatment, which is the envy of all those not able to make use of it.

4.2.1 Showpiece of urban care for the elderly: all-in-one care facilities

Big multi-storey buildings, their façades coloured in pale grey or yellowish ochre are inconspicuous in Tōkyō, except for the fact that they feature an immense driveway with white, not too expensive looking minibuses in a corporate design parked in front of a wide glass-door entrance. In this
4.2 Urban care institutions

case, such a building is an enormous care facility oriented towards the elderly, ranging from a variety of care forms for the elderly (e.g. visiting care, day care, institutional care and medical care, group homes, dementia care), elderly support bureaus (counselling, application for support measures) and also often childcare services (kindergarten, day care). These big all-in-one care facilities offer several advantages over a single-service facility as they allow cost-effectiveness by bundling services and personnel. Despite these benefits, all-in-one care facilities draw advantage from increased civic engagement through volunteering citizens.

I visited three all-in-one care facilities, each in one of the three aforementioned wards, on a regular basis through the respective volunteering programme for care for the elderly, supporting the medical and care worker staff in administering care. However, in Tōkyō it also showed that I was able to gain access to and insights into administering care to the elderly more easily by addressing all-in-one care facilities, as they are used to the idea of having outsiders in their facilities who interact with the seniors due to internships conducted by medical or social work students.

These immense and bulky care facilities strive to create a positive appearance and corporate identity for their elderly customers and their families. Hence, they often use catchy slogans or facility names to distinguish themselves from competitors. The slogan of a facility, for example, is also their proclaimed goal: "dream, easiness, goodness"—which sounds catchier in Japanese due to the use of alliteration in the logo and slogan "Yume, Yasashisa, Yokatta" (ゆめ, やさしさ, よかった). But like slogans of various other care institutions for the elderly, e.g. hāto kea (ハートケア, care with a heart) or aikaigo (愛介護, lit. lovely care), it not only sounds vacuous but also bland as ambitions are often confronted with political, personnel and financial hurdles. Especially in the context of institutional care with immobile, bed-ridden and patients suffering from dementia, who are experiencing their last life phase in group rooms without privacy, this slogan might sound cynical rather than encouraging. Nevertheless, for the usually up to forty day-care users it proves otherwise, as the institutions
support their livelihood with care and a daily variety of social interaction—especially through their focus on volunteering activities.

4.2.2 Hand in hand: synergy effects and internal organisation of labour

Care units for the elderly in all-in-one care facilities are divided spatially and according to the necessity of care. Patients from different units meet regularly, e.g. for joint or cultural events, but in some cases and for the sake of avoiding emotional stress meet-ups between patients from different care units do not occur. The individual care units of institutional and day care as well as additional ones, such as child care, are separated and work independently of each other. All care units thus stand alone and work independently in executing tasks—yet care units for the elderly are slightly interwoven due to the transition of patients from day care to institutional care as their health condition deteriorates. However, all these units are knitted together by the General Administration Bureau (GAB, 総合管理局, sōgō kanrikyoku). The GAB is in charge of personnel matters, applications for admission, patients’ premium payments through their insurance, staff salaries, fleet management, legal issues, patient excursions and the coordination of assisting subunits, whereas the care units for the elderly, as independent departments within a care facility, autonomously organise the daily care schedule for patients, the staff’s hours of labour and periods of rest, as well as administrative tasks, such as patient file updates and medication notes.

Large care facilities for the elderly, aiming at a concept of integrated care by including a broad range of services (care manager offices, day care, visiting care, assisted living and group homes), benefit from synergy effects that their size entails and facilitates through service accumulation. Large care facilities are organised in the main systems of care and detached auxiliary subsystems with designated staff. The labour division in main and subsystems serve three purposes: professionalisation, efficiency and cost-effectiveness.

87 Institutionalised patients by and large have severe physical and mental constraints, i.e. are bedridden or suffer from severe dementia. The latter especially causes emotional instability and insecurity, regularly leading to psychological stress and different states of anxiety and unpredictable behaviour.
In such an arrangement, care workers are exonerated from tasks unrelated to care as these are transferred to clerical workers or specialists. The latter are especially employed in areas such as medical examinations, food preparation and facility management. As each unit only executes its assigned duties, the presumed outcome is greater focus by the care staff on their main goal of providing care. However, if we compare such a strict division of labour to that in day-care-only facilities, it becomes clear the latter require stronger all-round orientation of staff members due to their less sophisticated organisation of labour division. The internal organisation of all-in-one care facilities allows employees to focus on their core tasks. Yet, this organisational benefit of comprehensive all-in-one facilities is turned into the extension of patient capacity in their respective units. Most prominent is the heightened capacity limit in day-care units, where it regularly reaches the upper limit of approximately 40 day-care patients in comprehensive facilities—as opposed to approximately 25 in day-care-only institutions. The drawback is higher pressure on personnel to take care of the patients' needs and less time for interaction with patients.

A daily necessity for the circa 100 inpatients and the 40 day-care patients is food preparation according to medical requirements, e.g. diabetes, lactose intolerance or nephritic ailments. These meals are cooked in and distributed from in-house canteen kitchens by employees who solely focus on meal preparation. Contrastingly, in one-unit-only care facilities, i.e. day care, these tasks are partly carried out by care personnel as well as additional part-time employees. These tasks in one-purpose institutions distract care staff from their actual tasks, while stress levels for the care workers involved are raised and care provision is reduced, thus limiting care efficiency.

Similar procedures are in effect for administrative tasks (e.g. fleet and facility management), freeing up time for care workers to interact with the elderly and provide care. Highly professionalised tasks of medical treatment as well as rehabilitation procedures are consequently not the main focus of day care for the elderly and are operated by auxiliary, on-demand subsystems. As these auxiliary subsystems in all-in-one care facilities are utilised by every main system, their synergetic potential comes into ef-

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88 See the last chapter for a detailed task description of single purpose care facilities for the elderly.
89 Minor medical treatment and rehabilitation gymnastics and massages are provided during day care by specialists if necessary, but not regularly.
fect, allowing an organisational design to reap the benefits of cost-effec-
tiveness and efficiency by phasing out diverting tasks.

Apart from the organisational division of all-in-one care facilities, their personnel hierarchy is also worth a brief look. Care workers form its functional basis, although one third of the 10 to 15 employees in day-care units are part-time employees. Despite the continuous fluctuation of staff members due to part-time employees starting and finishing their shifts, the number of staff members who are always present is kept at 8 to 10 during opening hours. The day-care staff are hierarchically organised and divided into one superior staff member (部長, buchō) and a deputy (副長, fukuchō), who usually plan the efficient transportation of patients, coordinate care workers to accompany elderly patients on the bus rides, draft working schedules and manage patient files. These positions are essentially filled by approved medical nurses. A medical employee (看護師, kan-goshi) and a physiotherapist (整復師, seifukushi) conduct minor medical examinations, physical exercises and massages in a separate part of the day-care unit, away from other patients. The remaining personnel are care workers (ケアワーカー, keawākā) and constitute the majority of the employees and have the most diversified work spectrum, while their professional training is the least sophisticated90. The basic principle of policymakers is to keep entry barriers to care work as low as possible due to an increasing demand and the wearisome work, and at the same time to keep expenses low. Care worker tasks range from assisting and supporting the elderly by:

- providing support with transportation from and to home and within the facility,
- helping the patients use the lavatories,
- washing immobile patients and supporting mobile patients in taking a bath,
- feeding patients at lunch and the pauses in-between,
- conversing with individual and seemingly isolated seniors,
- taking care of free-roaming dementia patients,
- actively encouraging individuals to participate in group activities,

90 The two professions of care workers and nurses are differentiated by their training. While the job requirements of the former stipulate they only provide assistance without having to fulfil tasks related to medical care, the latter are responsible for administering medication, changing dressings and minor health check-ups. This differentiation is consequently also reflected in wages.
– eventually moderating such activities with an inclusionary focus
– coordinating volunteers and seniors during pastime sessions during day care.

*Figure 4-4: Internal labour organisation of all-in-one care facilities*

As a result of this broad spectrum of physical and mental requirements due to the demanding working conditions, the upper age limit for care workers at these facilities is often set at 40 years in job advertisements. In addition to the employed staff members, individual and group volunteers visit the different care units and help either with the execution of the unit's daily schedule (e.g. changing bed sheets, feeding patients) or pro-

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91 San San Akasaka and Shinkatsushika Royal Care Center have detailed job descriptions on their websites and are continuously seeking new recruits.
vide their own entertainment programme, often traditional dances, folk songs or group gymnastics.

4.3 Still to do: meshing of public and social institutions

The rate of senescence in the three wards examined is still below that in rural Komagane city. The strain of the ever-increasing aged population on local financial budgets, however, is palpable in many of Tōkyō's wards. Among the rising social security spending, there has been an asymmetrical increase in LTCI expenditure that is not on par with what the increase in LTC patients would indicate. In order to curb frailty and ensure cost-containment, services are required that exceed the legal requirements of care provision under the LTCI law. This is not only necessary to spread health and illness awareness and stress the importance of prophylactic measures, but also to actually provide prophylaxis for geriatric diseases. Furthermore, interlocking social institutions (family, neighbourhood) and public institutions (care facilities, clinics, ward administration) is fundamental in establishing comprehensive community care, as suggested by the MHLW in the LTCI reforms (see chapter 2). Observations rooted in two issues found in Tōkyō's wards and among its elderly make the interlocking process appear rough and in need of more optimisation in the transition process as well as in the provision of prophylaxis.

First, the organisation of care in Tōkyō-to as a whole is a patchwork of similar but different approaches. As each ward is an independent administrative unit, strategies for coping with an ever-ageing population are rooted in local politics as well as different circumstances, e.g. the ratio of needy elderly (see also the ratio of aged persons in Table 4-1). Second, my overall impression, after interviewing recipients of care and care personnel, is that a high-degree of support from families is not expected—or not provided for several reasons, which leads to greater reliance on support and care measures offered by public institutions.

The basic concept of the ageing process is a gradually increasing dependency on social or public institutions as one's own autonomy is simultaneously decreasing through physical and mental health deterioration. While the family still represents an integral cornerstone of the elderly’s autonomy and a source of support, its influence is vanishing as the ageing process advances and health is affected more severely. In an ideal case, simultaneous support and merging of public institutions, ranging from or-
organised community activities, supportive measures, prophylactic pastimes and actual care would provide a social and care safety net. Wards use their leeway in creating community or neighbourhood oriented programmes and supportive measures that link together with the LTC measures which are required by law (see Figure 4-5).

The situation concerning approaches to the issues of ageing and care for the elderly, though, is quite diverse in the wards examined. In particular, Minato ward stands out in many respects. In terms of local ageing, the fairly old Katsushika and Taitō ward administrations already provide a broad range of additional services to bypass and prevent institutionalisation of their seniors (cf. Katsushika Kuyakusho, 2012, pp. 27–42; Taitō Kuyakusho, 2012, pp. 23–40). However, the still quite young Minato ward has a narrower selection, with prophylactic measures that exceed the provision of care required by law if compared to the other two wards (cf. Minato Kuyakusho, 2012a, pp. 39–52).

Figure 4-5: Meshes of welfare for the elderly with NPOs, wards and LTCI programmes

Source: Own representation.

This is problematic in the sense that Minato ward already has an immense amount of seniors in institutional care facilities in contrast to its fairly low elderly population rate (see also figures in the following sub-chapter)
4.3.2). Thus, in the long run, the Minato ward administration requires a stronger focus on prophylactic services. For one thing, the predecessors in local ageing processes and the issues arising from them, Katsushika and Taitō as examples, are already investing heavily in preventive measures to avoid intense uptake of LTC services and the subsequent rise in actual care expenditure. For another thing, major latent age-related gender and social issues are significant for future concerns in Minato ward (Minato Kuyakusho, 2012a, p. 22).

Through ageing the higher life expectancy of women comes into effect and creates a sex ratio disequilibrium that develops at higher ages. This is of significance as ageing reveals gendered vulnerabilities. Female seniors, in particular those in single-person households, run a high risk of poverty (Shirahase, 2011, pp. 119–122) The sex ratio among seniors in Minato-ku already shows a considerable imbalance with 39.7 per cent of those above the age of 65 being men and 60.3 per cent being women. And it is likely to rise further as the ward's ageing progresses to a higher level. The emerging issues that are already present in Taitō and Katsushika ward and will eventually also hit Minato ward are gender-based:

- financial dependency—especially among women who live alone,
- limited mobility due to the lack of a driving licence\(^\text{92}\),
- and an increase in social isolation\(^\text{93}\).

The even more noteworthy social fact is the stunningly high ratio of single-person households among the elderly—which in total renders 29 per cent of all seniors in Minato ward as living alone, 27.4 per cent in Taitō ward and 21.8 per cent in Katsushika ward (Minato Kuyakusho, 2012b, pp. 3–4)\(^\text{94}\). Minato-ku ranks sixth highest, Taitō-ku seventh highest and

\(^{92}\) Many female seniors did not get a driving licence earlier in life for several reasons, e.g. normative behaviour and zeitgeist values.

\(^{93}\) The relationships of couples experience shortcomings in later life. These eventually lead to highly increased divorce rates due to raised stress levels between couples. Retired but rather helpless husbands in the household thus earned their nickname nure ochiba (濡れ落ち葉, lit. wet leaves), which figuratively describes fallen foliage sticking to one's shoes. Nevertheless, it cannot be ignored that couples still comprise a basic form of social interaction and mental support (see also Alexy, 2007)—which ceases for widows, widowers and divorcees.

\(^{94}\) When we make a different calculation, i.e. by comparing the number of all households with at least one member over the age of 65 years and elderly one-person households, the numbers seem even more alarming and are often used in Welfare
Katsushika-ku second to last among all of the 23 wards in Tōkyō. Furthermore, survey results from 2011 illustrate that among all elderly single-person households in Minato-ku, 78.9 per cent were inhabited by women and, accordingly, only 19.2 per cent by men (Minato Kuyakusho, 2012b, p. 13). These results not only illustrate the renunciation of multi-generation households and a change of family structure and social organisation in each ward, but also the individualisation of life risks. Subsequently, the support for the elderly that would be provided in a multi-generation household is only possible to a certain degree for seniors who live alone as their kin lives separately.

Due to the ideal of filial piety and duty, however, living in a multi-generation household is still embraced locally, e.g. in Katsushika ward, not only as a social ideal, but also for financial reasons on the part of both parent and child generations—as the head of the Nursing Department of the Shinkatsushika Royal Care Center, Yamada Setsuko (山田 節, 06.08.2013), pointed out when talking about the patients’ family relationships.

What is said above provides a glimpse of the "forlorn feeling" that is regularly mentioned in conversations with seniors, and reveals that the issues of seniors who live alone are inherently highly gendered. These issues are reinforced and increased by the imbalanced sex ratio, which rises with age, and the high number of elderly single-households, which generates problems for elderly individuals. More than one quarter of elderly men who live alone (27.6 per cent) and approximately one seventh of elderly women (14.0 per cent) do not have a reference person to consult with in case they need to make important decisions or in cases of emergency (Minato Kuyakusho, 2012a, p. 24). But this question only taps into the tip of the iceberg with regard to social isolation. Even in the densely populated wards, e.g. by the Minato ward (Minato Kuyakusho, 2012a, p. 82). These numbers are 40.2 per cent for Minato, 39.5 for Taitō and 31.3 for Katsushika ward (Minato Kuyakusho, 2012b, pp. 3–4).

The higher ranking wards are Shinjuku with 33.7, Shibuya with 32.7, Suginami with 32.4, Toshima with 32.4 and Nakanō with 29.5 per cent. Some villages on the periphery of Tokyo-to have even higher rates, but were not considered here as my focus lies on the ward area of Tokyo-to only.

The non-respondent rate was 1.8 per cent. The survey was distributed among 3,947 citizens or 39 per cent of all elderly people living alone.

The question was: 「緊急時の支援者の有無」 (Kinkyūji no shiensha no yūmu?) [Do you have someone to turn to in an emergency?]
populated Minato-ku with tightly packed apartment buildings and busy streets and squares, 37.8 per cent of the seniors who live alone stated they have a weak\(^98\) or no relationship\(^99\) with their neighbours. These are not just mere aspects of urban anonymity among myriads of people, as the next answer indicates. Over shōgatsu-san-ga-nichi (正月三が日), the Japanese New Year's Eve period from January 1st until January 3rd, which is often packed with events and festivals, 33.4 per cent of the seniors surveyed stated that they spent these three days consecutively alone. Even more striking with regard to social isolation and forlornness are the results of a question concerning the Tōhoku Earthquake\(^100\) in 2011, a period of the highest insecurity, uncertainty and during which public institutions and organisations functioned distortedly. When asked whom the elderly contacted after the earthquake, the answers, besides family, relatives and friends, were:

- nobody (誰も, daremo) with 5.9 per cent,
- their care manager (ケアマネジャー, kea manejâ) with 4.0 per cent
- people from the town or neighbourhood council (町会・自治会の人, chōkai-no-hito / jichikai-no-hito) with 3.0 per cent,
- the district welfare officer (民生委員, minsei-iin) with 1.7 per cent
- employees of the seniors consultation office (高齢者相談センタの人, kōreisha sōdan sentâ-no-hito), 1.5 per cent.

Seniors experience situations and longer phases of social isolation, which leads to faster mental health decline among those affected—and, through psychosomatic effects, also to a deterioration of physical health. It also explicitly illustrates the prerequisites for countermeasures to social isolation. The chiiki hōkatsu kea shisutemu (地域包括ケアシステム), the Integrative Community Care System initiative in the newest LTCI reform by the national government in 2013 aims at an overarching measure which combines living support measures (seikatsu shien), prevention (yobô), medical treatment (iryō), one’s own residence (sumai) and eventually nursing care (kaigo).

\(^98\)「あいさつをかわすくらい」(Aisatsu wo kawasu-kurai) [We exchange greetings.]
\(^99\)「まったくつきあいがない」(Mattaku tsukiai ga nai) [There is no contact at all.]
\(^100\)「東日本大震災後の連絡相手」(Higashi Nihon Daishinsai-ato no renraku-aite) [Person contacted after the Tōhoku earthquake.]
4.3.1 *Betsubetsu*: the organisation of care for the elderly

Although the general framework of care requirements for the elderly is preset by the national LTCI law, its organisation and implementation in the Tōkyō metropolis is characterised by a patchwork of policies and implementation measures rather than a consistent approach. The complexity emerges from the composition of Tōkyō-to, which consists of 23 wards (and several smaller and middle-sized cities), each governed as autonomous administrative units and follows its own approach towards care for the elderly. In the inner part of the Tōkyō metropolis, the administrative units are the 23 wards, which in 2000 were granted the status of local public bodies\textsuperscript{101}—which means that *de jure* and *de facto* they comprise autonomous cities. Being independent units, each ward conceptualises and implements its respective welfare plan and executes its own approach to welfare for the elderly. On the one hand, the advantageous aspect of such a structure allows demand-actuated service provision and care-infrastructure developments according to the socio-demographic status of the elderly residents and their respective needs. On the other hand, though, it comprises a confusing array of care services for the elderly and perplexed seniors, as some desired services may be unavailable as their provision or accessibility abruptly ends at the street crossing due to changing jurisdictions, and greater effort has to be put into the coordination of trans-ward projects and measures. Despite the fact that, historically, Tōkyō has grown tremendously and the margins between neighbouring wards are meanwhile invisible, they have rather arbitrary administrative limits\textsuperscript{102}, which leads to a confounding complexity of care services for the elderly.

\textsuperscript{101} The official term is *chihō kōkyō dantai* (地方公共団体). Since 2000 several wards have started to use the term "city" to refer to themselves in English, but have retained their Japanese name for ward (*ku*), instead of *shi* (市, city). This simultaneous use is exemplified by Minato ward, which uses "Minato-ku" as its Japanese and "Minato City" as its English name.

\textsuperscript{102} Yotsuya (四谷), where the Palace of the Crown Prince and the Crown Princess as well as Sophia University (上智大学) are located, is such an example. Although geographically rather located in the direct vicinity of Minato ward and the neighbouring Akasaka district, its administrative "parent" is the Shinjuku ward far to the west of it, which is connected by a long stretch of administrative promontory.
<table>
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<th>Minato Ward</th>
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<th>Katsushika Ward</th>
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<td>介護予防の推進</td>
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<td></td>
<td>[Promotion of a worthwhile life and facilitation of social participation]</td>
<td>[Promotion of care prevention]</td>
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<td>2</td>
<td>介護予防の推進</td>
<td>認知症高齢者支援の推進</td>
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<td></td>
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<td></td>
<td>[Establishment and maintenance of a system of mutual support within communities]</td>
<td>[Promotion of medical care cooperation]</td>
</tr>
<tr>
<td>4</td>
<td>安心して住み続けられる住まいの確保・支援</td>
<td>ひとり暮らし・高齢者のみ世帯への支援</td>
</tr>
<tr>
<td></td>
<td>[Guaranteeing and supporting the continuation of safe residence]</td>
<td>[Support for seniors who live alone and elderly-only households]</td>
</tr>
<tr>
<td>5</td>
<td>介護サービス・高齢者福祉サービスの充実</td>
<td>居宅サービスの充実</td>
</tr>
<tr>
<td></td>
<td>[Strengthening care and elderly welfare services]</td>
<td>[Strengthening in-home services]</td>
</tr>
<tr>
<td>6</td>
<td>介護保険制度の円滑な運営</td>
<td>地域密着型サービスの充実</td>
</tr>
<tr>
<td></td>
<td>[Ensuring undisturbed operation of the LTCI system]</td>
<td>[Strengthening community-based services]</td>
</tr>
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4.3 Still to do: meshing of public and social institutions

<table>
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<tr>
<th>Minato Ward</th>
<th>Taitō Ward</th>
<th>Katsushika Ward</th>
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<tr>
<td>7</td>
<td>施設サービスの充実</td>
<td>高齢者にやさしい暮らしの整備</td>
</tr>
<tr>
<td></td>
<td>[Strengthening institution-based services]</td>
<td>[Maintaining an easy life for the elderly]</td>
</tr>
<tr>
<td>8</td>
<td>介護サービスの質的向上</td>
<td></td>
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<tr>
<td></td>
<td>[Improving the quality of care services]</td>
<td></td>
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<tr>
<td>9</td>
<td>高齢者の住まいの確保</td>
<td></td>
</tr>
<tr>
<td></td>
<td>[Guaranteeing homes for the elderly]</td>
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Note: Corresponding measures in different wards are of the same colour.

The general coordination of care facilities for the elderly under the LTC law is centrally aligned by the welfare department of each ward’s city hall (区役所, kuyakusho). Welfare plans are drafted triennially by assessing the living conditions of the elderly and needy population beyond the level of mere socio-economic background by including surveys concerning activities of daily living (ADL) and social inclusion, such as mobility issues, frequency of interpersonal contact and the availability of contact persons. Through their welfare departments, whether it is located in a modern glass and concrete office high-rise in the direct vicinity of the Tōkyō Tower in the Minato ward, a bright white skyscraper in the centre of the vibrant Ueno district in Taitō ward, or an unadorned functional concrete building amid lush alleys in Katsushika ward, every local government puts enormous effort into compiling and carrying out surveys for the welfare plans, incorporating up to one quarter of its elderly population into surveys103.

103 The number of seniors surveyed differs according to each particular survey, but ranges between 2,259 and 4,020 seniors, which comprises a range of 5.8 per cent to 10.4 per cent of the total elderly population of 38,511 citizens in 2012 in Minato Ward. The amount of Katsushika seniors who participated ranges between 1,295 and 1,731, approximately 1.3 per cent to 1.8 per cent of the 96,605 elderly citizens in Katsushika Ward.
The main purposes of each of the extensive Welfare Plans for the Aged in their fifth iteration in all three of the wards examined (Table 4-2) lies in three basic aims:

- the continuation of already established care services and, furthermore, the establishment of preventive and supportive measures are of major importance as rapid ageing is occurring, even in the still fairly young Minato ward\textsuperscript{104}
- the expansion of a cooperation network of local non-governmental actors and institutions to ensure an unproblematic shift from an independent to a dependent life phase with a seamless transition and continuous support between levels of dependency
- keeping afloat ongoing collaboration and convergence processes concerning welfare measures among the inner wards of the Tōkyō metropolis.

Ensuring the elderly access to care services is a legally binding requirement for all administrative bodies in Japan according to the LTCI law, which stipulates the establishment of care facilities for the elderly and the provision of supportive measures and actual care. However, as expenses rose, the main focus of the LTCI was shifted from care provision to care prevention—an approach aiming at both cost containment and quality of life improvements. Care prevention as a concept and its application were introduced in the LTCI reform of 2005, and the idea was even further expanded in the 2013 reform by addressing the "community aspect" of care prevention. Aligning the LTCI law and budget towards preventive measures of physical and mental preservation, the optimistic intention is to curb the cost-intensive expenses of long-term medication, nursing and institutionalisation in the elderly’s latest stage of life by investing far ahead in prophylactic measures of mental and physical training.

If we compare the major focal points of the respective welfare and long-term care insurance plans for the elderly, differences and similarities ward dwellers in 2012. In Taitō ward, 2,937 seniors took part in the 2012 survey, or 7.2 per cent of the elderly population of 41,033 citizens.

\textsuperscript{104} A 13 per cent increase in aged citizens is expected within a four-year time frame, i.e. from 36,119 seniors in 2011 to 40,917 seniors in 2015 (Minato Kuyakusho, 2012a, p. 12).
are clearly visible (Table 4-2). Similarities\textsuperscript{105} in the aims and also formulations of the three welfare plans examined arise from the implementation of the legally binding framework of LTC, but are also due to parallel developments of municipality ageing and health decline among the elderly. The required continuation of services undoubtedly has a high priority, while the cost-containing agenda of the LTCI reforms is of major concern. Targeting the same direction are attempts to foster the general use of outpatient care, household-based help and provision of living assistance, which kills two birds with one stone. Keeping seniors out of institutional care facilities which place a heavy strain on the budget, while allowing them to retain the chance to live, grow old and be cared for in the environment they are accustomed to among family and friends is, firstly, contributing to the \textit{ikigai dsukuri} (生きがいづくり, worthwhile living) efforts of local government initiatives for the elderly. And, secondly, it curtails expenses. Endeavours to foster social participation among the elderly and within their particular community are thought to inflict a heavier impact on the elderly’s well-being than the mere provision of long-term care for the elderly. Consequently, local governments target those areas beyond the range of the LTCI law’s requirements for care and prevention through holistic approaches towards community, well-being, livelihood and ageing by investing in community-oriented facilitation. Institutional learning from predecessors in terms of policy design, though, seems to be slow, as we have seen—and as will be shown in the next section.

4.3.2 Dichotomy of scales: long-term care usage

Differences in social structure and the housing situation are reflected in varieties of care for the elderly, as we have seen above. Besides that, the three wards examined also display another layer of disparity: elderly recipients of welfare and the expenditure involved. Conspicuously linked to the ageing progress in each ward, the fiscal situation is tight. Ever increasing social security expenditure forced the successive nationwide implementation of geriatric disease and care prevention oriented reforms in the LTCI law. Nevertheless, municipalities under extraordinary circumstances,

\textsuperscript{105} For example, numbers 1, 2 and 6 from the Minato Ward Welfare Plan are similar in wording and intention to that of Komagane (see chapter on rural ageing), as well as the corresponding aims/colours for Taitō and Katsushika Ward.
i.e. high senescence, lacking infrastructure and remote location, still suffered from the immense expenditure for LTC services\textsuperscript{106}. The delay until the reforms come into effect and the insufficiency of already available services account for that. Henceforth, municipalities additionally started to introduce their own prophylactic pre-care models and programmes, aiming to bridge gaps between the individual’s increasing frailty and the need for service uptake while trying to maintain autonomy. At their core, these services are geared towards seniors transitioning smoothly between different layers of dependency as well as attempting to lower seniors’ mental barriers to making use of preventive LTC services. These barriers especially\textsuperscript{107} constitute a principal incentive to avoid formal care and risk the consequences of health deterioration (Murayama \textit{et al.}, 2011).

Although different circumstances prompt municipalities to invest in care for the elderly on their own, the more or less urgent task is to deal with a rapidly ageing population and, hence, reduce tax revenues to maintain services while, simultaneously, social welfare expenditure rises. Even though the latter is partly borne by the national government and the prefecture, 12.5 per cent off all LTC expenditure remains with the local municipality (see chapter on care for the elderly in Japan for a breakdown of LTCI funding). However, the reasons for local supportive measures for the elderly might not only be driven by merely fiscal concerns, but result from them:

- below-average care infrastructure in municipalities, which is otherwise burdening immobile seniors, and also the drive to improve the quality of life in an ageing society
- the urgent necessity of cost-containment due to increasing physical and mental health decline among old-age seniors, which leads to above-average institutional care usage
- aiming at the political function of preventive programmes, serving as prestige objects by symbolising the future orientation of politicians and their local governments, which in turn might be used for political power leverage.

\textsuperscript{106} Local governments could apply for a deficiency payment (調整交付金, \textit{chōsei kōfukin}) of five per cent of the whole LTCI budget borne by the national government.

\textsuperscript{107} The term sekentei describes such a barrier, a "social-psychological process that restricts behaviour that does not conform to social norms such as family caregiving" (Asahara \textit{et al.}, 2001, p. 375)
4.3 Still to do: meshing of public and social institutions

Whereas in rural Komagane the first two seem to be the driving force, in Tōkyō the picture is more complex due to the greater diversity of its wards in terms of demographic composition, but also in regard to their political, organisational and bureaucratic interplay. Besides these arguments, that should be kept in mind as rapid population ageing and health decline is the major concern for many municipalities.

Minato ward, as well as other young wards, may not experience it yet because of their significantly lower ratio of older people, which does not place excessive stress on their LTC budget, but other wards, such as Katsushika and Taitō, are driven by high ageing and expenses. In fact, in Minato ward the contrary is the case, and initially calculated LTCI expenses turned out to be even lower than the actual figures (Figure 4-6)—although the number of LTC users continued to rise (Figure 4-7). This is remarkable as all the other budget reports of municipal and local governments never hinted at lower than expected expenses, which thus corresponds to the general narrative of ever rising expenditure.

The vast difference between the two shitamachi and the yamanote wards is also remarkable. The difference is not in patient numbers but in expenditure for institutional care services, which are immensely high in Minato ward and thus indicate cost-intensive medical and care treatment for their aged citizens. However, figures for the Minato ward seem to be completely out of proportion and maladjusted if compared to wards with a similar number of patients, such as Taitō ward. The figures also reveal that Minato, as an example of a young and vibrant ward, is inexperienced in terms of cost-efficiency in institutional care and, even more importantly, the ward's preventive measures have not trickled down to seniors yet.

Even though, as a consequence of enormous expenditure, it is already incorporated into the newer welfare policies, the evidence of avoiding and preventing long-term care in institutional care facilities is undoubtedly present in the disproportionate ratio of institutional care patients and institutional care expenses (Figure 4-6 to Figure 4-11). It further underlines the importance and necessity of local initiatives to curb and—at least partially—prevent frailty, age-related diseases and third-party dependency.
Figure 4-6: LTCI expenses in Minato ward per care category (in 10,000 yen)

Minato Ward - LTCI expenses per category

Source: Own representation, data from Minato Kuyakusho, 2012a, p. 29

Note: Community-based care expenses are such extremely low values between 216 and 270 units (each 10,000) that they are almost invisible in the figure above. However, these low values, especially in comparison to other wards in Tōkyō, might be an error in the welfare plan.

Figure 4-7: LTCI users in Minato ward per care category (in persons)

Minato Ward - LTCI users per category

Source: Own representation, data from Minato Kuyakusho, 2012a, p. 28

Note: "Preventive Services" have also been included in ambulant care since 2006, ranging between 520 and 778.
4.3 Still to do: meshing of public and social institutions

Figure 4-8: Taitō ward LTCI expenses per care category (in 10,000 yen)

Source: Own representation, data from Taitō Kuyakusho, 2012, p. 84.
Note: Community-based care expenses were included into ambulant care due to their low value, ranging between 2,800 and 3,200 units (each 10,000 yen).

Figure 4-9: LTCI users in Taitō ward per care category (in persons)

Note: Oddly enough, the Welfare Plan No. 4 for the reporting period of 2006 to 2008 does not contain any data for LTCI users per category in the year 2008.
4 A tale of two cities: diversity in a metropolis

Figure 4-10: LTCI expenses in Katsushika ward according to care category (in 10,000 yen)

Source: Own representation, data from Katsushika Kuyakusho, 2012, pp. 74–76.

Figure 4-11: LTCI user per category in Katsushika Ward (in persons)

Source: Own representation, data from Katsushika Kuyakusho, 2012, p. 68.

Note: Katsushika Ward has not considered data for patients in community-based care, even though expenditure for the very same kind of care is accounted for in the same welfare plan.
### Table 4.3: Changes in LTCI Users and Expenses in from 2009–2010 and 2010–2011

<table>
<thead>
<tr>
<th></th>
<th>Minato</th>
<th>Taitō</th>
<th>Katsushika</th>
</tr>
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<tbody>
<tr>
<td><strong>Institutional Care</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Users</td>
<td>16.0 %</td>
<td>8.7 %</td>
<td>-2.8 %</td>
</tr>
<tr>
<td>Expenses</td>
<td>15.5 %</td>
<td>7.2 %</td>
<td>0.4 %</td>
</tr>
<tr>
<td><strong>Ambulant Care</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Users</td>
<td>5.3 %</td>
<td>4.5 %</td>
<td>10.4 %</td>
</tr>
<tr>
<td>Expenses</td>
<td>7.7 %</td>
<td>5.8 %</td>
<td>11.2 %</td>
</tr>
<tr>
<td><strong>Community Care</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Users</td>
<td>10.3 %</td>
<td>-6.0 %</td>
<td>-</td>
</tr>
<tr>
<td>Expenses</td>
<td>25.6 %</td>
<td>-6.5 %</td>
<td>11.1 %</td>
</tr>
</tbody>
</table>


Note: The Minato and Katsushika data sets are from 2010 and 2011; the Taitō data is from 2009 and 2010.

While the shift towards focusing on prophylaxis is fiscally important, local governments also benefit from its social acceptance since preventive measures policies do not only serendipitously coincide with how seniors' conceive a desired and ideal ageing process—within their accustomed social and physical environment.

Surveying seniors on their desired way of living in the future, the majority of the elderly who receive no care or only preventive care stated that they would prefer a family-independent care model (26.3 and 29.5 per cent respectively). Only 17.4 per cent and 21.8 per cent respectively favoured receiving informal family care in their own household and simultaneously utilising external care services. Furthermore, only 15.2 per cent of actual recipients of care for the elderly would prefer care adminis-

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108 The question in the Japanese source was 「今後の希望する暮らし方」 (Kongo kibō suru kurashi-kata) [What is your desired way of living from now on?].
109 The answer was 「家族に依存せずに生活できるような介護サービスがあれば自宅で介護を受けたい」 (Kazoku ni ison sezu-ni seikatsu dekiro yōna kaigo sābisu ga areba, jibun-de kaigo wo uketai) [If there was a care service that allowed me to live at home without relying on my family, I would choose that].
110 「自宅で家族の介護と外部の介護サービスを組み合わせて介護を受けたい」 (Jitaku de kazoku no kaigo to gaibu no sābisu wo kumiawasete kaigo wo uketai) [I would prefer a combination of care given by my family and external care services in my own home].

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tered just by their family\textsuperscript{111}, while almost half of the recipients of care (49.1 per cent) expressed the desirability of a combined model of informal family care in their own household and simultaneous external care given by formal care providers (Minato Kuyakusho, 2012a, p. 20).

These answers imply that two factors are significant for the aged generation: the more obvious is autonomy, despite deteriorating physical and mental health. The second one is the desire to not be a burden on their family, although the notion of caring for the elderly is often taken for granted as a familial duty—as parts of traditional family values remain. The LTCI law in its contemporary iteration supports both a combined model of family care and LTC services as well as a sole and independent reliance on public support in caring for the elderly. In many cases, especially seniors who live alone, the reliance on social ties for care support proves problematic due to problematic relationships. Therefore, wards have started to expand their community-based care initiatives to handle the immense influx of needy seniors with only a limited number of human resources (see especially chapter 4.4.1).

Nevertheless, the results of these surveys represent a change in attitude since the post-war period and the then prevalent strong reliance on family care. This further exemplifies an ongoing change of values, as the reliance on public welfare institutions was stigmatised in the past (see Yong and Saito, 2012), despite the lingering sentiment of how the public perceives use of care services (Asahara \textit{et al.}, 2001; Murayama \textit{et al.}, 2011).

\subsection*{4.4 Less is more: preventive measures, day care and initiative taking}

Tōkyō’s wards, like almost every local government, have introduced their own supportive measures for seniors in addition to the nationwide implementation of care measures under the LTCI law. These measures basically comprise community-based projects, such as gardening and seniors’ clubs, but also support measures which enable and prolong autonomous living and safeguard livelihood. As an individual continues to age, the figure to the right (Figure 4-12) illustrates their progress through these meshes of}

\textsuperscript{111} 「自宅で家族中心介護を受けたい」(\textit{Jitaku de kazoku chūshin kaigo wo uketai}) [I would prefer care provided by my family in my own home].
livelihood support through increased dependency and a simultaneous decrease in autonomy.

Figure 4-12: Meshes of elderly welfare and livelihood support

Although all five relevant meshes of assistance and care are shown, the focus here is put on three meshes. First, the focus is on "Supportive Measures" and "Prevention", as are approached in a combined way by Katsushika Ward, which is an interesting method of ensuring the elderly’s livelihood through interlocking services. Furthermore, it showcases innovative tactics to approach seniors who are otherwise reluctant to utilise services.

Following that, the focus is on "Day Care" and its function as a social integrator. Day care applies a blend of care and social exchange in different but gendered ways by not only providing actual care, but also opportunities for social interaction, communication and recreation—and thus dwarfs social barriers to service uptake. The very first and the very last mesh are omitted here as the interlocking and the intermediation of social and public spheres in the life phase of increasing reliance on third parties is of valuable importance.

4.4.1 Ride my bicycle: patchwork of care for the elderly measures

We had to knock a third time before Yuma-san slowly opened the door. She was fiddling with the electric sockets, the nonagenarian woman who lives alone explained, since she cannot use the *suihanki* （炊飯器, rice cooker)
cooker), TV and air-conditioning at the same time. The electricity system in her apartment is as old as she is, she giggled, and the fuses blow regularly. Air-conditioning is essential in the hot and humid Japanese summers—at the end of August 2013, temperatures in Tōkyō-to reached 39°C with a relative humidity of 85 to 90 per cent, which resulted in numerous reported deaths of seniors through dehydration and heat strokes. We usually visited four to six seniors per day, and Yuma-san was our second stop after we had left the care manager’s office, and I was glad that, after our arrival, Yuma-san turned off the TV with its endless cookery shows, and switched on her air-conditioner. We, that is the care manager Segihara-san and I, were visiting seniors in the dense and labyrinthic Katsushika ward by bicycle in tropical temperatures.

Care managers have coordinating and advising duties for seniors who request LTC services, are responsible for compiling care plans and arranging appropriate support measures, act as the contact person in any sort of case, and most importantly deal with the abundance of forms and formalities the LTCI requires. Furthermore, their duty is to regularly visit and attend to seniors—a hybrid of the actual role of care managers and a novel community care initiative. I was granted my request to accompany a care manager during their daily routine as a so-called "trainee" after inquiring about hands-on experience of a care manager at the local General Consultation Centre for the Elderly in Horikiri district (高齢者総合相談センター堀切, Kōreisha Sōgō Sōdan Sentā Horikiri).

Living alone in her tiny and messy social housing apartment of approximately 25 square metres in an almost unlocatable thicket of narrow streets and narrower tenements, Yuma-san is proud to have retained her autonomy and independence to a high degree and underlined it with hospitality by offering us chilled mugicha (麦茶, barley tea) and senbei (せんべい, Japanese rice crackers). Nonetheless, her decrease in self-sufficiency is visible through the desolate state of her apartment interior, the dirt-stained

112 The frequency of my visits ranged between twice a week to once every two weeks, depending on the form of care (preventive care or day care), living conditions, family support and autonomy.

113 This was also my status when I was introduced to the seniors I visited to reassure them that everything was alright. Almost all of the seniors were pleasantly surprised by such an uncommon visitor and wanted to talk more to me than to the care manager, who they actually expected. A few even made me small presents on the spot.
carpet, and dust-layers on her furniture and less-used items. Additionally,
she is less independent than a swift look may reveal as she is backed up by
the local administration through a variety of support and preventive mea-
sures.

First and foremost in ensuring her primary livelihood is the welfare
support she receives in the form of the subsidised and very basic public
housing and financial additions to her meagre pension. Segihara-san, the
local care manager (23.08.2013), disclosed that a great deal of the seniors
she supervise who live alone are welfare dependent and rely on public
housing, as rents are too expensive in Tōkyō. For Yuma-san, the loss of
her husband significantly transformed her former life, making her eco-
nomically vulnerable and more dependent on public institutional support.
Even though she is the mother of three children, she expresses her grave
discontent about her relationship by telling us that "hontō ni kankei wo yo-
bararenai ne [you can't call it a relationship]^{114}" (#15, 23.08.2013) as she
only receives quarterly visits and no support at all from the three.

Second, Yuma-san is also supported by home helpers, even though their
nickname among care-related personnel and care recipients is helper-san
(ヘルパーさん, herupā-san, lit. Miss or Mister Helper). These profes-
sions inherently have rather low skill requirements as light medical treat-
ment or heavy nursing tasks are not within the remit of their duties. Thus,
these positions are often occupied by part-timers assisting seniors with
typical tasks in their daily life, e.g. support buying groceries, household
maintenance and cooking, but also support with personal hygiene. In par-
ticular, Yuma-san had required assistance buying groceries and doing the
housework. The care manager briefed me prior to our visit that she was
going to suggest additional cleaning help for Yuma-san, as she increasing-
ly seemed to be overwhelmed with it. In order to deal with the increasing
demand for minor tasks, the Welfare Department of Katsushika ward al-
tered the typical home help sessions of 30-minute blocks into smaller 20-
minute blocks. This way, minor activities that require less time can be
utilised three times instead of twice an hour—for the same fee and co-pay-
ment rate, which renders the new time units more versatile for seniors.

The third method of supporting Yuma-san is a small electronic device
that is worn around the neck, which gives Yuma-san courage in her daily
life: a pendant (ペンダント, pendentō). Equipped with GPS sensors and a

^{114} 「本当に関係を呼ばられないね」
calling device, the pendant is connected at all times to a centre of opera-
tors with access to helper-san, nurses, doctors, ambulances, hospitals, po-
lice and the fire department; these kinds of functional jewellery represent a handy solution for seniors lacking the mental and motoric capacity to op-
erate mobile phone technology for their benefit. Yuma-san used it once to call for help after she tumbled in her apartment.

The fourth, and probably the most flexible form of support Yuma-san enjoys, is that of a care manager. Through informal conversation while being treated with tea and some rice crackers, care managers evaluate seniors’ sorrows and concerns, their need for additional support, prescriptions from medical doctors, explain how to use emergency utilities, such as the aforementioned pendants, and help with daily occurrences. For Yu-
ma-san, a letter from the ward administration was confusing enough that she decided to wait for her care manager to help her decipher the legal lan-
guage and the city hall's request.

Despite her physical capacity diminishing successively, Yuma-san enjoys a self-determined life while relying on welfare programmes. The mechanisms which enable her livelihood are a dense network of public in-
stitutions on which she strongly relies, as her receiving familial support is rather unlikely. Then again, in her case, familial care and support from her children might have completely ceased after they realised that public bod-
ies provide adequate assistance for their mother. Although cases like Yu-
ma-san are common, the norm according to Segihara-san (care manager, 23.08.2013) is a combination of both private and public care support, in which the spouse is the main caregiver, who is supported by formal care programmes. Two peers of Yuma-san, who we visited on our bike tour, had such a combination. Both of them were octogenarian males and com-
pletely reliant on their wives for their livelihood as they organised the men's care, daily routine, activities and care support from public institu-
tions. The latter partially relieved their spouses of the burden of caring for their husbands.

These few seniors exemplify the altered principle of subsidiarity in the Japanese system of care for the elderly. Commonly, if the individual fails to provide for its own livelihood, the family steps in as a social and econo-
mic unit and is even obliged to do so under the Japanese Civil Law115. In

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115 Japanese Civil Law Book 4, Chapter 6, Article 877 states that "直系血族及び兄弟姉妹は、互いに扶養をする義務がある" [Kinship by blood as well as sib-
lings are obliged to furnish mutual support] Minpō (2013).
4.4 Less is more: preventive measures, day care and initiative taking

case the family become unable to provide for their relatives, the (local)
government enters into the frame. The LTCI introduced hybrid livelihood
upkeep support for the "family" part of the original subsidiarity principle
by offering support to caring family members in that phase. In most of the
cases I visited and heard reports on, the main caretaker was the family
(spouse and children, mostly women), who were supported by formal care
measures which gradually moved from less to more intrusive forms of
care. Care managers and community care are the palpable manifestations
of the delaying process of the "family" phase in the subsidiarity principle,
pushing the phase of total public reliance into the background and eluding
its resource-intensive involvement. The "family" phase is extended by
these minor adjustments by local governments and is still performed by
mostly female family members without proper remuneration. Informal
care, nevertheless, still received an upgrade as informal carers are now ap-
preciated. Furthermore, the family’s opportunity to receive care support
and care respite is considered to be a relief because it alleviates the family
and kin from care burdens in both a physical and an emotional way (Arai
et al., 2004; Miura et al., 2005). In addition, processes of social change
and normative behaviour were set in motion about how and in what way
the family is responsible for care:

"The LTC scheme has demonstrably changed the attitudes of caregivers.
More caregivers came to believe that society must look after the elderly after
only one year under the new program. In the short space of a year, there was
an obvious shift from the idea that the care of old folks falls to the family to
the virtually unheard-of notion that society must shoulder the problems of the

Such a notion as well as interpersonal conflicts are difficulties that Yuma-
san and her care manager have to deal with.

4.4.2 Getting old, getting poor: increasing poverty among the elderly

After approximately one hour of the morning routine, i.e. pouring and
serving green tea and senbei (せんべい, Japanese rice crackers) to pa-
tients, on my second day in the Shinkatsushika Royal Care Center, one of
the female-only care workers approached and told me that one of the male
patients wanted to converse with the tall gaikokujin (外国人, Jap.: for-
eigner; without any pejorative intention). Joining the "men's table", usually
occupied by six still quite healthy men, Takeba-san, an octogenarian
wearing a netted vest typical of hobby and professional photographers, introduced himself in humble Japanese keigo (敬語, honorific language) as a lifelong Katsushika ward citizen originally born in the Ibaraki prefecture. While our conversation continued, he explained that in the past he had actually been a photographer and had worked in a laboratory for photo development nearby. After retirement, however, he became frail and now has to rely on care services such as day care, which, as he laughingly explains, is a good opportunity to talk eagerly about his strong affiliation to Buddhism.

What struck me most in his introduction was that very early on Takeba-san casually disclosed information about his financial status by saying "watakushi-ha binbo no hito desu yo [I am a (financially) poor person]"116 (day-care patient #41, 06.08.2013) and emphasised his dependency on services provided by the ward. The nonchalance of talking about one's own financial status was not mere humbleness but had the deeper implication of providing economic background information on other seniors, as he hinted that many other day-care patients were in the same situation as him. Earlier that morning, Yamada Setsuko (山田 節子, 06.08.2013), the head of the nursing department in Shinkatsushika Royal Care Center, confirmed this information while giving me a tour through the care facility and a general overview of the elderly people there and their social background. According to her, this is also the reason why it is still common in the surrounding area of Katsushika ward to live in three-generation households as living individually is often unaffordable for many families.

Takeba-san became financially dependent after retirement as his pension was not sufficient to provide a livelihood for him and his wife, even though in times of self-employment he was also an employee of a small-sized enterprise. Such cases are widespread throughout Japan. A correlation between the advancement of age and increased impoverishment rates prevails and is indicative throughout Japan (Figure 4-13 below), pushing the elderly into welfare dependency on local administrations' livelihood assistance programmes. The minor symptoms show themselves in the discontent of seniors who live alone with food prices117 (Minato Kuyakusho, 2012b, p. 22), but the effects reach much further. As the most exposed and

116 「私は貧乏の人ですよ。」
117 When asked what is troublesome in the neighbourhood (地域での困りごと, chiki-iki de-no komari-goto), 32.7 per cent of 3,689 seniors participating in a multiple-choice survey stated that "the prices are too high" (物価が高い, bukka ga takai),
vulnerable population to the levering effects of age and finances, seniors who live alone also experience tight household budgets with little or no disposable income. Consequently, more than twenty per cent perceive their financial situation as slightly to quite problematic\textsuperscript{118} (Minato Kuyakusho, 2012b, pp. 22, 38).

**Figure 4-13: Relative poverty rate according to age group and gender in Japan 2012 (in per cent)**

![Relative poverty rate in Japan](image)


Note: Data on the relative poverty rate is mentioned in the Naikakufu White Book only until 2012; later editions do not provide this data anymore, but have rather switched to more abstract GINI coefficient analyses.

While individuals who live alone are considered to be most vulnerable in terms of economic risks, cohabitation is often regarded as a traditional and social way of avoiding economic risk. Prolonging cohabitation in multi-generation households, as is often the case in Katsushika ward, is in a wider sense a social manifestation of functional equivalents coined by Estévez-Abe (2008, pp. 3, 30-32). Functional equivalents represent a

\begin{itemize}
  \item which was the second-highest answer after "nothing troubles me" (特に困っていない, \textit{toku-ni komatteiru koto ha nai}) with 39.3 per cent.
\end{itemize}

\begin{itemize}
  \item The aforementioned survey also asked for the current financial situation (現在の経済状況の意識, \textit{genzai no keizai jōkyō no ishiki}) with the result that 14.4 per cent responded with "it is partially problematic" (やや苦しい, \textit{yaya kurushī}) and 7.4 per cent even stated that their economic outlook was "quite problematic" (かなり苦しい, \textit{kanari kurushī}).
\end{itemize}
proxy commitment to welfare policy through investments in remotely related public fields (agriculture, construction, etc.) to enable livelihood through the backdoor for families. Thus, functional equivalents act as a work-around to a rather—and arguably—weak welfare state. Work programmes for seniors act as pension equivalents. However, if their health forbids this option, cohabitation between seniors and their children remains a viable option. Related to that idea, economically forced cohabitation in a modern and post-industrialised society, is, in the sense of functional equivalents, a surrogate for insufficient public welfare measures to enable livelihood for needy seniors.

However, even though cohabitation is believed to reduce economic risk, multi-generation households are still financially vulnerable if one of the household members requires care. In 2013, approximately one quarter (23.6 per cent) of these households reported to have no financial leeway—in addition to mental and physical exhaustion (Katsushika Kuyakusho, 2013b, p. 151).

Coinciding with this data, even the rather upper-class ward Minato experienced a rise in poor households, i.e. households receiving welfare payments under the Livelihood Protection Law (生活保護法, seikatsu hogohō). In a five year span, the number of supported households grew by twenty per cent (1,471 households in 2007 up to 1,764 in 2011). Besides this considerable growth in neediness, the noteworthy detail is that 53 per cent of all these are seniors’ households119 (Minato Kuyakusho, 2012a, p. 153), which elucidates an aggravating development for the elderly. As living expenses in Tōkyō-to are considerably higher than in more remote areas of Japan, they are causing financial choke points for households. Furthermore, for households with seniors, LTC services and medical treatment co-payments additionally diminish the disposable income of households.

Co-payments for LTC services are ten per cent and constitute a considerable chunk of the money low-income elderly households receive. Despite that, preventive measures and day care have an egalitarian key component that is highly detached from the economic background of patients (see chapter 2 for an argument on the egalitarian design of the LTCI system, but also Campbell et al., 2010). Co-payments were introduced to

119 The term used is 高齢者世帯 (kōreisha setai), literally "old person household". But it is not further specified whether these are multi-generation households with seniors or seniors-only households.
avoid abundant misuse of ambulant LTC services in particular. However, the LTCI serves not only the function of providing actual physical care, but also social care.

For the minority of men in care facilities for the elderly, like Takeba-san, day care often exhibits a benefit that goes beyond the disadvantages of co-payments that might exceed the household's budget: social interaction with other men\textsuperscript{120}. As his frailty has developed and his eyesight has become increasingly untrustworthy, Takeba-san has had to give up his big passion of photography. Furthermore, cohabiting with his wife could not sate his need for adequate social interaction with external contacts and peers, which he hopes to find at the "men's table" at Katsushika Royal Care Center. And it shows as he is one of the few active men in day-care facilities laughing, chatting, joking and talking about Buddhism.

4.4.3 "Yappari kazoku ni mendō wo shitaku nē": women as actors in day care

Working as a volunteer with the main task of "attentive listening" (傾聴, keichō)\textsuperscript{121} directly among the seniors and staff members at San San Akasaka, as well as other care facilities, was advantageous. My presence in the institution was perceived by the others and experienced by me on two different levels: feeling embedded and excluded. Being part of different social contexts, involved in the facility's processes and interacting with staff members while being associated as trustworthy due to my approved volunteer status was beneficial—as was being the first foreigner at this care institution. The latter especially proved to be advantageous as the seniors explained their habits, values, mindsets, motivations and familial context in thorough detail. This was the case when seniors talked about their family, being curious about intergenerational cohabitation and care for the elderly in Germany, or inquired about my marital status, comparing it to their grandchildren's.

The task of being an "attentive listener" was actually not made up to squeeze a foreign volunteer, who was struggling with the Japanese lan-

\textsuperscript{120} Despite a few instances of small talk, men and women mingling and inter-gender conversations are quite exceptional and even dysfunctional.

\textsuperscript{121} The term hanashi-aite (話し相手) is also used synonymously, literally someone to talk to.
guage, into the care institution, but is a developing volunteering activity in many care institutions for the elderly. Seniors experience a lack of social interaction and communication, even in cohabiting relationships, and are often short of a conversational partner while feeling the need to communicate. Besides their endeavours, care workers cannot fulfil this task alone and have to rely on volunteers (福島 弘子, Fukushima Hiroko, volunteer coordinator, 7.11.2012).

While chatting about foreign food and beverages, in particular the many sorts of bread, sausage and beer—a perennial and popular topic—that some of the women had experienced during their journeys abroad and in Germany, care workers interspersed and often combined these talks with a spontaneous geographical quiz on the white board. These conversations occasionally tended to gravitate towards the topics of family relations, care for the elderly and care responsibilities in general, causing brisk discussion about norms and values among the women.

A female octogenarian patient (day-care patient #5, 16.11.2012), cohabiting with her daughter and bound to a wheelchair after a stroke, stated she initially refused care services, but her deteriorating health condition forced her into service uptake. Furthermore, despite living with another family member, she lacked social interaction, which she admitted by uttering that "mainichi uchi ni itero, ne, naka naka sabishiku natta ne [I was getting lonely by being home all day]". She added another striking point: "yappari kazoku ni mendō wo shitaku nē [I don't want to be a burden to my family after all]". This argument is remarkable as the majority of the elderly patients I met who were cohabiting expressed their desire to unburden their families from care responsibilities.

However, elderly patients do not solely ascribe the lack of social devotion to their family's unwillingness to look after them, but extrapolate unsatisfactory circumstances from intergenerational social changes, as a late septuagenarian from Saitama prefecture dryly expressed (day-care patient #7, 16.11.2012). Her observation was that "mukashi ne, kazoku ha isshoni sunde-te, koureisha wo mamotte-te... demo, genzai no kangaekata ga chigaimasu, ne... hitorigurashi kōreisha ya wakamono ga ōi, ne [in the past, families lived together, they took care of the elderly... but today's way of thinking has changed... there are a lot of seniors and lads who live alone]"

122 「毎日うちにいる、ね、中々寂しくなったね [...] やっぱり家族に面倒をしたくねえ。」
Assuming that the children’s generations are experiencing more social and economic pressure due to society’s senescence, an octogenarian woman (day-care patient #3, 21.11.2012), visiting San San Akasaka day-care unit five days a week, adds "wakamono ha watashi-tachi, ne, obāchan, ojīchan, wo shinpai shinakattara hougai to omou ne. Genzai seikatsu ni mo sutoresu ga ippai aru ne [I think it's better if the young don't worry about us, you know, grannies and grandpas. Nowadays life is already stressful enough"]124, expressing the tension she feels in her household, which she shares with her daughter and her daughter's husband. Familial care burdens and consideration of the living circumstances of younger generations are portrayed as an influential incentive for elderly women to rely on formal care support rather than refer to traditional values and claim familial care support. Despite their considerate thoughts, the dissatisfaction among the attending women with the status quo was perceptible.

Seniors utilising day-care services yields another vital factor in their daily life aside from receiving care. Even in cohabitation households the risk of being isolated during the day and being excluded from social interaction prevails since children hindered by work may not support their parents during the day in their daily life activities, such as hygiene, transportation, meals or conversation—or may be reluctant to do so due to tense family relationships. Consequently, another driving force behind elderly women utilising day-care services in a two or three-generation household is the need for social interaction. A septuagenarian woman, always with perfectly styled hair and make-up, a flirty attitude and constant usage of honorific Japanese, even described it as a retreat for her, a "sanctuary" from everyday life that also benefits her family:

"Dei kea ne, atashi ni ha, tokidoki sankuchūari darou to omoun desu kedo... kihonteki dei kea ga aruna ba-ai, kazoku ni sutoresu ga ōki-sugiru desho125 [For me personally, day care is sometimes like a sanctuary, at least I think so... basically, the stress put on families would be too much if there weren't day-care services]" (day-care patient #7, 16.11.2012).
Participating in day care is often perceived as recreational, despite the fact that it serves a medical and nursing purpose. Even the morning bus pick-ups are recognised as a diversion from the daily routine and welcomed – as the daring, jaunty and dark-humoured centenarian Fujida-san, who often occupied centre stage, put it: "dei kea aru kara yokatta. Asa ni kankō shitte ne [giggles], gogo ni tanoshimu" [I'm glad that there's day care. In the morning I go sightseeing [giggles]; in the afternoon I have fun] 126. This tiny woman with oversized glasses clearly took pleasure in visiting the day-care centre, telling jokes to her fellow residents, ragging with staff members, and addressing me with omae or anta127 with a smirk that drew painstaking smiles at first from staff members. Nevertheless, as far as the chatty and joyous atmosphere in the afternoon hours is concerned, most of the participating attendees share the similar notion of enjoying it, talking with newly met acquaintances and friends and about politics—which at that time was the Senkaku or Daioyu Island incident and Tōkyō's former right-wing governor Ishihara and his candidacy for the new Japan Restoration Party (Nippon Ishin no Kai, 日本維新の会)—as well as family issues and, of course, Japanese and Korean TV dramas.

For many seniors, day care is not only about the provision of outpatient care, a break from everyday life or has recreational value, but rather constitutes a major social event during the week. What is usually observable among the women in day care is the dedication they put into their outer appearance, wearing make-up, having coiffured hairstyles with a purple tint, wearing some pieces of jewellery, and even touching up their make-up during the free-time sessions. The kakarichō (係長, Jap.: chief clerk) of the Shinkatsushika Royal Care Center day-care unit, Satō Kimiko (佐藤 貴美子, 06.08.2013), explained that day care represents one of the few occasions for the elderly to interact in a social environment among staff and their peers128. Hence, the typical behaviour is oshare wo suru (おしゃれをする), dressing up and eagerly awaiting the next day-care visit for talks, discussions, games, fun and actual care. However, this applies only to

126 「デイケアあるから良かった。朝に観光してね [くすくす笑う], 午後に楽しむ。」
127 Both of these personal pronouns are considered rather rude and forms of the Japanese language used more by men or juveniles. Omae, however, was also used as an honorific pronoun.
128 And often rather new, as new patients move in and older patients either get a new schedule or move to institutional care. Or in some cases pass away.
those patients with a solid health condition, in particular women, as men suffer from ill health more often.

The sex ratio is heavily imbalanced at high ages demographically and also among day-care patients, so is the interaction rate between genders. While women are active and outgoing, men behave fairly passively, without participating during conversations and other social activities, making interaction with other patients or staff rather impossible—which is probably caused by their physical and mental handicaps. Familial caretaking in these cases would not only pose financial and severe burdens time-wise, but also a heavy mental strain. Since the mental and physical state of the male patients repeatedly indicates that they could not be left home alone, they would require monitoring by family members throughout the day. The assumption is therefore that the majority of male patients did not voluntarily choose the day-care centre by themselves, but that their family had to decide.

Nevertheless, male day-care patients still seem to socially benefit from the time in day care, besides the advantages that professional care treatment has to offer. One of the few men was a sporty but rather unresponsive octogenarian (day-care patient, #4, 22.11.2012), who had lived in the United States for some years and is now suffering from dementia. His condition led to unforeseeable behaviour, such as randomly getting up and roaming around the facility. In one of his better moments, he mentioned that "kochi ni ha, ii da ne [laughs]... iron na akuteibitī wo yatteru kara [it's nice here [laughs]... because I can do several activities] "129. Even though he is by far not in the same state as Takeba-san, the chatty photograph, and usually does not express his feelings to either the care workers or the nurse, this octogenarian obviously enjoys his time in day care.

4.4.4 Captives of mind, body and family relationships: seniors in institutional care

Although attending day care was entertaining and often uplifting due to my conversations with the elderly, their stories, narratives and glimpses into their past, institutional care rarely was. But this is often rather an issue

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129 「こちには良いだね　[笑う]。色んなアクティビティーをやってるから。」
of patients "becoming cucumbers" (Long, 2003) and consequently of the lack of ways to communicate properly with staff, peers or the very rare volunteers\textsuperscript{130}. But even without the proper means of communication, I encountered highly demented and physically disabled patients who expressed their joy at conversing with someone, being held by the hand and talked to with a smile. Even though the care personnel eagerly try to fulfil this function, time constraints and other duties are regularly a hindrance to more extensive social interaction and communication.

Yet another account on ageing issues in Japanese society was given by a physically handicapped woman in institutional care, who presumed that socio-economic circumstances and the pressure that is imposed by society on younger generations are decisive:

"Mukashi no kazoku ha oji-chohan wo mamotte-te, ki wo tsuketa. Genzai wa totemo chigau ne. Ima no wakamono, ne, ima no shakai ha, iron-na mondai aru ne. Shōshika ga dete, kōreisha wo mamoranakute, shigoto mo nakute, setai-ninjō ga dan dan waruku nachatte…
[The family of the past protected grandpa and grandma; they took care of them. Today it's completely different. Today's youth, today's society, they have different problems. A declining birth rate has surfaced, seniors are not protected any more, people don't have work, and the customs and behaviour have gradually worsened…]"\textsuperscript{131}

(institutional care patient, #6, 05.12.2012)

This patient's pessimistic and acrimonious view on society's handling of care for the elderly and care responsibilities is also a consequence of the complicated circumstances of her relationship to her family. Although still in better physical and mental state than her fellow seniors in the institutional care unit, she cannot live an autonomous life just by utilising day care and relying on her social or familial ties due to her increasing dementia and physical incapability and, hence, had to be institutionalised. As she has the impression of having been pushed out and already abandoned by her family, she perceives institutional care as the initial phase of gradual death, increasingly becoming boke (呆け, a derogatory word for senile pa-

\textsuperscript{130} A Japanese Christian priest from the church next door was a weekly visitor to the institutional care units and very dedicated in his routine. Other volunteers are uncommon in institutional care for several reasons.

\textsuperscript{131} 「昔の家族はおじいちゃんとおばあちゃんを守ってて、気をつけた。現在はとても違うね。今の若者ね、今の社会は色々な問題あるね。少子化が出て、高齢者を守らなくて、仕事もなくて、世帯人情が段々悪くなっちゃって。。。」
tients) and growing rapidly senile due to insufficient outside contact and in the end a mindless body. During our initial meeting, she expressed her situational discontent by scolding me for visiting, as it gives her the feeling of being a zoo animal that is gazed at by tourists and passers-by. But her anger dissolved shortly after; she opened up and eagerly talked about her passion for history, the Sengoku period and the Kamakura shogunate.

I surmise that many institutional care patients experience similar fates, which are combinations of inaccessible support through social institutions, basically the reliance on familial care, and are partly driven by the limits of formal care provided by public institutions. Here especially organisational structure and personnel are limiting factors. The former is a requirement to keep most institutional care units off limits for visitors due to concerns for safety, privacy, intimacy and medical reasons. The fact that institutional care facilities are often off limits is often for the safety of patients, as patients with dementia might erratically start to roam around and leave the building, which might endangering their lives\textsuperscript{132}. However, as care facilities for the elderly are usually tightly staffed and inpatient care is both work and time-intensive, the aspect of social interaction between staff and patients might be neglected. The lack of diversification (contacts, activities) and the tendency towards totalitarian institutions (Goffmann, 1961) in aspects of daily routine and autonomy especially might hit patients with a better health condition severely and initiate their social passing in:

"a place of residence and work where a large number of like-situated individuals, cut off from the wider society for an appreciable period of time, together lead an enclosed, formally administered round of life" (Goffmann, 1961, p. xiii).

\textbf{4.5 State of affairs: an interim conclusion}

I have tried here to depict a comprehensive overview of care for the elderly in inner Tōkyō. By illuminating demographic and social differences between yamanote and shitamachi wards, I have made it clear that each ward has its own approach to welfare and care for the elderly. Furthermore, combined care facilities for the elderly ("all-in-one") are widespread due

\textsuperscript{132} Care homes for the elderly in Germany regularly and successfully utilise fake bus stops in front of their facilities to "catch" free roaming dementia patients. In Japan access to such facilities is limited with access control systems.
to the restricted availability of space in Tōkyō and the utilisation of synergy effects.

Three bigger issues, rooted in the macro, meso and micro levels of interaction, can be concluded here: care organisation, reliance on public institutions and women as actors.

First, the complex network of metropolis care organisation, if looked on from above, appears like gigantic patchwork of regulated and less regulated areas of welfare and care for the elderly. While the LTCI law regulates the availability and provision of services, local governments may enhance them with additional, custom-made services they regard as beneficial for their senior demographic and their social support. However, the high diversity of the demographic composition and socio-economic backgrounds is indicative for the complexity of Tōkyō-to and the approaches of its wards to welfare. The diverse situation is also reflected in LTC budgets, with Minato ward now spending less than expected, while Katsushika ward is in need of a supplementary allowance.

Second, the elderly in all wards showed high reliance on formal institutions as providers of their livelihood overall. The stigmatised image of formal care receivers as welfare scroungers has long since passed, so seniors may use LTC services without any qualms as they are entitled to—and have even had to be stopped from abundant over-utilisation of LTC services through reforms. Nevertheless, such feelings cannot last in the contemporary society of Tōkyō. High economic pressure and the diversification of lifestyles weigh heavily on families, especially if they provide informal care for their parent generation and have reached retirement age themselves. In this regard, the impression of seniors in care facilities as having been socially abandoned by their families seems less harsh, in particular if one realises that informal caregivers are often aged sixty and over, providing care for their twenty to thirty year older parents, and are confronted with their own physical and mental limits as well as frailty. These social issues, however, are clear to many caretakers, as the high reliance of seniors on public support shows. While there are cases of total reliance on welfare and care services for one's livelihood, the majority use a combination of informal and formal care. The reasons for this are either to unburden the family by, at least partly, phasing out care duties but still having their relatives remain in the accustomed environment, or, in case of complicated family circumstances, to be cared for without having to put a brave face on a bad situation.
And, third, and directly connected to the paragraph above, is the capability, especially among women, to utilise the situation of them needing care to their own and often their families' advantage. Attending day care was in the case of most women their deliberate choice as a means of social interaction and actual care. For elderly women, the need for social participation and avoidance of isolation are driving factors to choose day care over—or in addition to—home help. Otherwise, it is their physical rather than mental handicaps that hinder them from maintaining frequent social ties within their community. Social interaction, however, is in fact considered essential for immobile seniors, as a wheelchair-reliant nonagenarian concisely put it: "uchi wo deru ne, hanashi wo kiku, kakeru ne, ichiban taisetsu datte omou no [I think that leaving the house, listening to stories and telling them is most important]"133 (day-care patient #5, 16.11.2012). For elderly men the picture is different as it seems that their families made the decision to utilise care services and were even pressured to act due to their low levels of autonomy and poor health condition.

These observations indicate altered power distribution within the family. Basically, it appears as a reversal of the institutional functions of the family as a result of changes in the power and processes of decision-making due to ageing. It renders women as conscious and confident actors with intentional reliance on public support to avoid family care tie-ins as much as possible, while men, often at a stage of mental incapacity, have no other option but to rely on a mix of private and public care or institutionalisation.

Labelling it as kojin shugi (個人主義, individualism), seniors do not only try to describe and explain the rudiments and developments of an individualising society, but also familial conflicts of role and interest. It becomes clear in conversations with seniors that their children's generation is trapped in a conflict between responsibility, care and aid for their parents, and responsibility for their own life, including family and employment. Such a value change manifests itself in a persistent decrease in three-generation households and the simultaneous increase in single-person households134, of which the amount of elderly single-person households has grown exceedingly. Based on the spatial separation of different generations, care for the elderly given by their children is impractical or

133 「家を出るね、話を聞く、かける、ね、一番大切だって思うの。」
134 Note the difference between the different wards.
even impossible and creates conflict potential through further diverging opinions on responsibility and changing values. In some interviews, day-care patients uttered their discontent about their children's reluctance to give them care, their low level of affection towards their parents and traditions, and the resulting necessity for seniors to utilise day-care services—although at times it sounded more like an attempt to legitimate their usage of public care services. But it also depicts the often precarious situation in which seniors find themselves and which requires action. Contributing by offering options to set up a custom-made patchwork of welfare and care services for the elderly, local governments try to alleviate the gaps and issues that an ageing society and social change entails.
5 Diversity in care for the elderly

Major differences exist in the implementation and execution of care for the elderly in urban and peripheral areas. The availability of comprehensive and integrated care facilities is less developed in rural areas and has a stronger focus on single-purpose care facilities, providing only particular care services (e.g. day care) within the respective town districts. Community and family care is emphasised in rural areas, and the aim is the creation of a family-like atmosphere and environment, while urban care facilities for the elderly tend to convey a more formal, public facility-esque mood. Differences, however, are not only found in the set-up of care institutions, but also in other domains, e.g. gender-based labour division, activities among patients as well as social interaction.

The varying, but existent diversity between urban and peripheral care institutions and arrangements is a salient point when comparing the implementation of care policies. Through me conducting fieldwork in both areas, the interlocking and coherence of the local care system for the elderly and its production of integrative effects came to light. The several meshes of prevention and care measures in Komagane interlock seamlessly and provide a coherent arrangement of care (see Figure 3-4 for an overview of the meshes). Partially, this is also true for Tōkyō as well, although the stronger local diversity and a closer inspection of the meshes of welfare for the elderly reveal complex but rather mixed results concerning the inclusionary effect of care for the elderly.

Differences between the facilities in Tōkyō and Komagane in terms of their set-up can be linked to three essential points: personnel, the equipment of the facility and the activities conducted, i.e. they are rather tied to the meso-level of organisation. Care facilities have to guarantee the provision of a spectrum of care measures and prove that specific criteria (e.g. nurse to patient ratio) are met to get permission to operate as care facilities. However, variations in their organisational structure, methods and approaches towards the patients exist and will be explicated in the next part.

Personnel constitutes a pivotal point in institutions that aim at providing care and facilitating social interaction, such as day-care centres. They are an intermediate point between personal contact and an institutional frame for the seniors and should ideally represent the patients gender-wise to be
able to adequately discuss and handle gender-based issues if patients raise them. Interestingly enough, in Komagane approximately five per cent of the care personnel are male in the care facilities of *shakyo*, a non-governmental institution which has close ties to the city’s administration (see chapter 3). In a private all-in-one facility (day care, institutional care, assisted living and group home) circa ten per cent of the care staff are male.

The differences in these institutions are not only the ratio of males to females, but also their methods of communication. Male care workers are rather prone to task-oriented communication while female care workers are well versed in both task-oriented and sociable communication about family and household, and it seems easier for them to engage in general small talk with patients. But on the other hand, an equal proportion of staff in terms of gender is not necessarily favourable if the composition of the target group is evaluated—60 to 100 per cent of them are female patients. And for many female patients it is important to have female contact persons, in particular for hygienic tasks.

### 5.1 Multiplicity in care facilities for the elderly

Social welfare and care for the elderly are, despite all the efforts of gender research and governmental and company-based equality promotion, whether voluntarily or involuntarily, a woman's domain. It was clearly visible during all my visits to care facilities in urban and rural Japan that women are still regarded as the main providers of care, welfare and sociality. The next paragraphs will illustrate gender-based observations among care personnel, patients and even activities.

Despite political and societal debates about promoting gender equality in the labour market, the care profession is still a female domain, which shows in particular at times when things have to be improvised or household chore-like tasks have to be carried out. The *Honobono Club* in Komagane, a preventive measure to circumvent age-related diseases and issues, such as immobility and loneliness, positions itself as an intermediary between maintaining self-dependence in old age and at day care, and can be understood as pre-day care. The whole club is operated by three female full-time employees and one female part-timer, who joined during my fieldwork, and depends fully on their performance, i.e. pick-up services, medical examinations, conversation, daily programmes, partly the prepa-
ration of meals and snacks\textsuperscript{135}, and the preparation of futon beds for the seniors’ afternoon nap. According to the deputy head of the local shakyo, Katagiri-san (片桐), men in Komagane could not perform this kind of work since they primarily lack essential cooking and social skills. The Honobono Club leader Nakajō Yoshiko (中城 芳子) agreed and confirmed that point by stating:

\begin{quote}
Iroiro-na mondai ga detekimasu node, dansei ga sono shigoto dekinai to omoimasu. Josei no furekushībiritī ga hōgaiī desu. Tokuni sōsharu sukiiru ya ryori tsurikata nado tokui desuyo.
[I think that men could not do such kind of work since many problems / issues arise. Women have greater flexibility. In particular, their social skills and cooking skills are better developed.]
\end{quote}

Another considerable difference in the two regions lies in the organisation and equipment of their care facilities. Tōkyō is dominated by all-in-one institutions which, besides day care, also offer institutional care and are equipped with big rehabilitation areas, in-house canteen kitchens which prepare meals for more than 100 patients according to medical guidelines (diabetes, lactose intolerance, etc.), and in-house medical professionals. Admittedly there are variations between the facilities, but this is the defining impression of Tōkyō’s care institutions for the elderly.

The higher number of patients in Tōkyō’s day-care centres (see Table 5-1), which can reach 40 per day, exposes care workers to a higher stress level in fulfilling sanitary and organisational tasks, which results in less social interaction with the seniors. Also, the two day-care centres in the shitamachi districts, Asakusa in Taitō-ku and Horikiri in Katsushika-ku, resemble clinics and hospitals in their their furnishings as they are equipped with linoleum floors, plastic table cloth and twinkling, washable latex paint on the walls. This is also apparent in an all-in-one care facility in Komagane. In contrast, one all-in-one institution in yamanote had rather cosy furnishings with carpeted floors, decorations and flowers as well.

\textsuperscript{135} Lunch is prepared and delivered from a nearby day-care facility, but is charged at 500 yen per meal.

\textsuperscript{136} 「色々な問題が出てきますので、男性がその仕事できないと思います。女性のフレクシービリティーが法がいいです。特に、ソーシャルスキルや料理つくり方など得意ですよ。」
Table 5-1: Overview of patients and care personnel of the day-care facilities I visited daily

<table>
<thead>
<tr>
<th>Facility</th>
<th>Location</th>
<th>Type</th>
<th>Patients</th>
<th>Care staff</th>
<th>Female care staff ratio</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 (SSA)</td>
<td>Minato ward</td>
<td>Day care¹</td>
<td>≤ 30</td>
<td>10</td>
<td>60%</td>
</tr>
<tr>
<td>2 (SKR)</td>
<td>Katsushika ward</td>
<td>Day care¹</td>
<td>≤ 42</td>
<td>8–12²</td>
<td>100%</td>
</tr>
<tr>
<td>3 (ASK)</td>
<td>Taitō ward</td>
<td>Day care¹</td>
<td>≤ 45³</td>
<td>8–12²</td>
<td>70%</td>
</tr>
<tr>
<td>4 (HB)</td>
<td>Komagane</td>
<td>Pre-Day care⁴</td>
<td>≤ 18</td>
<td>3–4</td>
<td>100%</td>
</tr>
<tr>
<td>5 (KE)</td>
<td>Komagane</td>
<td>Day care</td>
<td>≤ 28</td>
<td>10–12</td>
<td>80–90%</td>
</tr>
<tr>
<td>6 (YE)</td>
<td>Komagane</td>
<td>Day care</td>
<td>≤ 30</td>
<td>10–12</td>
<td>80–90%</td>
</tr>
</tbody>
</table>

Source: Observation and interview data.

Note: ¹ an “all-in-one” care facility with dedicated day care and institutional care; ² during my fieldwork understaffed with three persons; ³ segmentation of the day-care unit into two divisions (patients without and with stronger signs of dementia), numbers combined; ⁴ not covered by the LTCI, but with 1,300 yen/day less expensive than LTCI with 10% co-payments.

In Komagane, care institutions for the elderly are generally divided spatially according to the extent of the care needed, institutional care only or day care only. Day-care centres in Komagane are designed on a smaller scale in regard to range and number of personnel, patient capacity and outfit. The consequence is that the care staff require a stronger all-round orientation, i.e. care workers are responsible for the carpool and patients' pick-up, while in Tōkyō these tasks are carried out by dedicated personnel and/or administrative employees.

5.1.1 *Ii fun’iki*: enjoyable settings for day care users

With regard to financial resources, non-profit care organisations for the elderly are restricted and mainly rely on revenue from the national LTCI funds. Additional income is generated by offering supplementary services, e.g. single rooms. Despite the financial limits for care facilities, day-care facilities in particular, ranging at the intermediate level of the neediness scale of frailty-prone seniors, endeavour to create *ii fun’iki* (いい雰囲気), a friendly and cosy atmosphere. To achieve such an atmosphere, three fac-
tors are essential: the behaviour of the personnel, the inner and outer appearance of the facility, and the design of the care programme’s daily schedule. In spite of the fact that the facility's appearance, e.g. wall and entrance decorations, is commonly a merely optical element, it has a considerable impact on the patients’ mood. The behaviour and attitude of the care staff, on the other hand, are significant factors in seniors' satisfaction with the care services provided and are also used as inclusionary action (see section above, 5.4). The same applies to the care programme’s design, i.e. teatime, afternoon naps, extra services such as park visits or excursions during national holidays, e.g. hanami, aim at achieving a policy of bringing people together in these facilities, but are at the discretion of the care facility managers to decide upon—and cannot be provided under dire conditions, e.g. lack of personnel.

The creation of a pleasant atmosphere begins with the transportation of the up to forty day-care patients from Monday to Saturday. The usual policy, which is due to constrained resources, is to only pick up patients within a small radius of the respective care facility in white, facility-owned minibuses equipped with wheelchair loading arms. The care programme design of San San Akasaka, though, is extended beyond that, and patients within the whole of Minato ward are picked up and returned from doorstep to doorstep without the facility demanding the usual extra charge\(^ {137} \). According to the Volunteer Coordinator of San San Akasaka, this was a decision made by the facility's head to enhance a friendly atmosphere and positive attitude among the seniors and towards the care facility:

"Kōreisha ni ii fun‘iki wo suru tame ni, kachō, ne, muryo kōtsū wo kettei shimashita [To create a friendly atmosphere for seniors, the head of the facility made the transportation free]"\(^ {138} \) (Fukushima Hiroko 福島弘子, 24.10.2012). The next ii-fun‘iki-step is experienced after arriving at the facility. While the following part is true for many of the facilities I visited as they also

\(^{137}\) Several other day-care institutions for the elderly in Minato ward illustrate on their websites and in their pamphlets which areas are served by their transportation services and which require an extra charge. Usually, the radius is up to a maximum of three kilometres around the institution, which, considering the dimensions and complexity of Minato ward, is still a rather extensive shuttle transfer.

\(^{138}\) 「高齢者にいい雰囲気をするために、課長ね、無料交通を決定しまし
た。」
offer a rich style of decoration and are oriented towards creating an enjoyable ambiance, San San Akasaka was quite outstanding in its way. Upon entering the *genkan*, the Japanese entrance, patients, personnel and visitors change their shoes for slippers. This is common in all care facilities, but the novelty I experienced in the care facility in Minato was the slightly perceptible scent of vanilla and sweet chestnuts. Wearing slippers throughout the day and in the whole care facility, which features a fully carpeted floor—except in the sanitary facilities, where toilet slippers are available—the seniors slowly hobble and wobble towards the main room. The walkway from the *genkan* to the day-care room is furnished with a seating area with a birdcage containing two lively budgerigars and a golden hamster in cages, a small aquarium with vibrant, tiny fishes, and several shelves filled with colourful books, handcrafted origami, pictures made out of bottle caps and knitted goods made by patients. This potpourri of colours alone caters for a positive mindset. Seniors also use the seating area during their free-time time slots in the daily schedule to rejoice by watching the tiny, yet busy animals frolic.

Differences I experienced and observed between the *yamanote* and *shitemachi* facilities occur in these points. Particularly if the financial situation is unsatisfactory, from the perspective and duty of providing and guaranteeing care for the elderly, decoration and atmosphere seem like minor and negligible points. Hence, nice-to-have items, such as outer appearance and supplementary free-of-charge services are reduced or unavailable.

The day-care room, or more commonly the so-called day room (デイルーム, *dei rūmu*), itself is openly constructed as a big space with shelves and boards as room dividers for napping, massaging, or medical examination areas. Day rooms are occupied by seniors sitting at washable tables on thick-cushioned chairs, watching TV and chit-chatting about local elections, the rise in Japanese consumption tax\textsuperscript{139}, or the weather while they are waiting to be bathed or engaged in an entertainment or exercise programme by staff members or volunteers. In order to create an even more homely atmosphere, the temperature, especially in the day room where most of the day-care activities take place, is raised to approximately 23°C to 24°C in winter and is cooled to 28°C in summer. Besides some minor

\textsuperscript{139} Raising the consumption tax from 5 to 8 per cent was debated frequently, but the argument that it is needed for reconstruction was convincing.
differences, such as linoleum instead of carpet, that applies to almost all
day-care centres.

Further, the day rooms in Komagane's day-care centres are designed
and decorated to resemble living rooms, e.g. with floors carpeted with eas-
ily exchangeable carpet tiles, wood panelled walls with plenty of colourful
origami, pictures and calendars posted onto them, and, since all facilities
are at ground level, big glass sliding doors that—at least theoretically—
allow access to the veranda and green spaces. The interaction between
care personnel and patients in Komagane is a mixture between task-orient-
ed and care-oriented communication (questions concerning the seniors’
condition, family, daily life) and sociable communication (small talk,
weather, TV programmes)—at least the latter was rarer, but definitely also
present in Tōkyō's shitamachi facilities.

The day-care facilities had a greater diversity in their institutional set-
up, their care focus for geriatric care and their organisation of care work,
which will be discussed in further detail in the next paragraphs.

5.1.1.1 Minato ward: San San Akasaka

Opened six days a week, the comprehensive care facility San San Akasa-
ka, lying in the shadow of a luxurious 45-storey apartment skyscraper with
its own spa and concierge service in the eponymous Akasaka district, of-
fers three types of welfare services ranging from childcare to care for the
elderly within individual units. San San Akasaka is a shakai fukushi hōjin
(社会福祉法人), a social welfare service corporation operating on behalf
of the Minato ward administration, but it belongs to a holding company
focused on establishing social welfare facilities.

While a separate wing of San San Akasaka’s first floor houses a child
welfare service that offers educational support to and organises free-time
activities for up to 60 children, the second and third floor are reserved for
institutional care. The latter is provided for seniors with severe mental or
physical disabilities, such as dementia or the after-effects of a stroke. Its
available capacity is 100 patients or 100 beds in total, of which 80 beds
are accessible on a regular basis and 20 beds are reserved for short-term
institutionalisation of up to two weeks. These are to be used for medical
treatment and as mental retreats for seniors and their families. However,
due to cost-effectiveness and scarcity of space, of these 100 beds only 24
are located in single rooms, which are additionally charged for, while the
majority are two-person or four-person rooms, the cost of which is covered by the LTCI.

Finally, the day-care unit is located in another wing on the first floor of the facility and provides services for up to 40 elderly patients with only limited mental or physical handicaps. Those 40 seniors are further divided into 30 so-called regular patients and 10 patients with advanced mental or physical decline. Their condition is not severe enough for them to be institutionalised and thus allows them independence to a certain degree by using day-care services. In total, San San Akasaka is an average-sized all-in-one care facility with 100 institutional care beds, but is ranked among the bigger day-care services with its capacity for 40 patients.

The institution itself is well maintained and radiates a friendly, homely atmosphere with its well-lit and nicely decorated and carpeted entrance and day-care area, featuring a reading corner, an aquarium and a caged, lively budgerigar. The floor walls to the so-called Day Room, in which the day-care patients reside throughout the day, as well as the Day Room itself, are decorated with hand-made pieces of handicraft by the seniors, which provides inviting scenery for new and already accustomed patients.

5.1.1.2 Taitō ward: Asatoku

The all-in-one care facility of Asatoku is part of the Taitō ward administration's social welfare service (社会福祉事業, shakai fukushi jigyō) and is operated under the legal form of a social welfare corporation (社会福祉法人, shakai fukushi hōjin). It is located between the red-light district of Senzoku (千束), which is even busy at noon, and the crowded tourist hub of Asakusa, the Sensoji temple (浅草寺) and its famous long strip of trinket booths and snack kiosks. The ward's administration operates several other comprehensive care institutions for the elderly in Taitō ward, i.e. in Minowa, Yanaka, Ueno and Asakusa, each opened six days per week and

140 In Tokyo the average is 99.88, the minimum 57 and the maximum 120 beds per care facility (Minato Kuyakusho, 2012a, p. 66).
141 The average capacity is 27 patients, but ranges from 8 to 50 patients (Minato Kuyakusho, 2012a, p. 67).
142 The facilities full name is Taitō-kuritsu Tokubetsu Yōgō Rōjin Hōmu Asakusa (台東区立特別養護老人ホーム浅草, Taitō Ward Intensive-Care Home for the Aged), but both staff and patients use "Asatoku" for the sake of simplification.
with its own corporate identity. Asatoku, although located in a calm by-road, is embedded in a lively neighbourhood surrounded by a small park and an adjacent elementary school, which themselves are set in a residential area with four to five-storey high buildings with occasionally looming small mom-and-pop shops and restaurants.

As a five-storey all-in-one facility, Asatoku hosts a centre for visiting care and home help, as well as a community care bureau, which is in charge of counselling seniors and organising events for the elderly. Furthermore, it provides institutional care for heavily demented and bedridden patients and has a capacity of 84 patients (4 are short-stay patients). Day-care users utilise the centre’s capacity, which is available for normal (40 seniors) and slightly demented patients (12 seniors).

Some aspects of organisation, however, make Asatoku stand out among other comprehensive care facilities. First, I was deeply surprised by the frankness in which the head of the institution Yama (山) and the head of Special Nursing Marutani (丸谷) both addressed and even apologised for the neglected look of their facility in our initial meeting (Yama Masayuki 山 昌幸, Marutani Masato 丸谷 正人, 07.08.2013). Yama continued by explaining that the facility had not undergone much renovation since its establishment in 1985, and elucidated that continuous renovation fund applications had been rejected—hinting at administrational and organisational issues with the ward’s administration. Consequently, it had led to the situation of them merely focusing on "shisetsu no seibi"143, i.e. maintaining the facility (Yama Masayuki, 07.08.2013). While the lack of refurbishment shows most obviously in the murky entrance, it is also apparent in the dated but still functional equipment, tainted wall paint and occasionally battered linoleum on each floor.

Second, normal and demented day-care users in Asatoku are separated into two different day-care units. Asatoku uses two different floors to differentiate between the patients’ mental health status: slightly demented patients are located on the first floor while mentally healthy patients seeking day care, who constitute the majority, are cared for on the fifth floor.

143 「施設の整備」
5.1.1.3 Katsushika ward: Shinkatsushika Royal Care Center

Despite its pompous name, there is nothing ostentatious in the Shinkatsushika Royal Care Center (新葛飾ロイヤルケアセンター, Shinkatsushika roiyaru kea sentā). In fact, it rather resembles an average comprehensive care facility, somewhere between the facilities in Minato and Taitō wards in terms of condition and cheerfulness, e.g. decoration, interior design and daily programme. The Shinkatsushika Royal Care Center is an all-in-one care institution with day care for the elderly, a centre for rehabilitation, and a home help and community organisation centre located on the ground level, while the remaining three floors have been allocated for institutional care. The private facility is part of a corporation which focuses on medical care and care for the elderly, the Itabashi Medical System (IMS), running several hospitals and care facilities for the elderly that are mostly located in the outer parts of Tōkyō metropolis, e.g. Itabashi-ku, Kita-ku, Katsushika-ku and Hachiōji-shi.

While the institutional care unit houses up to 150 patients, including capacity for 50 dementia and short-term patients, up to 40 patients visit the day-care unit on six days per week in a massive day room. Even though the day room is bright, looks freshly renovated and the building is well-maintained, the facility conveys a hospital atmosphere. This results from the combination of linoleum floors and, for easier disinfection and cleanliness, latex painted walls, as well as the vast dimensions of the day room. The latter, besides several load-bearing columns without any room dividing elements, is an enormous part of the gigantic hall that encompasses almost the whole first floor. The day room part is slightly decorated with handicrafts, calendars and pictures, but as part of a gigantic hall, it does not have the traits of a cosy living room atmosphere, which many day-care facilities try to establish, but rather that of professional streamlining and efficiency.

The Shinkatsushika Royal Care Center is embedded in a residential middle-class neighbourhood with an equal mixture of blue and white-collar employees occupying the crowded Keisei Chūō-sen, which operates between Narita International Airport and Tōkyō and traverses through Horikiri-shōbu-en station (堀切菖蒲園), where the facility is located. The care facility for the elderly is surrounded by its holding company's sub-branches: the adjacent Shinkatsushika Royal Clinic (新葛飾ロイヤルクリニック) for minor medical issues and the Shinkatsushika Hospital (新葛飾病院 Shinkatsushika Byōin) on the opposite side of the street. Conse-
quently, this hub of medical care and care for the elderly embeds the Shinkatsushika Royal Care Center in a privately (IMS group) and publicly (ward administration) created dense network of local elderly livelihood providers, easing the issues of counselling, service up-take and seamless progression into more comprehensive forms of care as a patient’s health declines. From an infrastructural viewpoint this facility seems to offer a great setting for a municipality’s ageing population.

5.1.2 Human resources management and organisation of care

In all areas that require direct contact with patients, women are either overrepresented or the sole care personnel. Although mentioned in earlier paragraphs, spatial disparities are observable in this context, too.

Peripheral Komagane was a particularly good example of female over-representation. Six out of the eight care facilities I visited had a care staff consisting of women only; the remaining two also had male care workers who made up a fifth of the whole of the care staff. In these two facilities, which provided day care, even though the range of duties overlapped as a matter of course, slightly different gender-based assigning of remits was evident. Men often had physically more demanding tasks, which also required the use of technical equipment and devices, such as fleet management and maintenance (driving minibuses, handling patient pick-up and preparing wheelchair ramps), maintaining the grounds, and the handling and preparing of equipment (moving beds, spreading out the futons for after-lunch naps and heating up the yutanpo foot warmers). Whereas women were almost exclusively engaged in the direct contact with the elderly and performed mainly medical (measuring blood pressure, handing out medication), nursing (hygiene, feeding) and social tasks (communication, interaction through playing).

144 What is meant here are all the facilities I visited, not only those which I visited regularly or daily, as depicted in Table 5-1. This includes day-care facilities, all-in-one facilities, group homes, more informal ōchanomikai and saron (see chapter 3.3.1 for more information on the latter). I visited and volunteered at three facilities on a daily basis.
In the four facilities I visited in Tōkyō the observed gender images were less indicative, although the basic trend seems to be a more equal distribution of sex ratios and task assignment, and the performance of the care personnel. One day-care facility in the yamanote (number 1 in Table 5-1) district had almost gender equality in regard to sex ratio and duties, while another one (number 3 in Table 5-1) had about 30 per cent male care workers and assigned tasks to them between "technical-functional" and "social-nursing", as is done in Komagane. On the other hand, in the third and last institutions (number 2 in Table 5-1) in Tōkyō there were solely female care workers. Generally, in all the care facilities for the elderly in Tōkyō that I visited, duties such as fleet management or maintaining the grounds were done by dedicated employees, usually from the administration offices, and not by the care personnel as in Komagane. This is due to the synergy effects that all-in-one care facilities entail.

In communication with patients, female care workers regularly proved to be more empathic to topics and sensitive to moods than their male counterparts, habitually having small talk about preferences, family, flowers and daily life, whereas men rather limited themselves to initiating task-oriented dialogue.

Nevertheless, one aspect that was equally pronounced in both Komagane and Tōkyō is that the majority of the administrational staff were men. In particular, this is true in elevated positions. Even though some unit heads were women, e.g. in an all-in-one care facility in Tōkyō's shitamachi or a day-care centre in Komagane, when it comes down to the facility's or company's head, they were solely men.

The observation was that care work is a highly gendered profession with a more or less strict division of labour. Furthermore, it seems that there is a hierarchical and structural component to gender in care work because:

"the LTCI Act contributed to reinforcing structural gendered divisions of care work: a division between institutional care and domiciliary care, care services and domestic services, and private companies and WNPOs [welfare NPOs; author's note]. There is an unequal distribution of gender for each type of care work. [...] After the LTCI Act's implementation, female family members may provide less unpaid care services in the household. However, although WNPOs, which are still predominantly run by middle-aged women, place a rela-

145 Of the four care facilities for the elderly that I visited, I visited three on a regular, daily basis.
tively high value on domestic task services, responding positively to the high demand for such services based on skills gained through being a housewife, these services are now placed at the bottom of a hierarchy of care work by the Act.” (Yamashita, 2011, p. 441)

In this way, the formerly unpaid care work by women was formalised and incorporated into the LTC structure, which now exerts its hierarchical dynamics in the low-paid, part-time care work labour market. With this in mind, the statement by Komagane’s preventive day-care coordinator appears in a different light.

5.1.3 The price of functional effectiveness

Despite the relatively low entry barriers to care work in contrast to more medically oriented professions, e.g. nurses or physiotherapists, care work is an exhausting profession as the deteriorating health of the elderly patients drains employees physically and mentally. Personally, I did not encounter any care worker above the age of 50 in Tōkyō, with the majority of the care workers being between 30 and 50 years old—and many of them were lateral recruits from other service-related or clerical professions. This is, first, due to the increasing numbers of seniors seeking care and the simultaneous lack of sufficient care workers. And, second, the profession's inherent demanding characteristics often lead to illnesses, such as back complaints, and combined with relatively low wages, in addition to overtime work that is detrimental to health (see e.g. Japanese Nursing Association, 2010), result in an extraordinarily high turnover rate among care personnel.

One of the few foreign employees (full-time day-care worker #8, 20.08.2013) in care work, who shares her name with Catholic saints and overcame the high obstacles to entering the profession, incidentally reported understaffing. On an extremely hot and exhausting day in August with the extraordinary number of 42 patients in day care and only ten members of the day care personnel, including two physiotherapists, there to attend

146 This is true, even bearing in mind the anticlimactic approach of the Japanese government since 2008 to attracting foreign care workers from South Asia (Philippines, Indonesia and Vietnam). The results were rather unsuccessful and incredibly low numbers of care workers were attracted, amounting to only 1,128 by March 2014 (Mogi and Shimodoi, 2014).

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to them, I learned that prior to my volunteering period three care workers had quit. Regardless of the reasons for quitting, it increases the pressure on the remaining personnel who tried to handle the massive number of day-care patients by hurrying and being torn between the bathing room, the lavatories, the seating area and the individual tables. My lack of care work education and legal, sanitary and privacy issues meant I only had a support function in minor tasks. In order to ease the lack of manpower, seniors who needed to use the lavatory got a buzzer to signal when they were ready for their return trip.

Table 5-2: Turnover rates for employees in care professions

<table>
<thead>
<tr>
<th></th>
<th>Total</th>
<th>Regular employees</th>
<th>Irregular employees</th>
</tr>
</thead>
<tbody>
<tr>
<td>Average of all industries</td>
<td>15.4%</td>
<td>12.2%</td>
<td>25.9%</td>
</tr>
<tr>
<td>Visiting care</td>
<td>16.9%</td>
<td>18.2%</td>
<td>16.6%</td>
</tr>
<tr>
<td>Day care and institutional care</td>
<td>25.3%</td>
<td>20.4%</td>
<td>32.7%</td>
</tr>
</tbody>
</table>


But also in my follow-up visits to another care facility, several months after the start of my initial volunteering activities, in addition to changes among the patients, approximately one third of the care work personnel had been replaced by new recruits—an unsurprising fact according to the turnover rate survey by the MHLW (Table 5-2) and the manifestation of the fast-paced exhaustion of care workers. But it is not only in care facilities that working conditions are strenuous for the care staff; in visiting care the time limits for taking care of patients are so tight that travelling to and from patients takes longer than the actual administering of care (Broadbent, 2013).

The high turnover rate curbs effectiveness in the execution of care as new personnel have to become adapted to the institution's processes and set-up. All facilities related to caring for the elderly are affected by this, though, and it is rather a sector-wide issue that has to be dealt with politically. Furthermore, there is a fine balance between the affordability of care

147 During hot days the number of patients is increasing quickly as they want to use the bathing services that is provided by day care facilities (Yamada Setsuko (山田節子), head of the Nursing Department, 06.08.2013)
for the elderly, efficient organisation of that care, social justice and the exploitation of human resources in care work.

5.2 Gender as a differentiator in care for the elderly

My observations of patient interaction and analysing data from interviews present vital information on the gender aspects of ageing and care for the elderly. The majority of the patients are women, and the quota is approximately two thirds women up to women only, depending on the week day and facility. Basically, two key points in motivation, which lead to the usage of day care, have to be distinguished between. First, there is the explicit request to attend day care even though, from the senior's point of view, physical care is not required, but the need for social interaction is their incentive to attend it anyway. And second, there is the medical and familial situation, which requires and urges the utilisation of day-care services. In interviews, women uttered the reasons why they desire and have made use of LTC services:

- the need for social interaction and to reduce social isolation at home
- the feeling of being a burden for their family as caretaking is a physically and mentally exhausting task, and family members and kin often seem to be overwhelmed by it
- the rising difficulties with ADL, in particular among seniors who live alone and in seniors-only households.

A combination and overlapping of the aforementioned motives are reasons for visiting day care. The main motives and also main concerns for female seniors are social interaction and the idea of unburdening their family. The immense extension of life expectancy in the last fifty years has severely changed the age composition of the Japanese population and had a major impact on family structures, cohabitation and values. Three-generational households, which were the norm during the Meiji era and until the immediate post-war period, declined in number rapidly and the trend towards one-person households and seniors who live alone continues. Declining social contact due to ageing incrementally lead to a decrease in social interaction. Day care, in such cases, is used to ease isolation among the elderly who live alone, but also in cohabitation households since familial and marital relations are regularly complicated and uncomfortable. Female seniors further utilise LTC services to relieve their families from on-site
and off-site care burdens—and partly if there is discontent with the informal care they have received.

Although motives for day-care usage vary to a certain degree in their characteristics, they were universally valid and are mostly identical in peripheral and urban regions. They manifest themselves especially after women have concluded their productive (retirement) and nursing (widowhood) life phase. For this reason, women tend to be quite active and outgoing in day care, seeking chats with other women and often trying to establish "table societies" with similar minded women. Despite the desire to satisfy social needs, one cannot use LTC services "just like that" but has to be categorised as eligible.

Male patients in day care, in contrast to women, are quite different as they are inclined towards passive behaviour and convey the graphic impression that they lack the ability to look after themselves. The motives for these passive patients to use day care are difficult to deduce in general due to futile communication and their indifference towards their location, surroundings and their own status. The few who are interested in communication and interaction are, in contrast to female patients, rarely interested in sharing their reasons for using LTC besides their obvious care needs. Through some insights from the nursing staff, I concluded that men in day care have not chosen but were consigned to LTC services (day-care patient #4, 22.11.2012, day-care patient #44, 15.08.2013).

In addition to issues with interaction, passivity and indifference exemplify the fact that formal care institutions represent a new, unfamiliar social space for men. Furthermore, men suffer a more intense rupture from the public idea of self-perception, their societal role and social embeddedness than women when they enter care institutions. While female patients use day care and pre-day care consciously as a resource to satisfy needs and wishes, men experience difficulty interacting in the new environment and distinguishing between options for appropriate action. This is mainly rooted in three aspects.

First, access to and interaction in social networks for men and women was and is structured differently. Today's elderly men largely experienced company-based adulthood socialisation with hierarchical positioning, division of tasks and a certain range of authority. Whereas female seniors, who were mostly housewives, underwent neighbourhood-based socialisation.

Second, their loss of power, social disintegration and thus also their loss of identity is more aggravating for men. Being the household head for the
majority of their life, which is a symbol of masculinity, men suffer from the incremental loss of physical and social power and status and the subsequent change of social roles. Men are hit severely by this status passage as their self-concept might be rooted in masculinity (Bieri, 2005, p. 100) and, in the long run, might even lead to self-destructive behaviour due to their loss of social capital (Bornschier and Keller, 1994, p. 98).

Third, the organisation of day-care pastimes and activities is essentially adjusted to the needs of the majority of the target demographic—elderly women. Handcrafting, colouring games and chats with tea drinking tend to be activities female patients engage in. Nevertheless, many care facilities for the elderly specifically keep providing pastime activities for men in mind as well, such as distributing newspapers.

A combination of these three points creates greater obstacles to men entering care and further demonstrates that ageing processes are highly gendered.

5.2.1 Talk, talk, talk: activities in care facilities for the elderly

The structure and type of social networks before people enter old-age care have a decisive difference for both genders in how they experience their new social environment. In particular, in the periphery of Japan, social networks for men require a physical and health-related component to a higher degree. If the physical requirements are not met or such networks are unavailable or do not function well, their social interaction is vastly reduced or even collapses. What is meant here is that any social interaction I observed among the middle-aged and elderly in Komagane was connected to physical strength, activity and mobility, which shall be illustrated in the following points.

Social inclusion transpires mainly through occupation and on-the-job social interaction, which requires physical performance, especially in the agricultural and manufacturing industries. Outside the family, societal interaction in free time occurs through attending and participating in sports activities and membership of sports clubs and other associations, which in younger years are often budō sports (Kendō, Jūdō, Karate, etc.) and baseball, and with rising age become "softer" variants, e.g. softball or bocce, or the local and community-based organisations, such as the neighbourhood associations. Post-retirement social interaction often takes place through men having inspector and supervisor positions at public facilities and so-
cial events, such as district and neighbourhood festivals and festival processions. These positions are almost exclusively taken by men and often require a significant level of physical fitness. The physical aspect, thus, embodies an essential part of male social interaction. If men are not physically fit, their social participation is curbed and they gradually lose their extra-familial contact and reference persons.

For the majority of female seniors' pastimes, physical fitness is not required. These activities are limited to light exercise, such as gymnastics, stretching, t'ai chi, and, on the other hand, to social events. The focus of the latter is social interaction which necessitates ceremonial and cultural knowledge in varying degrees of punctiliousness for tea ceremonies (sadō), flower arrangements (ikebana), collective cooking and so on. Such events are simultaneously made use of to exchange news and gossip from the neighbourhood. Those kinds of activities can be performed up to high ages and without a high degree of physical activity, and allow women to stay socially active despite increasing frailty and declining health. It becomes an issue when members of these social groups cannot attend them any more due to immobility or if they pass away, diminishing the established social circle. But the skills acquired from these gatherings are used by women in day-care centres to their advantage.

Day-care centres offer a lack of "male activities". Since the majority of patients are women, the activities provided until bathing or lunch take place are centred on activities elderly women seem to like, such as handicrafting, origami, painting pictures, playing marble games, and talking about flowers and food. Men actually do participate as well but do not seem to be very excited about doing so. And as just described in the paragraph above, it is easier for women to retain their social role in such an environment, whereas men do not know how to interact or do not want to.

A day-care facility I visited in Komagane had a surprisingly high ratio of male users of up to 40 per cent. Hence, the facility’s management was keen to offer "male activities" in order to satisfy these patients as well. Those activities involved the distribution of newspapers to the men's table, handing out A4-formatted playing card sets or encouraging the male seniors to play the skill game ‘Jenga’. All the men seemingly liked these activities more than the usual ones, and they gave them an opportunity to engage in conversation in a more familiar situation.

Still, I only witnessed these activities in this rural old-age care setting and only in one of the several care facilities I visited, which was the one that had a high ratio of male patients. In Tōkyō, care facilities either did
not have enough free time slots for male group activities in their daily schedule or not enough staff members available to allow elderly men to participate in them.

The result is that elderly men seem to be left behind in care institutions and experience higher levels of exclusion due to their poorer health and the inappropriateness of the social context. Day-care centres in general seem to pose an institutionally ingrained disadvantage to male patients. This is firstly due to the composition of the aged population with a massive surplus of female patients and secondly to the different courses of life and the socialisation context, which are still in effect. And thirdly, institutional boundaries and the limitations of the social context of care for the elderly constrain the realisation of an even stronger focus on inclusionary activities for men.

5.2.2 Aspects of social interaction in care for the elderly

Day-care centre interaction occurs on two levels and reveals distinctive differences. Direct interaction with staff members is the first vertical and binding level; interaction with other elderly patients is the second non-committal and horizontal level.

Evidence from all the day-care centres I visited confirms that communication throughout the day is task-oriented, such as the conducting medical examinations correctly, transportation and cultural activities within a confined time frame. If seniors spend a whole day at a day-care unit, the first half of the day offers them little opportunity for social interaction with other patients since a fixed time limit compels care personnel and medical staff to handle patients quickly. Still, the morning leaves some unspecified time for idling and for patients to socialise—which is interrupted regularly by staff members wishing to perform their tasks.

After lunch, the afternoon offers a limited opportunity in the timetable for the seniors to further socialise and engage in recreational chit-chat with less task-oriented communication. Nevertheless, those are not free-for-all sessions; instead, the recreational activities in the afternoon are moderated by care workers. Usual activities are playing quiz games, such as *shiritori*, a word-chain game, talking about a certain topic, e.g. delicious food in autumn, or conducting small physical games, such as ball-throwing bingo, and encouraging everyone to join in. These moderated activities mainly serve the purpose of activating, strengthening and sustaining mental and
physical capabilities. Moderation becomes more stringent if official items are on the agenda, i.e. attending sessions held by teaching volunteers. The aim of moderation in the latter case is the prevention of spontaneously emerging discussions and group dynamics which might disturb the activity. The two main reasons for this behaviour are rooted in preventing too strong groups being formed, which consequently exclude non-group members, and furthermore in drawing the seniors' attention to the guest, i.e. the individual volunteer or volunteer groups, who for example may be giving a musical performance.

This feared exclusion of individuals manifests itself frequently and can be easily observed during the recreational phase. Active, talkative seniors rather unconsciously take on the role of not only opinion leaders, but also of peer-group moderators. In discussions they directly address other seniors and occasionally even interrupt instructing volunteers, e.g. in ike-bana or origami, by forming a small group of conversation partners on the spot. These active group members tend to know each other, while silent, introverted seniors who are new to the centre or less well integrated are excluded in these conversations since they are not addressed by these 'grannies' and eventually get stuck in a passive behaviour loop. A full-time care worker noted on situations like these that "genki sugiru obāchan ga mannaka ni ite, itsumo hanashi wo kakete ne [the overly vital grannies are always in the middle, always telling stories]" (佐藤 一輝 Satō Kazuki, 26.10.2012). Thus, care workers tend to adopt inclusive behaviour by moderating and addressing each senior separately, asking them questions and for their opinion, and expecting the others to wait until their turn has come to be addressed as well.

Though this aspect of moderation may sound very harsh and strict, comments from and smaller on-topic discussions involving all participants are, as a matter of course, possible and desired. The moderation by the care personnel also encourages patients with a short concentration span to lay their focus on the activity performed or the discussion in question. However, at the same time it also creates a classroom atmosphere in which seniors tend to wait until being asked, which coincides with the unwillingness of some patients to voluntarily communicate, leaving a few patients

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148 「元気すぎるおばあちゃんが真中にいて、いつも話しをかけてね。」
in apathetic, silent idleness, waiting for their turn while gazing at the table or into the distance.

The behaviour of passive individuals changes in most of the cases when agenda activities end and established groups are formed and their dynamics come to the fore again. The majority of female patients gather in small groups, speak freely and enthusiastically about their past life experiences and make small talk, while other—mostly male—patients fall back into their solitary activity of browsing through colourful books or staring at the TV screen and quietly singing along to subtitled folksy karaoke songs presented on the screen via a DVD.

Aware of the issue of activity moderation, the care staff apply communicative strategies to cheerfully foster the seniors’ participation in cultural activities and ease complicated situations. Applied behavioural patterns are expressed through polite remarks and frequent praise for the seniors’ appearance (e.g. hairstyle, clothing), behaviour (e.g. being polite, exchanging small handmade presents), or abilities (e.g. independent walking, nice handcrafting, a good memory). Another method used by the care personnel and patients is to joke about uncomfortable situations in order to ease them and prevent patients and staff from losing face, (see Backhaus, 2006, 2009; Yamashita, 2011 for a detailed description of praise and humour in care-related communication). Care workers in such cases often try to diminish their status by making fun of themselves and drawing attention away from a tense situation, e.g. male care workers imitate the goofy character, boke, from the traditional Japanese comedy of manzai by grimacing and being slow on the uptake, while female care workers play the counterpart in this comedic duo, tsukkomi, to everybody’s amusement.149

Another successful method of initiating interaction in situations of passivity is claiming ignorance, in which care workers pretend to have not had a certain experience, which in return fosters conversation. Additionally, they ask for and take an advice from the otoshiyori (お年寄り, seniors), who then feel glad to be able to share their experience and insights. This most often occurs in dialogues about seasonal food, delicacies and travel locations or through historical anecdotes.

The Confucian concept of filial piety (ōyakoko, see Linhart, 1997) is perceptible in the care workers’ interaction with the elderly. It appears to

149 In every care facility I visited throughout Japan, this behaviour was solely conducted by male care workers—which probably coincides with the gender of the traditional comedy figure.
be an influential, intrinsic driver in the relationship between elderly pa-
tients and the comparatively young care workers (up to 70 years differ-
ence) through their use of honorific language and their expression of a
mothering attitude. Despite the appearance of the opposite during conver-
sations, an unequivocal power hierarchy exists between staff members and
patients. Politeness and humour in the context of care institutions for the
elderly do not only function as means of communication, reducing uneasi-
ness or lubricants of social interaction, but also disguise a power balance
shift that elderly patients might not perceive as such in the first place.
Even though seniors select services and institutions by themselves¹⁵⁰ and
coopay for the services they require, their power in care facilities is limi-
ted. By its very nature, entering into care for the elderly is a manifestation
defined power.

If we understand ageing as a process of physical and cognitive ability
decline, usage of care services for the elderly comprises a definite change
in social status and social position. Autonomy and decision-making power
gradually decline, indicating an irreversible process towards immaturity
and eventually death—as one institutional care patient cynically put it (see
part 4.4.4). Although such a change approaches more slowly in the micro-
context of a family, it is even more visible there. By transferring the posi-
tion of household head and inheritance to their successor, seniors gradual-
ly forfeit their authority, which moves them into the background of the
family. Despite that, emotional and familial ties as well as living in a fami-
ly-owned household still provide them with autonomy in their daily sched-
ules to a certain degree. Care facilities, however, are clearly totalitarian in-
stitutions, as mentioned earlier.

Throughout the day, all patients are monitored and restricted in their
discretion for the sake of their health and well-being. The daily schedule at
care institutions places the patients in tight manacles which reduce their
overall autonomy and is streamlined by financial and personnel limits in
order to handle patients in a rational, cost-effective and yet humane way.
Certainly, a difference between institutional care and day care exists,
though in the end it only means that patients in day care can return home,
while the others remain in the institution in multiple-user rooms with al-
abaster glass doors. Unsurprisingly, in an institutional care environment,

¹⁵⁰ Service selection is usually assisted by a care manager, who helps to organise the
daily and weekly schedules, the applications to institutions as well as counselling
in cases of discontent.
the acceptance of these circumstances and compliance with patronisation as the norm of interaction hints at patients surrendering to the institutional frame of decline. In the structurally dismal environment of care institutions for the elderly, the facility's management and staff members employ a variety of techniques to disguise power relation shifts and the patients’ lack of independence by trying to create a nice and homely atmosphere for them.

5.2.3 Amplifying social networks through care for the elderly

Patients in day-care facilities value social interaction as a very important aspect of their current life phase. Thus, the topic of different care forms and their advantages and disadvantages occasionally surfaces—especially if a friend or neighbour has an accident and their subsequent, rapid health decline requires medical treatment and institutionalisation. Among patients in a day-care group, every senior knows or has heard of someone who recently experienced such a tragic event, with the result that different care forms are discussed regularly and overtly. While the seniors were exchanging opinions on the upsides and downsides of forms of care, it was not surprising to see that institutional care is considered utterly unfavourable and should be only utilised as a last resort—only if other forms of care or the family cannot provide assistance and care. Being institutionalised denotes a two-step death for the patients: first a person’s social life disappears and they become forgotten; then the person itself disappears. Day-care patients, who are concerned about their future health and afraid of institutionalisation, are glad that the possibility of day care and visiting care exists, as it allows them to enjoy independence for as long as possible.

Day care as a form of care was favoured over institutionalisation by almost every patient and by most even over visiting care. Leaving the house, being driven around the neighbourhood like on some sort of sightseeing tour, and gathering with other seniors are perceived as immensely advantageous in comparison to visiting care. Socialising and the expansion of acquaintances are perceived as essential reasons to opt for day care. In particular, in the "years after retirement, the roles of social networks become increasingly important in providing access to support in the face of escalating losses and growing frailty" (Wenger, 1997, p. 93). Weak ties to social and support networks are seen as a crucial concept in avoiding so-
cial exclusion through social interaction (Cass et al., 2008, pp. 406–408). Day care, however, involves the successive replacement of former social networks due to the amount of time spent at outpatient facilities—which is not an issue for most patients as it creates new social networks. Nevertheless, such a beneficial outcome of social network expansion by attending a care facility only applies to female patients—as already stated above.

Table 5-3: Care forms and their associated social networks

<table>
<thead>
<tr>
<th>Social networks</th>
<th>Visiting care</th>
<th>Day care</th>
<th>Institutional care</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Family</strong></td>
<td>– co-habitation, or home visits</td>
<td>– co-habitation, or home visits</td>
<td>– occasional to regular visits to facility</td>
</tr>
<tr>
<td><strong>Friends</strong></td>
<td>– declining number of friends and visits due to ageing</td>
<td>– declining number of friends and visits</td>
<td>– no to regular visits by friends</td>
</tr>
<tr>
<td><strong>Neighbourhood</strong></td>
<td>– social ties slowly decrease due to ageing</td>
<td>– social ties slowly decrease due to ageing</td>
<td>– non-existent after institutionalisation, although former neighbours pay visits</td>
</tr>
<tr>
<td>**Neighbourhood associa-</td>
<td>– regular visits / meetings, participation in local processes possible</td>
<td>– lower participation rate and engagement</td>
<td>– non-existent after institutionalisation</td>
</tr>
<tr>
<td><strong>Care staff</strong></td>
<td>– task-oriented interaction due to time constraints</td>
<td>– task-oriented and social interaction</td>
<td>– task-oriented and social interaction</td>
</tr>
<tr>
<td><strong>Volunteers</strong></td>
<td>– occasional visits by NPOs</td>
<td>– regular exchange and participation</td>
<td>– rare exchange and participation</td>
</tr>
</tbody>
</table>
5.2 Gender as a differentiator in care for the elderly

<table>
<thead>
<tr>
<th>Social networks</th>
<th>Visiting care</th>
<th>Day care</th>
<th>Institutional care</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Extension of social networks, but gradual deterioration</td>
<td>Extension of social networks, but gradual replacement and deterioration</td>
<td>Loss of almost all social networks and social life</td>
</tr>
</tbody>
</table>

Source: Own representation, based on conversations with patients in care facilities for the elderly.

Although, from the aspect of social networking, visiting care ought to be favourable as well, patients uttered their concerns and the flaw they perceive in it during conversations. The notion is that unfamiliar people intrude into the privacy of one's home, which was disliked. Seniors regarded their house as a place of refuge for themselves, their family and close friends, which should not be invaded by strangers. Elderly people visited at home by volunteer care organisations felt embarrassed in various ways, but often they perceived their home to be not tidy enough to be visited by strangers and thus rejected the outside help (Nakano, 2005, pp. 125–126).

Nonetheless, in summary entering a care institution is considered a process of marginalisation and a gradual (day care and visiting care) or vast (institutional care) decline in social participation and power in decision-making. In particular, the patients' independence is almost totally consumed by the frame of an elderly institution, leaving them only little room for autonomous activity, e.g. during the recreational phases. Additionally, the extension of social networks in the initial phase of day-care attendance replaces older social ties after a time due to the amount of time spent in the institution, which allows the individual to incrementally anticipate the process of institutionalisation.

5.2.4 Volunteering: an essential pillar in care for the elderly

Unexpectedly and fortunately enough, my contact to Volunteer Coordinators (VC) turned out to be a pivotal point during my fieldwork. The responsibility of VCs is to coordinate volunteers in their willingness to provide help and activities as well as coordinate them with the needs of old-age facilities and care units. Thus, they have acquired a key position with basically universal access to the facilities they work with and for. This position enjoys a special, detached status within the hierarchical and or-
organisational structure of the care units and care facilities network. VCs are employees of the welfare corporations, but are neither affiliated to the units that actually provide care, nor do they interfere with those units’ administration and organisational bureaus, but rather provide additional and helpful support with interested volunteers. Thus, the VCs, in consultation with the respective care units, coordinate the activities of many volunteers—in Tōkyō, the VC of the all-in-one care facility in Minato ward supervises and coordinates approximately 130 volunteers (Fukushima Hiroko 福島 弘子, 07.11.2012), while in Komagane the VC of the local shakyo was in charge of 50 to 60 volunteers in several care facilities for the elderly (Kurata Takumi 倉田 拓美, 05.04.2013). As a result, the VC not only has access to the unit and facility coordinators and staff members, but is also acquainted with many of the patients and, of course, the volunteers.

During my fieldwork, the VCs provided me initial and continuous access to several areas of the care institutions. Very open and eager to support a struggling student and the first foreigner in their institution, they made it clear in our first meetings that everybody’s task at the care facilities is to "kōreisha wo mamoru"151 (Fukushima Hiroko 福島 弘子, 17.10.2012), which literally means to protect the elderly. Consequently, in all care facilities for the elderly, more or less formal non-disclosure agreements for volunteers, which state that they may not share explicit and detailed information and data on individual patients, their diseases and medical status, or their relationship with their family, are common152.

A few care facilities are regularly in search of new volunteers, but their approach is neither active nor passive. A call for volunteers to participate is put onto their home pages with a brief description of potential activities and areas to volunteer in. Besides that, actively pursuing an advertising campaign is out of financial bounds. This approach demands that people interested in volunteering have to act and find this information on the facilities’ websites—as I did. The majority of care facilities, however, provide no information on volunteering activities or calls for volunteers, thus curbing the presence of volunteer helpers. The existence of volunteers in old-age institutions proves to be crucial and beneficial for the staff and patients, though. The volunteers’ activities and duties have a wide spectrum, but generally fall into one of these three categories:

151 「高齢者を守る。」
152 Anonymous or synonymous data usage was permitted.
support in everyday operations by changing sheets or feeding frail patients
communication with patients by singing, listening, talking and playing games
instruction in conducting simple gymnastics, handcrafts, ikebana and origami.

The focus for volunteers lies on communicative and instructive activities. Care personnel cannot sufficiently provide social communication due to dire time constraints, which also leads to a lack of activities. In particular, this is true for institutionalised patients, as their contact persons are usually the care and medical personnel as well as fellow patients. Outside contacts often occur only once a week, sometimes even only once a month. For many concerned families the situation is embarrassing and painful, but unfortunately unchangeable for several reasons (Fukushima Hiroko 福島弘子, 07.11.2012). In those cases, volunteers are an immense benefit since they act as supporting contact people and constitute an additional communicative and psychological pillar. Institution outsiders such as volunteers allow the establishment of a relationship and confidentiality on a different level as well as the chance to address distinct concerns and topics that might not be possible with care staff. Volunteers alleviate communication issues between staff and seniors in certain cases. Seniors are reluctant to address staff members on certain topics or problems. In those cases, especially during the activity of "attentive listening" (傾聴, keichō), volunteers act as go-betweens and can anonymously inform staff members of ongoing issues.

Although day-care patients generally have greater opportunity to engage in social interaction, their communicative exchange with volunteers is important as well. Most of them visit the institution several days a week and thus lack variation in their communication partners. On the one hand, a small change of communication partners might promote close-knit communication and integration if patients harmonise, but, on the other hand, conflicts may be triggered and erupt due to animosities between individuals. Volunteers fill this gap and can have a catalysing and harmonising effect.

Not only do volunteers constitute a benefit for patients, but they are also a relief for organisations and in particular for the nursing personnel. Courses run by volunteers, e.g. ikebana, result in elderly patients focusing on the activity. This facilitates the personnel in surveying and moderating group dynamics, supervising and assisting needy patients, and at least
temporarily relaxing from their physical and emotionally exhausting labour as care workers—occasionally by doing paperwork at a table close by. In the presence of volunteers, the amount of care personnel required is reduced drastically, and for the supervision of up to 15 patients only one third of the normal number is regarded necessary (see Figure 5-1). The freed-up personnel can in turn prepare the return transport for patients and handle administrative tasks. During my volunteering sessions, one staff member was involved in the proceedings as a moderator, who directly addressed elderly patients and motivated them to actively participate, and one had a supporting function to either help patients go to the sanitary facilities or to "catch" the roaming dementia patients.

**Figure 5-1: Amount of care workers and volunteers in different activities**

![Bar graph](https://example.com/bar_graph.png)

Source: Observation and interview data.

### 5.3 *Pinpinkorori*: local normative ethics manifested in an ideal death

In the peripheral area around Inan in the Nagano prefecture, which includes the cities of Komagane, Matsukawa, Iida and Ina, an often heard term in conversations with seniors is *pinpinkorori* (ピンピンコロリ). It is composed of two words: *pinpin* means "cheerful" and "spirited", and the meaning of *korori* is "sudden*. *Pinpinkorori* describes a concept of ageing and death in which health is savoured right up until old age is reached, and
then a sudden but good death is experienced\textsuperscript{153}. It represents an ideal type of passing away since there is no time to suffer from diseases, reflect on concerns and mistakes, be dependent on care or be a burden to one’s family. Instead, there is the joy of self-determined, active and cheerful retirement. Such a mentality is widespread and I encountered it regularly in conversations in the rural area of Komagane, where farmers and amateur gardeners sow their rice according to the visibility of snow on the summit of the southern Japanese Alps.

Staying active until old age also means retaining one’s capacity to work and supporting the family through physically exhaustive work—either in the fields or with household chores. This is particularly observable in April and May when elderly farmers, their spines deformed by their work, sow rice seedlings in the paddy fields with painstaking effort. With regard to this image, a female day care senior mentioned that it is desirable to pass away in the paddy fields in harmony with nature: "\textit{tanbo no naka de naku natte, shizen to issho ni naru houga-ii to omoun da-yo}" [If you die in the fields, you become one with nature, which is what I would prefer]\textsuperscript{154} (day-care patient #33, 21.03.2013).

The idea and principle of \textit{pinpinkorori} are conveyed and incorporated socially through local songs. In the day-care and preventive day-care centres in Komagane, the \textit{pinpinkorori no uta} (the pinpinkorori song), depicting the daily life of seniors in rural regions and rewarding them with a sudden death, is sung on the request of the patients. This way, \textit{pinpinkorori}, as a local concept of ageing, forgoes burdening family and friends with the process of ageing, but instead requires and demands the elderly's personal activity. It does not conflict with the principle of \textit{oyakoko} in general, which rather assumes and upholds a passive image of the elderly, but upends it.

Further, the \textit{pinpinkorori} concept is institutionalised and also implemented in many care facilities for the elderly and their procedures. In Komagane, but not only there, adjacent to the meeting place for seniors, the \textit{Fureai Center} of Komagane's \textit{shakyo}, is another centre for vigorous and talented seniors—the \textit{shirubā jinzai sentā} (シルバー人材センター). Se-

\textsuperscript{153} Here, it coincides with the idea of \textit{pokkuri-shi} (ポックリ死): instant death. Reportedly, some Japanese pray at \textit{pokkuri} temples for a sudden and painless death (Woss, 1993).

\textsuperscript{154} 「田んぼの中でなくて、自然と一緒になる方が良いと思うんだけど。」
niors who are capable of gardening, are good at repairing mechanical objects or are talented in any other way can register and will be kept on file if other citizens are seeking paid assistance or part-time employees for minor tasks. With an additional income as a side effect, this institution serves several functions by a) integrating aged persons into productive processes, b) giving the retirement phase a new structure and c) instilling seniors with the feeling that they are useful to society and not a burden to their families. Interestingly enough, this institution is 90 per cent frequented by men, who mostly engage in agricultural and janitorial tasks. Presumably, the self-conception and understanding of working life between the genders is decisive here.

I did not encounter a similar concept of ageing and passing in Tōkyō metropolis, but due to the broader diversification of lifestyles and life courses in urban areas, which does not occur in the agricultural work which is ubiquitous in and therefore defines rural environments, the absence of a concept like pinpinkorori is to be assumed.
6 Summarising social risks and the dual character of welfare

The last chapters provided a comprehensive account with rich empirical evidence from different urban and peripheral contexts in an ageing society. While such a deep glimpse into the organisation of care for the elderly and individual issues of ageing reveals issues on a small-scale level, it also is indicative of proceedings on a larger level.

Synthesising and abstracting from observations made and data gathered, the next paragraphs will summarise my findings and assumptions on how and why the LTCI in Japan has an effect on the load distribution in the welfare mix and the institutional reliance of the elderly and their families. My intention is to answer my main research question:

- Why and how has the implementation of the LTCI, done so to address the social risks of ageing, shifted the welfare mix between the state, the market and the family, and reintroduced the role of the local community?

Although this endeavour is the main objective of this work, the inherent and much bigger discussion lies in how the micro level I have researched mirrors developments on a bigger societal scale—and vice versa. Moreover, the micro-level data reveals how normative behaviour and mindsets are due to change while they lag behind developments in policies and welfare mix alignments.

We have seen which development the Japanese government underwent in its post-war approach to welfare in general and care for the elderly in particular. Four phases are distinguished here as important steps towards today's comprehensive LTC system, rendering it a one-stop shop for age-related needs (actual care requirements, medical treatment, welfare needs) rather than the patchwork it was before.

First, care for the elderly was an ostensible ideology of social behaviour for Japanese citizens, which found its literary expression in the muddled nihon-ron and nihonjin-ron literature. Although its measurable outcome is questionable and was questioned (Campbell, 1992, pp. 21–23), the nihonjin-ron ideology nevertheless contributed to normative role modelling and reinforced persisting gender differences and expectations. The family, in that regard, was responsible for old-age care as its societal duty—and here it meant women as the 'natural' carers.
Second, while issues relating to care and welfare for the elderly grew increasingly acute, the family was incrementally unable to provide appropriate care. The national government was urged to further expand its patchwork approach of countermeasures to welfare for the elderly, which already ranged from gratis medical care and limited access to social housing to welfare payments for the impaired and the bereaved. However, loopholes in the systems of welfare, medical care and care for the elderly led to unequal treatment and municipalities and the national government being over-encumbered in both administrational and financial terms. The distinction between medical and care-related treatment was a major loophole which allowed seniors to abuse medical hospitals as geriatric clinics by occupying hospital beds for several months—and putting a severe strain on medical budgets.

Third, at the turn of the millennium a comprehensive and far-reaching approach towards care for the ever increasing ageing population was initiated. By introducing measures apart from mere medical treatments, long-term care insurance provided not only a relief for hitherto predominantly informal carers, i.e. women in general, wives and daughters. Besides that, it also strongly relieved medical care institutions of responsibilities relating to caring for the elderly and their lack of specialised staff and processes of care. Furthermore, it reduced the strain on the national health budget by setting up a sophisticated method of funding from municipalities, prefectures, the national government as well as those insured themselves. Although the LTCI was publicly pitched as providing support for families in an ageing society as well as strengthening individual autonomy, which both certainly cannot and will not be denied at this point, the LTCI's main purpose was and still is the containment of expenses for cost-intensive long-term and terminal care.

And fourth, accompanying the developments mentioned above is the stronger focus on prophylactic approaches to caring for the elderly. By promoting mental and physical capacity building and maintenance in earlier old age, the LTCI aims to foster a prolonged healthy life and less dependency on formal institutional support. Reducing deep formal institutional involvement is necessary in spite of an increasing elderly population and a continuing shortage of domestic care personnel. Additionally, social

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155 Japan’s initiatives to promote international migration of care personnel at this point can only be described as rather lacklustre and inconsequential (see also Mogi and Shimodoi, 2014)
networks and support networks are addressed and prompted to participate in an umbrella of the so-called integrated community care system by providing support to neighbouring elderly citizens.

These steps in old-age policy mirrored pervasive changes in Japan’s post-war demographic composition, but furthermore, they are also rooted in less perceptible developments in the process of change in social institutions. Although this work is a brief snapshot of the ageing part of Japanese society, it also glimpses at normative alterations revealed in interviews and discussions with seniors and formal caretakers and their perception of changes to societal ideas and social norms. The values and norms of the contemporary generation, i.e. the working population, were occasionally perceived by seniors as subjectively disadvantageous, which regularly resulted in their refusal to accept these "newer" norms and thus in them not being able or at least trying to bridge the gap between generations—and vice versa, of course. However, changes in elderly welfare policies and, successively but inertly, in socially accepted behaviour were, on the other hand, also welcomed and deemed necessary. Consequentially, they were experienced as relief of the social consequences for certain behaviour, i.e. relying on formal institutional support, through welfare or care uptake, became widely socially acceptable and was reviewed beneficially. This change was also induced by the implementation of the LTCI law, which shifted the relationship of welfare institutions and caused their rebalancing, which led to adjustments in provision responsibility and reliance.

Nevertheless, what we have here is deep and intricate institutional entanglement on several levels, enclosing endogenous demographic, economic, political and social developments on the micro and macro levels within Japanese society, as well as exogenous inputs. The agreement between generations on mutual care (children-parent-grandparent generation) is continuously changing in accordance with the developments of the Japanese labour market, its welfare regime (which are both still highly tangled, thus creating corporate welfare institutions) and the societal understanding of an individual's and society's responsibilities.

6.1 Risk of seclusion

Leading a single life while facilitating autonomy and individuality is, in many respects, problematic for seniors as it requires a considerable degree of mobility. Seniors lacking a sufficient degree of mobility due to physical
constraints or environmental effects cannot perform daily life activities properly or at all. Physical functioning looms large for the subjective perception of independence and own autonomy. Environmental effects, however, depending on the locality and its infrastructure, account for a considerable part of the independence and sense of belonging one experiences as well. In general, living alone means that as soon as seniors’ mobility (walking, standing, balancing) is restricted, they cannot move independently, and consequently their livelihood and quality of life is endangered and limited. While this is partly negligible in urban areas with a good infrastructure, it is a decisive factor in less well-off and peripheral regions. As a result, activities of daily living (e.g. buying groceries, visiting friends and doctors, or going for a stroll) cannot be experienced autonomously—and seniors have to rely on external help from their kin, neighbours, social welfare organisations and care programmes, which in turn limits their overall sense of security as they require third-party support for their livelihood or ADL, and, because of their limited mobility, also their ability to survive. For many seniors, this is an undesirable image of ageing, which was uttered by many of the seniors I interviewed. The notion of an undesirable death, which is described as "medicalised death" (Long, 2003, p. 60), a long process in a sterile and clinical environment, also coincides with the unfavourable image of ageing.

A stark contrast between peripheral and metropolitan regions, and especially Tōkyō, is exhibited in the differences in the establishment, density and maintenance of public transportation and their effect on seniors' mobility. Well distributed public transportation has a strong inclusionary effect on the aged by connecting them to social and public life via trains, buses as possibility of ride sharing, e.g. shared taxis and community buses, which facilitates mobility despite given or growing impairment to their locomotor system. In order to ensure basic medical provision, the LTCI covers required taxi rides to hospitals, clinics and doctors—in addition to transportation services for shopping and leisure activities that are locally offered by the elderly welfare bureaus of each city and ward.

Still, transportation remains an issue in rural and remote areas as the development of infrastructure has not reached a similar level compared to urban areas, despite heavy investment in public works (Matanle and Rausch, 2011). In fact, infrastructure there is already deteriorating through processes of demographic decline along with the discontinuation of services due to financial bottlenecks. The withdrawal of the community bus Komachan (こまちゃん) in Komagane in May 2013 is representative of such a de-
velopment. Although there is definitely a need for transportation for the elderly in the city of Komagane, this bus service was running dry due to it departing too infrequently, too few passengers and too few bus stops, which were also too far away for many seniors living in remote locations. A few residential districts, or rather a cluster of forlorn huts and wooden houses, are located a 15-minute drive away from the next supermarket and are awkward to reach without any means of transportation due to the hilly landscape. Former supermarkets in those districts, mostly small mom-and-pop vegetable shops or the co-op markets operated by the Japanese Agricultural (JA) cooperatives, have been closed down due to their unprofitability (co-op) or the owners retiring (mom-and-pop). The vacant, abandoned and dilapidated buildings with their weathered signs can be spotted occasionally between lush rice fields and abandoned farmland.

Institutional frames that are sometimes required also limit the mobility of seniors. Every citizen from the age of 75 years on has to take a test in "roadworthiness" and, if they pass it, post a so-called silver mark (シルバーマーク, shirubā māku), a bicolour sticker on the car they drive. It is assumed that through this warning sign other road users will, first, be forewarned of possibly arbitrary behaviour and longer response times and, second, act more generously and behave more considerately themselves. However, if seniors do not pass this test and are unable to operate a vehicle, e.g. due to an impaired visual faculty, independent mobility for them is impossible. Although less of an issue in areas with well-developed transportation, in peripheral areas, where the slogan "no car, no life" holds true, it endangers seniors’ livelihood. Nevertheless, the rather bizarre but remaining alternative form of mobility in such cases is a motorcycle, which currently has no institutional limitations placed upon it and is used frequently by seniors.

Community taxis and taxi coupons do exist but are less commonly used by the elderly, i.e. even though the cities’ and wards’ welfare offices hand out discount coupons to needy individuals and also those who apply for them, the number of seniors who use taxis is rather low as taxi fares in Japan remain high even with a discount156.

While all seniors who live alone are affected by a decline in their mobility—which is their autonomy by proxy—women who live alone are

156 These coupons and vouchers are provided for free-time usage. Visits to medical facilities by taxi are generally fully covered either by the health insurance or LT-CI systems—in a similar way to the system in Germany.
more severely affected. According to several interviews with preventative care users (Patient #15, 20.05.2013; #18, 09.05.2013; #19, #20, and #21, 10.05.2013), women in rural areas traditionally did not hold a driving licence and are thus unable to drive vehicles nowadays.

In Komagane, 9.4 per cent of all seniors live alone (Komagane Shiyakusho, 2014, p. 36) and 65.2 per cent of those who are 65 years or older are women (Komagane Shiyakusho, 2014, p. 8). These circumstances consequently drive rural elderly women to use alternative methods of mobility. Walking is one, but when it becomes too strenuous, a few obāchan turn to the more dangerous scooters to maintain mobility and continue to engage in activities of daily living (see also chapter 3.3.2). This is also reflected in findings from other peripheral cities, in which approximately 90 per cent of the male seniors in their 60s and 70s had a driving licence, while only 68 per cent and 47.5 per cent of the female seniors respectively had one (Özşen and Tokuno, p. 7), which restricted them in their mobility.

For widowed female seniors, and they are the majority among the elderly in care facilities, ageing in contemporary rural Japan appears to be more burdensome than for men. The social norm in post-war rural Japan did not require or even allow them to acquire a driving licence—and shaped their life in such a way that now, in an ageing, mobility-dependent region they are more vulnerable and their livelihood is endangered to a higher degree. In cases where it is possible and, more importantly, socially acceptable, seniors rely on their children and also neighbours to run errands for them. However, getting minor things, such as shopping, done does not necessarily avoid the risk of old people being socially isolated.

The drive to avoid social isolation ("uchi de samishii ne, hitori-de suwatette, okyaku matteru ne... onorisan ga amari kurenai ne. [It is lonely at home, I sit there alone and wait for visitors... the neighbours do not come by often]"157, preventive day-care patient, #24, 23.05.2013) was mentioned frequently as a reason to favour nearby care facilities over visiting care. Since neighbours who work are usually not at home during the day, aged persons cannot find reference or contact persons to ask for assistance even in well-inhabited districts. The aged persons who live alone that I interviewed often described their daily routine as overly filled with

157 「家で寂しいね、一人で座ってて、お客待ってめるね。。。お隣さんはあまりくれないね。」
TV and gardening without much interpersonal contact—a routine which they consider increasingly undesirable. One patient especially, who had experienced the recent loss of her son after her husband had passed away early, made her drive for social interaction palpable as she explained that "uchi ha chotto hanaretete, ichinichi-chū hitori-de, samishikatta... roku- nen-mae inu wo katta, mainichi tanoshindete... ureshii [My house is a bit secluded, I was alone the whole day and felt lonely... six years ago I bought a dog and enjoy the time every day... I am happy] 158 (female preventive day-care patient #26, 24.05.2013). She then showed pictures of her fawn dachshund, which she kept in a photo album that she carried with her at all times.

Single lifestyles in combination with initial and innate manifestations of social isolation pose various risks to physical and mental health among the elderly. While the former result in the unavailability of immediate help in emergencies, the latter are a long-term development of mental decline and psychosomatic illnesses (e.g. Kawachi and Berkman, 2001; Lowenthal, 1964). My interviewees mentioned it occasionally as an observation about their own or their neighbours’ behavioural patterns, but during pick-up visits in day care and also during home visits with a care manager, I also witnessed that socially isolated seniors tend to develop ingrained mannerisms, live in dilapidated households, and experience health endangering physical conditions due to dehydration and malnutrition—often accompanied by nascent phases of dementia. In such cases, a close-knit community or well-established relationship to their kin might serve as a controlling mechanism for social behaviour and health status in order for them to maintain and ensure their livelihood and social inclusion.

6.2 Rebalancing responsibilities in care for the elderly

Mobility issues for the elderly who live alone are a facet of livelihood endangerment. Another essential element of uncertainty in ageing societies is the reliance on social and public institutional arrangements—and the resulting responsibility for family, kin and also neighbours. Jesting and laughing with her younger peers during the pleasurable afternoon sessions,
a centenarian in Tōkyō (day-care patient #1, 31.10.2012) known for her jaunty attitude, put the widespread misery of old age in a nutshell one afternoon:

"musume, ne, jibun hachijū-sai ni natte... mago, ne, mō rokujū-sai da to omotte-ru [...] jibun to kazoku wo mamoru tame ni dei sābisu wo shita.
[My daughter herself recently turned eighty years old... I think that even my grandchild is already sixty years old [...] to protect myself and my family I've chosen day care]"159.

Having grown up with the doctrine of oyakōkō (親孝行), a Confucian concept of filial piety, many seniors are confused about and often cannot comprehend the change in values of their subsequent generations. Often labelling it as kojinshugi (個人主義, individualism), seniors (and sociologists) not only try to describe and explain the rudiments and developments of an individualising society, but also the familial conflicts of role, interests and responsibility, which are, in the end, rooted in a change of social organisation.

Interviews with seniors clarified that most of them are clearly aware that the child generation is trapped in a conflict of responsibility between providing care and support for their parents as well as simultaneously bearing the responsibility for their own life, family and career. Generally, changing values also manifest themselves in a society's demographic structure and its social fabric—and vice versa160. Japan underwent a tremendous transformation, and latent adaptations in social organisation can be observed through changes to household structures, i.e. the prolonged decrease in three-generation households and the simultaneous increase in single-person households. The latter especially have grown exceedingly among the young and the old in Japan.

Based on the increasing spatial separation of different generations, care for seniors given by their children is impractical, or even impossible, and creates the potential for conflict through diverging opinions and values on how care for the elderly ought to be. In some interviews (e.g. female institutional care patient #6, 12.12.2012, female preventive day-care patient #24, 23.05.2013, female day-care patient #30, 21.05.2013), day-care patients uttered their discontent with the unwillingness of their children to

159 「娘、ね、自分80歳になって。。。孫、ね、もう60歳だと思ってる
[...] 自分と家族を守るためにデイ・サービスをした。」

160 This is surely a kind of chicken and egg question, i.e. what comes first, value change or demographic change?
care for them, the low levels of affection they show towards their parents and traditions, and the resulting necessity for the seniors to utilise day-care services. However, at times the latter sounded more like a way for them to legitimize their use of public welfare services without being frowned upon; it also indicated the precarious situation of uncertainty in which seniors regularly find themselves and which they have to act against.

One of the reasons for the elderly receiving unsatisfying or insufficient support from their family is the change in social cohesion and cohabitation, which is an indicator of the former (Beaujot and Ravanera, 2008; Brines and Joyner, 1999). Aggregate data from Komagane and Tōkyō (Komagane Shi yakusho, 2014; Ministry of Internal Affairs and Communications, 2012b; Tōkyō-to Sōmukyoku Tōkei-bu, 2014) indicates that the ratio of multi-generation households in Komagane and in shīta-machi areas is higher than in Tōkyō's yamanote districts, which leads us to assume that social cohesion and the willingness to uphold traditional lifestyles is greater in less central areas.

Nevertheless, as the Nagano prefecture, in which Komagane is located, is also the prefecture with the highest longevity throughout Japan, another growing issue becomes apparent: the ageing of caregivers. The majority of children who care for their elderly parents are close to or already beyond the retirement age and are, in addition to their parents, increasingly prone to health issues, which in the long run renders their care responsibilities successively burdensome and exhausting—and underlines their increasing need for external support.

Oyakōkō has grown to be an unfeasible concept, which is illustrated by internal migration, which affects metropolises and the periphery. A few of the seniors I interviewed (e.g. male preventive day-care patient #17, 09.05.2013) revealed that either they migrated after retirement to a place which they considered to offer a higher quality of life, or they were professionally transferred by their company and stayed put after retirement. As a result, younger generations are left behind and seniors find themselves without physical family support at hand. The opposite case is even more common: education and career-oriented outmigration of younger generations in order to take an academic and professional chance, who usually gravitate towards sprawling major hub areas, such as Tōkyō and the Kansai area, while depopulating peripheral areas (Matanle and Rausch, 2011, esp. chapter 4; Suda et al., 1988) and affecting intergenerational cohesion.
The gist is that oyakōkō, even though its ideal is still widespread among the elderly, is impossible to maintain under such circumstances. Seniors’ reliance on family members, especially on their children’s generation, represents a conflict of not only physical performance and time constraints, but also a generational conflict of diverging values, which puts those affected by it under strain. Still, the idea of oyakōkō in general and family reliance in particular has changed massively with the introduction of the LTCI, leading to both distress about the alleged loss of social cohesion and relief about the ways that have been opened up to ensure seniors’ livelihood at the same time. The notion prevailing among numerous seniors and young adults is that younger generations should have the moral duty to care for their parents and grandparents. And, since the LTCI is already established and functioning, the moral imperative to do so is fading—even though legally custodial duties exist according to Japanese Civil Law\(^\text{161}\).

Elderly patients as well stated that their expectations have gradually changed, and they now try to be less demanding and less of a burden to their families—it seems as if they have chosen to make this decision. As a consequence, due to the change in family structure towards smaller core families and the introduction of additional age-based social insurance, the responsibility for the ageing society and especially caring for the elderly is shifting from social to public institutions for old-age support and welfare. This is partly due to the placement of the LTCI as a new element in the welfare mix, and partly it is due to the gravity that the state exudes as an actor.

In the first years after the LTCI law was enacted, the initial mistrust and social stigmatising of it faded and the ensuing necessity to resort to public institutions became evident. While, at first, services were utilised rather hesitantly, the LTCI and its service spectrum experienced a landslide success after a short period (Tsutsui and Muramatsu, 2007)\(^\text{162}\). The unexpect-
edly high success had to be curbed by ensuing major reforms in 2005 and 2011 and minor reforms in 2003 and 2013 (see also Ministry of Health, Labour and Welfare, 2012; Shimizutani and Inakura, 2007; Tsutsui and Muramatsu, 2005; 2007; Yong and Saito, 2012 as well as a discussion in chapter 2), but also expressed the need for and the trust in the new system among seniors. Trust, but perhaps also hope, in the new care system was also shared by a former nonagenarian restaurateur without any considerable income for private care services (female day-care patient, #49, 26.08.2013) in a care facility in Tōkyō’s red light district, Senzoku:

Dei sābisu ga deta-node, yokatta desu yo. Kazoku ha inai-shi, hitorigurashi de, toshi ga agatta-kara, shinpat shite... ō sureba wakarimasen deshita.

[I am glad that day service [= day care] came into existence. I don't have any family and live alone. Because I have aged, I was worried... I didn't know what to do]163.

Trust in an abstract construct of social insurance, however, was not the sole driver for the widespread utilisation of LTC services, but rather a twofold urge: to retain autonomy and purge uncertainty. As Japan had had a dichotomous and rather antagonistic system of care in the past, which was either family care or institutional care164, the idea of a means-based hybrid care model was widely acknowledged. The beneficial point was the range of services provided, stretching from lightly invasive (meal delivery, home help) via an average (day care) to a total level (institutional care) of geriatric care measures. Instead of the former binary yes-or-no decision, there was an opportunity to gradually, even if partly, shift responsibilities as ageing progressed from social institutions, e.g. immediate family, other kin and neighbours towards public institutional support, i.e. food delivery, care managers, care centres, group homes, doctors and making use of the arrangement of public care institutions.

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163 「デイサービスが出たので、良かったですよ。家族はいないし、一人暮らして、年が上がったから、心配して。どうすれば分かりませんでした。」

164 In the second chapter, which provides an overview of care for the elderly in Japan, the issues of old-age care misuse are illustrated. One of the major issues was basically the (mis-) use of general medical facilities by seniors for geriatric purposes due to the fact that individual expenses for medical care were lower— and for a time even free—than for actual geriatric care. The result was overcrowded, underfunded and overwhelmed medical facilities and an unbalanced national health budget.
Research was primarily carried out in care organisations for the elderly that provided day care, which resembles the hybrid model of care for the elderly depicted above: an overlap between social and public institutions in terms of responsibility and care tasks. The diagram (Figure 6-1, right side) illustrates a status quo in which the shift from social to public institutions already took place, while the initial starting point without it is shown on the left. However, the transition from social to public institutions for an individual's livelihood increases with age and deteriorating health—as well as their reliance on these as the demand for care for the elderly and medical care rises.

Figure 6-1: Balance of responsibility between public and social institutions before (left) and after the introduction of the LTCI in Japan (right)

Source: Own representation.

Note: The different size of the circles symbolises responsibility and workload.

The figure above is an illustration of processes on an individual and familial level that are depicted in the previous chapters concerning care for the elderly in peripheral and metropolitan Japan. Formal old-age care through public institutions played a subordinate role\(^{165}\), its influence, though, has grown since the enactment of the LTCI. The increasing necessity for care caused by heightened longevity and materialising geriatric diseases\(^{166}\) is also attributable to this shift, rendering informal care more demanding.

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165 The misuse of medical facilities for geriatric care is also taken into account, although *de jure* it never existed.
166 The question of whether increased longevity contributes to the medicalisation hypothesis or to the compression hypothesis is not answered here, i.e. whether a decrease in mortality is accompanied with an increase or a decrease in morbidity. See Spindler (2014) and Breyer (2015) for a more elaborated account.
The shift above, however, has a double connotation: it is a transfer of livelihood responsibility and dependability, and it is an intrusion into the private sphere of the receivers of care and caregivers as well.

If we take day care as an example, at the early stages of LTCI usage seniors’ service uptake is limited to one or two days per week, while they spend the rest in their accustomed social environment at home and in the local community, often in combination with assistance from home helpers and visiting care services. When their health deteriorates, the time seniors spend in day care increases progressively, e.g. for rehabilitation procedures, while simultaneously the time they spend embedded in former social networks decreases. This physical, psychological and, in particular, social relocation is in many cases an involuntary process of change, triggering discontent and uncertainty—often among male patients. On the other hand, such change causes new processes and sparks opportunity and action among the elderly, who successively accept the newly established institution of care and, what is even more important, learn to utilise it for their own needs and wishes.

6.3 Care institutions for the elderly as resources

Not only does taking advantage of care institutions to satisfy one’s own social needs and enhance one’s everyday experiences mark interesting management of social and public institutions, but it also illustrates a prevalent gender gap in care facilities for the elderly. Furthermore, it dissolves the widespread notion of seniors who receive care as passive sufferers of their circumstances—even if this is partly the case. If we disregard institutional care, care facilities are not only perceived as places of heteronomy, although this is generally and objectively true, but as a new chance for diversion and enrichment of daily life in old age. In particular, seniors often make use of care facilities, such as preventive day care or day care, that leave patients some discretionary leeway to adjust care services to their own preferences and fit them into their daily and weekly routine. Consequently, care institutions are used as resources. This, of course, is only possible within the boundaries of each respective institution and the seniors’ cognitive and physical capabilities, i.e. the level of care assigned to them. Institutional care, for example, does not provide much discretionary flexibility since most patients already lack the cognitive or physical ability to embrace these options, or—and this is unfortunately
frequently the case—the care facilities lack personnel and equipment to provide options and room for manoeuvre.

However, using institutions as resources is better distinguished among female patients and more comprehensible during conversations. While some female patients accept their stay in old-age care homes as an inevitable, defeatist course of events and try to come to terms with these circumstances, others try to benefit from the new, interdependent link between their social and public spheres of reliance by accessing social networks. Although this happens through gatekeepers, it often has satisfying results for the patients. Generally, these gatekeepers are care managers or care unit coordinators who elaborate, in consultation with the patients, a care plan in accordance with the level of care granted. Compiling a weekly care schedule, care managers try to take into account a patient's wish for e.g. rehabilitation training, gymnastics and free-time activities, but also the available capacities at care facilities and decide on the desired institution.

In order to underline the aspect of the patients' creative and demand-based leeway, care patients are not merely called patients (病者, byōsha; 患者, kanja) or even seniors (高齢者, kōreisha; 御年寄, otoshiyori) in care institutions, but plain and simply users (利用者, riyōsha). Day-care institutions use image creation and cultivation in their advertisements to not present themselves as care facilities that limit freedom, but rather as service providers of old-age support from which seniors can order a menu tailored to their needs. These thought processes can be found in the patients' expectations towards the facility's management and, although they have no direct connection to the financial handling of their own care, they regard themselves as paying customers and demand the services are executed, e.g. serving tea. A septuagenarian who lived alone (female day-care patient, #47, 12.08.2013) explained to my astonishment why she had chosen a particular care facility, stating that:

"hokano dei sābisu ni haicchattakedo, chūshoku wa oshikunattan desu. Desunode, otonari-san wa kono shisetsu de oishī-te, koko ni haittemashita ne.

167 In case of cognitive disabilities, seniors and persons with age-related disabilities (which can use LTC from the age of 40 on) are under the guardianship (成年後見人) of direct family members.
[Initially, I was in another day service [= day care], but the food for lunch wasn't delicious. Because, according to my neighbour, the food in this facility is delicious, I joined them [i.e. the facility]]168. Being part of a so-called ‘table society’ with four other obāchan, another female patient chipped in and mentioned that she had switched facilities because the current one apparently provides better massages and rehabilitation services. A further octogenarian, female patient who lived alone (female day-care patient #48, 12.08.2013) explained that she wanted to be in the same facility as her neighbour (the former day-care patient #46), who, having worked in a Japanese katsura producing traditional wigs for Kabuki theatres, mentioned persistent gender discrimination in the post-war era. Understanding day-care facilities as services providers, a grim female patient presumably deemed day care as a 'day café' with annexed care, and demanded apron-wearing care staff and volunteers to serve her extra green tea in addition to the cups already served in the breaks between activities.

Added to the sensation of being a user in contrast to that of being a patient is the notion of perceiving day care as a social event and, thus, of following social rules of preparation for public social interaction. According to the day-care unit coordinator at the Shinkatsushika Royal Care, Satō Kimiko (佐藤 貴美子, 06.08.2013), some patients regard their attendance of day care as special events and rare occasions for social interaction during the week, so they dress up, use make-up, get their hair done, basically oshare wo suru (Jap.: be fashionable)169, and enjoy themselves.

The points above illustrate that care institutions for the elderly have partly taken over the care responsibilities of and seniors’ dependency on families by formalising the act of caring for the elderly. More than that, as the elderly spend a considerable amount of time in care facilities, social interaction has grown to be a significant part of the formal care provided for them. Nevertheless, it is regularly provided in a patient–patient relationship rather than in a patient–personnel one, especially in preventive and day-care type facilities. Furthermore, the institution of care can be utilised as a resource for the satisfaction of individual needs, especially social needs, e.g. communication. What was evident during participant observation is that women more frequently and consciously used care institu-
tions as resources than men, in particular the institution of day care for their well-being. Of course, this can be attributed to a large extent to the comparably better health of women in old age. But a major role may also be the women's better ways to orient themselves in speech and social interaction-oriented environments due to different socialisation processes among the genders at earlier life stages.

6.4 Duality of welfare regimes

Socialisation processes provide structuring elements to individual lives and their courses, evoke normative expectations, and familiarise seniors with the discretionary power granted to them by institutions, thus providing them with a corridor of action. The defining institutions which shape life courses are the family, the education system, the labour market and the welfare state (Leisering and Schumann, 2003, pp. 199–200; see Sackmann, 2003, pp. 567–568 for an argument about how welfare regimes shape life courses). While different starting positions and shaping mechanisms influence a life’s trajectory, "standardized life-course patterns are giving way to more individualized trajectories, under the influence of changing or new social risks in different domains of life" (Dewilde, 2003, p. 119). Merton (1968) already stated that those stimuli and trajectories accumulate over time and have an increasingly advantageous or disadvantageous effect. This is a crucial insight for ageing societies since "part of the nature of aging is the existence of systematic and regular life-course patterns in the development of intracohort [sic] inequality on health-related as well as resource characteristics" (Dannefer, 2003, p. 334). The last third of life, however, unites the elderly insofar as they all enter retirement, and a minor re-standardisation of life-course trajectories and patterns occurs as similar processes are experienced. Thus, if we examine elements of the late stages of life, structured according to age, and assess seniors' social surroundings, differences in locality and gender become graspable. Even though re-standardisation manifests itself upon a person’s retirement, the differences in the course of a life still loom large after retirement, most

170 According to the life expectancy figures for women and men in Japan of 86.6 and 80.2 years (Ministry of Internal Affairs and Communications, 2016), the last third of life therefore starts in the age group of 55 to 60 years.
prominently in the differences in pension benefits among the self-employed and full-time employees (see also 1.2.1).

Meeting and interviewing 49 seniors in Tōkyō and Komagane in all ambulant and hospital care forms, with a particular focus on day care, I became increasingly aware of temporal patterns in the life courses of the elderly

Spatially diverse life courses result from different employment structures rooted in variable prerequisites of locality, resources and infrastructure, which, prior to retirement, have a considerable influence on the course of a life in the sense of external steering. Additionally, traditional values and social and behavioural norms have led to gaping curriculums between genders, often representing a clear-cut differentiation between seniors’ roles as male breadwinners and female nurturers in the earlier phases of their lives. If we look at the lives of the patients and seniors I interviewed, divergent stages in the immediate pre-retirement and post-retirement phases for men and women are distinguished between in the tables below. The difference between genders and locality is not only rooted in an earlier phase of dependency and decline, but also one of different outlooks on the developments in their social environment, including their access to social networks and interaction within the community.

6.4.1 Urban duality

In Tōkyō, the chronological order of social and physical deterioration is generally steeper for men than for women (Table 6-1). Besides underlining the greater dependency of men on their kin and social networks after falling ill or becoming frail, it also illustrates that the image of women as carers is perpetuated as they are in charge of caring for their spouses. Being cared for by their wives, daughters and daughters-in-law was and still is widely expected by today's male seniors, and 68.7 per cent of informal and professional carers are still women according to a representative

171 Even though a considerable amount of data was gained through interviews and participant observation, caution is advisable when trying to derive general patterns from it since only the elderly who already receive assistance and care are included.

172 Of all caretakers, those who cohabit with the elderly are 26.2 per cent spouses, 21.8 per cent are the elderly's own children and 11.2 per cent are children-in-law.
survey by the Ministry of Health, Labour and Welfare (2015b, p. 32), which is a decrease of 6.2 per cent in nine years (Ministry of Health, Labour and Welfare, 1996). The notion of women as caretakers is still prevalent, even since the introduction of the LTCI:

"Care recipients' wives reported the lowest levels of normative filial obligation, but their levels did not change before and after the LTCI [sic] implementation. Wives' low expectations may reflect the trends of declining roles of daughters-in-law and increasing roles of spouses (especially wives) in Japan. Older women in our study are likely to have personally experienced challenging caregiving roles as daughters-in-law and thus may feel wary of expecting others (especially their own children) to do the same. Their expectations of support from children may have already declined earlier in their life course and thus may have become immune to the impact of the LTCI [sic] implementation" (Tsutsui et al., 2014, p. 7).

The moral obligation that elderly women feel about caring for their husbands is one part of the reason why care facilities for the elderly are predominantly utilised by women. As men rely on them for care, they provide it until either their spouse passes away or until they are in need of care themselves. This might be a deeply ingrained normative form of how families should work and gender division of labour is supposed to be. The other part is the higher longevity of women, which renders them in need of care at older ages.

The social networks of men deteriorate faster and more drastically upon retirement, leaving them with abrupt changes in social relations as these are heavily work-related. Furthermore, their more or less mandatory first retirement often presses them into post-retirement employment—for economic but also social and psychological reasons.

Of the carers who do not cohabit with seniors, 14.8 per cent are professional caretakers, 9.6 per cent are family members, 1.8 per cent are kin, 0.5 per cent parents, and 13 per cent are unknown (Ministry of Health, Labour and Welfare, 2015b).
6.4 Duality of welfare regimes

Table 6-1: Old age phases among Tōkyō men

| Age span | Phases of Tōkyō men | Social environment / networks | Social inclusion |
|----------|---------------------|------------------------------|-----------------
| 55–60    | First retirement\(^{173}\) | Strong reduction | ¬ |
| 55–75    | Continued employment | Light expansion | ¬ |
| 65–75    | Physical and mental deterioration | Strong reduction | ¬ |
| 65–75    | Informal care | Great reduction | ↓ |
| 75–      | Death | - | - |

Source: Own representation.

Table 6-2: Old age phases among Komagane men

| Age span | Phases of Komagane men | Social environment / networks | Social inclusion |
|----------|------------------------|------------------------------|-----------------
| 55–60    | Retirement & inheritance | Continuation | ¬ |
| 55–70    | Continued employment | Slow decline | ¬ |
| 65–75    | Physical and mental degeneration | Strong reduction | ¬ |
| 65–80    | Informal care | Great reduction | ↓ |
| 75–      | Death | - | - |

Source: Own representation

Oddly enough, this reverses the concept of social integration or social inclusion upon retirement. The standard course of men’s lives, assuming they have full-time employment, is classed as a major factor in their social integration in general\(^{174}\) and into social networks in particular and curbs deviance. The positive effect of social integration on health (Berkman et al., 2000) loses its impact to a high degree when men retire.

\(^{173}\) A widespread labour market practice is to lay off and immediately re-employ older employees in order to prevent the loss of human resources while curbing high wages due to seniority principles.

\(^{174}\) See also the seminal work by Durkheim (1990) on how integrative measures prevent anomie and deviant behaviour, and influence individuals.
In Japan, the importance of full-time employment for fully fledged social integration is underlined by the common view that one becomes a *shakaijin* (社会人, lit. "person of society") upon entering regular employment, paying taxes and nurturing one’s own family. And while men usually enjoy this status in Japan’s male-breadwinning oriented welfare regime (Ōsawa, 2011), the women’s role is often confined within the limits of both career orientation and family orientation, i.e. child-rearing, care provision and household duties. Of all employed women, 57.5 per cent were engaged in non-regular employment, while for men the rate was 22.1 per cent in 2012 (Ministry of Internal Affairs and Communications, 2014c). The part-time employment of women coincides with domestic workload, the vast majority of which is borne by them. Household chores are still overwhelmingly performed by women, and the only change within a decade was an increase in men participating in housework, while the time women spent doing the same work remained stable (Kobayashi *et al.*, 2011, pp. 8–10; Ministry of Internal Affairs and Communications, 2002).

This data once again underlines that women historically had and still have more ruptures in their life courses and that, consequently, the so-called standard course of a life for women is rather a patchwork of life phases. Hence, normative modelling and structuring through institutions and social policy (Leisering and Walker, 2008, p. 434) exerts less influence on women than on men since women often find themselves in an in-between state. The plurality and heterogeneity due to the 'fuzziness' of career and family development, however, has the effect that women exhibit better coping abilities and mechanisms than men as they get older. Due to the patchy courses of their lives, which necessitated the development of social skills to adapt to different social environments, a certain bonding among aged women is expected:

"der Anteil von betagten Frauen mit hohen Sozialkompetenzen [wird] (weiter) ansteigen, weswegen aus einer schweigenden Gruppierung nach und nach eine durchaus aktive Interessengruppe werden kann. [...] [durch die] Hetero-

---

175 All forms of non-regular employment, such as part-time work (*パート・タイマー*, *pâto-taimâ*), dispatched workers (*派遣, haken*), day labourers (*日雇い, hiyatoi*) and NEET (*ニート, Not in Education, Employment or Training*) are not considered as *shakaijin* occupations and people in these forms of employment are thus not full members of society. Although such a notion is considered to be outdated by many due to decades of a changing labour market and new forms of employment, it is still prevalent in conversations and uttered in self-descriptions.
The standard life course and employment history found among elderly men in Japan makes clear that their socialisation occurred through employment and professional networks—and it underlines a major gender difference in socialising. Employment-based social networks, in which present-day male seniors were socialised, are isolated, exclusive networks with access to them restricted to company members. They also fundamentally cease to exist upon retirement. Thus, the experience of leaving the workforce is more aggravating for men in the sense that it cuts down a major part of their social interaction. The one-sidedness of employment-centred social networks exerts its constraints even beyond employment—their ability to navigate in non-employment-centred social networks is limited and less successful.

In contrast, women usually fulfil a double role between additional earners and child-rearing during the productive phase of their lives, often in addition to being a "social authority" in the neighbourhood. This is due to the socially demanded stipulation that women adopt a "familienbiografischen und einer berufsbiografischen Orientierung weiblicher Identität" (Richter, 2002, p. 102). The result is that they are better versed in dealing with ruptures in their lives, more experienced in navigating within different social networks and more successful in adapting to new social environments, e.g. in old-age care institutions.

The main point, however, is that the male-breadwinner-oriented social policy in Japan has a two-sided gender effect at higher ages. First, it leads to men experiencing a larger social rupture upon retirement and throughout their old age. Compared to women, men lose their social and even their self-identity anchor, which is regularly grounded in their full-time employment and capacity to work. The advantage of women, on the other hand, is their embeddedness in a more broadly oriented mesh of work-related and neighbourhood and community-rooted social networks. It provides elderly women with wide-ranging abilities to cope with social exclusion upon their entering retirement age through the breadth of available social networks. In addition, retiring from a part-time position, which is predominantly done by women (Ministry of Internal Affairs and Communications, 2014c), has less incisive effects on the social environment and one’s self-perception than retiring from a full-time position.

Cynically speaking, however, the longer life expectancy of women is growing to be a disadvantage for them since they are expected to be social
nurturers and carers for their children, to take over household chores in the family, and fall into the role of a carer again when their spouses become frail or fall ill.

6.4.2 Rural duality

For women the stages of old age develop differently, since most of the female seniors that I met did not work full-time and were expected to be responsible for the household. However, some of them worked part-time and retired either simultaneously with their husbands or upon reaching the former retirement age of 60. This also shows (see Table 6-3 and Table 6-4 below) that the social environment of women expands upon them reaching old age as they quite often engage in volunteering activities and become part of neighbourhood circles.

In the Japanese periphery, old-age life courses are structured differently than in urban regions. Since the continuation of blue-collar or white-collar employment is rather uncommon in rural areas upon retirement, the occupation of elderly men regularly changes into full-time farming, which they already carried out throughout their lives as spare-time work. Ploughing fields, sowing seeds and harvesting crops in fields they own or lease are basically family tasks in which three generations actively or passively participate.

As far as the social environment of men is concerned, an incisive reduction of their social contacts upon retirement, as seen among Tōkyō’s seniors, does not occur. In fact, a continuum is given through the prolongation of agricultural activities as a post-retirement occupation and, in particular, through social engagement, which are both sustained by the seniors even after bequeathing real estate and farmland to their children. Social interaction within the scope of agrarian activities is preserved and even necessary to meet agricultural agreements. Although gradual physical wear and tear due to manual labour occurs and successively pushes elderly men out of agrarian labour, the reduction in their social network is less drastic than in employee-only occupations. Male seniors are and remain closely involved in organisational, systemic and structural processes and cooperation in local and trans-local communities i.e. irrigation control, agricultural cooperatives, distribution networks and local politics (George Mulgan,
2013)—and are welcomed due to their expertise, seniority and local standing and influence through personal relationships.

Table 6-3: Old age phases among Tōkyō women

<table>
<thead>
<tr>
<th>Age span</th>
<th>Phases of Tōkyō women</th>
<th>Social environment</th>
<th>Social inclusion</th>
</tr>
</thead>
<tbody>
<tr>
<td>55–65</td>
<td>Retirement from part-time job</td>
<td>Light reduction</td>
<td>¬</td>
</tr>
<tr>
<td>55–75</td>
<td>Volunteering and family care</td>
<td>Light expansion</td>
<td>¬</td>
</tr>
<tr>
<td>75–85</td>
<td>Slow physical and mental degeneration</td>
<td>Slow reduction</td>
<td>¬</td>
</tr>
<tr>
<td>75–95</td>
<td>Day care</td>
<td>Light expansion</td>
<td>¬</td>
</tr>
<tr>
<td>85–</td>
<td>Death</td>
<td>-</td>
<td>-</td>
</tr>
</tbody>
</table>

Source: Own representation.

Table 6-4: Old age phases among Komagane women

<table>
<thead>
<tr>
<th>Age span</th>
<th>Phases of Komagane women</th>
<th>Social environment</th>
<th>Social inclusion</th>
</tr>
</thead>
<tbody>
<tr>
<td>55–65</td>
<td>Retirement from part-time job</td>
<td>Light reduction</td>
<td>¬</td>
</tr>
<tr>
<td>55–75</td>
<td>Social engagement and family care</td>
<td>Light expansion</td>
<td>¬</td>
</tr>
<tr>
<td>65–85</td>
<td>Pre-day care</td>
<td>Light expansion</td>
<td>¬</td>
</tr>
<tr>
<td>75–85</td>
<td>Slow physical and mental degeneration</td>
<td>Slow reduction</td>
<td>¬</td>
</tr>
<tr>
<td>75–95</td>
<td>Day care</td>
<td>Light expansion</td>
<td>¬</td>
</tr>
<tr>
<td>85–</td>
<td>Death</td>
<td>-</td>
<td>-</td>
</tr>
</tbody>
</table>

Source: Own representation.

As we can see, the tendency for men’s social surroundings to disintegrate is lower in rural and peripheral areas than in urban areas, which is due to the denser social organisation there. People’s stronger connection to local districts and neighbourhoods, which is based on social ties and, in the past, on mutual reliance for economic cooperation, leads to tem having strong personal and social commitments.

Surprisingly, elderly women in Tōkyō and Komagane pass through similar life stages since their lives are structured without a preponderant dependence on occupational status. They are also perceived as nurturers and...
carers, and households as their domain. Some female seniors (e.g. female day-care patient #7, 16.11.2012) still consider a strong gender gap to be the "right" social value, and it should become the norm in today's society again. They deduce that from how stressed and exhausted their daughters and daughters-in-law are, who in fact deal with child-rearing and household chores, as well as part-time employment to make ends meet.

Preventive day care in Komagane functions as an additional option for seniors to participate in social interaction and organise pastimes. As it is usually predominantly frequented by women, making new social contacts that reach beyond pre-day care is possible and occurs regularly, with the result that community ties are renewed or newly established. Pre-day care as such resembles informal meetings between friends and neighbours due to the activities performed, e.g. hanami and grilling yakiniku at the kitchen table, but structures these occasions with a formal frame. Moreover, the groups in pre-day care are largely aggregated by districts and neighbourhoods, so that acquainted neighbours can meet but also make new acquaintances.

Table 6-5: Visualisation of social inclusionary prospects according to gender and locality

<table>
<thead>
<tr>
<th></th>
<th>Men</th>
<th>Women</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tōkyō – yamanote</td>
<td>![circle]</td>
<td>![circular]</td>
</tr>
<tr>
<td>Tōkyō – shitamachi</td>
<td>![circle]</td>
<td>![circular]</td>
</tr>
<tr>
<td>Rural and peripheral regions</td>
<td>![greycircle]</td>
<td>![circular]</td>
</tr>
</tbody>
</table>

Source: Interview data and participant observation. Own representation.

Note: The traffic light system is used for the sake of simplification, light grey = rather positive, dark grey = mediocre, black = risky. Also note that this is just an extremely simplified visualisation of a complex set of institutions and processes on different levels.

Trying to summarise the findings that I encountered during my fieldwork and have depicted in this project, I have illustrated the social outlook of seniors after retirement above (Table 6-5). The visualisation above tries to depict the likelihood that seniors might experience the effects of social exclusion or social inclusion through the development of social networks af-
ter retirement. As has been represented in previous chapters, the effects and seniors’ inclusionary prospects vary to a significant degree according to gender and locality—and of course retain a highly individualised outcome. It helps, however, to generally identify risk groups and, with the knowledge of gendered ageing as a backdrop, to anticipate issues and coordinate inclusionary measures.

6.4.3 The duality of the welfare mix

In addition to the transformation of responsibility that has occurred through the introduction of the universally accessible LTCI, the findings in the two regions researched hint at a distinguishable composition of the Japanese welfare mix. If we orient ourselves along the quadripartite care diamond model (Ochiai, 2009; 2014a), the result is that locality matters insofar as care institutional dimensions are emphasised differently. In particular, the community as a care institution differs in its dimension according to region.

As has been shown (see i.a. section 1.2.5 for spatial differences), rural and remote regions were not only hit by administrative reforms, but were impacted more strongly by the demographic change with resulting outmigration, rapid ageing and fiscal scarcity, which marginalises an astonishing amount of these regions. Local governments struggle with impaired authority as the demographic trends maintain their negative population outlook and, simultaneously, hinder their service provision and maintenance.

Social ties, however, are upheld through traditions and adapt in order to ensure communality and power relations. In spite of the continuing trend of net outmigration, social and community ties are maintained and refreshed transregionally through community events, such as festivals, and trans-local political engagement in community activities (Okubo et al., 2015). The community plays a greater role in rural peripheral regions in the provision of livelihood and welfare for the elderly, which is rooted in historical mutual dependence, but also in the fact that the market for care for the elderly has penetrated rural areas less, which requires other care institutions to "fill the gap". The latter especially became obvious after seniors I was interviewing in Tōkyō opened up on the point of choosing care facilities based on their desires and not solely based on geriatric care needs (see also 4.4.3), which is impossible in rural regions due to the distribution and availability of care organisations.
What the point basically illustrates is that a regional disparity in the accessibility and availability of care institutions exists. In regard to the welfare mix, two characteristics exist in relation to locality (Figure 6-2, below). For urban regions, the market is well established and proves to be three-dimensional in regard to breadth, expertise and the availability of care services and facilities. In rural communities the market is rather vertically oriented, providing the required care services but lacking the variety.

*Figure 6-2: Welfare mix for care for the elderly in urban and rural and peripheral areas*

The aspect of familialistic orientation among the welfare regimes is almost equally pronounced in both urban and rural regions. However, in rural and remote regions the care institution of the immediate family and other kin is involved to a higher degree in caretaking duties due to the lower availability of care facilities to meet certain requirements, e.g. geriatric care for severely handicapped seniors.

The major difference lies in the community. Although the market for care the elderly is less developed in rural and peripheral regions, this shortcoming is compensated for by a close-knit and engaged community...
which goes beyond individuals engaging in volunteering activities in care homes. The community aspect in rural areas is ingrained in everyday life, in which personal acquaintance signifies a stronger commitment in communal and local activities. Furthermore, it is prominent in public–private partnerships, the financial, organisational and administrative support that local welfare groups and councils receive in order to strengthen and ensure the livelihood of seniors through the community and neighbourhood networks. This community aspect is also distinct in urban areas with many available volunteers, but is less developed than rural areas, where it goes beyond volunteering and is almost entirely all-encompassing.

In this regard, the strengthening of the community by the Ministry of Health, Labour and Welfare (Ministry of Health, Labour and Welfare, 2011a; Tsutsui, 2014) is a hopeful endeavour to formalise civic engagement and funnel it into a comprehensive, supportive form of care for the elderly in a society with a declining population and a shortage of care personnel.

It can be concluded that the Japanese welfare system of care for the elderly is fundamentally composed by the four institutions of the market, family, state and community, each of which contributes to the creation of welfare. The characteristics of these institutions, however, vary between rural and urban regions, being pronounced to differing degrees, and so, with regard to the available data, it might be said that two welfare regimes are present in Japan—one in urban and one in rural areas. Despite the different characteristics, the institutional arrangements of the respective welfare mix compensate for the shortcomings in one of the institutional dimensions. The question, however, is what mix is more favourable for the elderly, local governments, the market, and families and communities.

6.4 Duality of welfare regimes
7 Conclusion

The research topic of this project was examined and analysed from three different perspectives: the top-down perspective with policy analysis, the bottom-up view with ethnography-inspired fieldwork, and the perspective of the social risks of ageing for elderly individuals and their families. Overall, the conclusion is that the introduction and implementation of the LTCI law has led to a rebalancing of the existing welfare mix as the Japanese state set up a game-changing framework. As such, the framework of the LTCI is not only committed to welfare creation itself, but caused other institutions of welfare creation to respond appropriately, partly as financial incentives were created through taxation, and partly as the benefit for families and individuals was seen and the new care institution utilised. Local communities were politically and financially encouraged to actively pursue integrated measures for old-age care. The positive response to the LTCI and the associated synergy effects show that it was and is highly anticipated and needed. Despite the positive evaluation of the LTC system by patients and local governments in welfare provision and financial support, open questions for further discussion and research remain.

We have seen that the term *two worlds of ageing* applies in many respects to the Japan. The two worlds refer, in their very basic sense, to the urban–rural divide in ageing. In addition, they refer to the demographic urban–urban divide as well. Even more striking is that the term connotes to the gender divide that is experienced in ageing and individual pathways in risk management. But more than that, the term illustrates that the implementation of the LTCI functions differently in these regional settings, creating two distinct worlds of welfare between urban–rural and urban–urban settings. These two worlds of welfare can be recognised in the constellation and characteristics of the respective welfare mixes which, even though implemented top-down, manifest themselves differently in actual care.

This research project has contributed in multiple ways to research on the Japanese welfare regime and in particular its welfare mix. By introducing the regional component into welfare mix analysis, the project has contributed to a better understanding of local welfare creation and institution-
al dependencies. Furthermore, parts of this dissertation, which draw on rich, ethnography-inspired research methods, will provide sociological and socio-anthropological insights into local community organisation in rural and urban areas in Japan and the interplay between institutions in ensuring livelihood. Additionally, data on gender differences in care for the elderly, two burning issues relating to social policy in Japan, were investigated and data on positive outcomes and shortcomings provided in order to improve the approach to care for the elderly not only according to gender, but also to region.

For the moment, however, the following points should be considered as brief suggestions for welfare organisations and policymakers:

- First, male seniors have to develop an awareness of and willingness to utilise formal geriatric care services. Formal care does not only provide 'breathing space' for caring spouses, children and children-in-law, but also has the potential benefit of improving the social environment of those who receive care as well as caregivers. This is in particular true for outpatient care, through which the social network of the seniors who receive care is enhanced. Essentially, elderly men experience larger deterioration of their social networks, and consequently also of their mental and physical health, upon retirement from lifelong full-time employment. However, this issue will disappear over time as the traditional normal biography for men has undergone massive changes through the deregulation of the Japanese labour market. The results might be similar to those of elderly women, who fare better due to the multitude of their social networks and also their ability to cope in new social environments.

- Second, care facilities for the elderly have to take the gender issue of the ageing society into consideration. The vast majority of those who receive formal care are women—in stark contrast to informal care—and so the leisure and pastime activities in care facilities are oriented according to their demands and requirements. This might be the reason why male patients behave more passively in care facilities and are less attracted to formal care, besides their comparatively worse health and the still widespread belief in normative gender division of tasks and duties. Utilisation of formal care could improve men's health and relieve spouses and other kin of their care burdens.

- Third, a societal change in the level of awareness of formal care utilisation is occurring slowly but surely and has already led and will further lead to the wide acceptance of the LTCI. This is due to a change in
values that used to see the family as the sole provider of care. Moreover, the change will likely put formal care institutions under more pressure since the amount of needy seniors is increasing while a shortage of care personnel and care capacity still exists and is likely to increase. The stress, however, will also be put onto families and communities as they share care burdens and care responsibilities with formal care institutions due to the high societal ageing.

- Fourth, while the planned formalisation of community approaches to welfare for the elderly seems promising, many questions about how such an institutional set-up will play out remain open and need to be evaluated in the future. In particular, the aspects of the regional implementation of this system need to be assessed and analysed. So far, research has shown that community activation is done in varying ways by municipalities and so are the effects thereof. It also has to be determined in the nearer future whether through such an approach to civic engagement a change in the Japanese welfare mix will occur and whether it will mean a reduction in familialistic elements in the Japanese welfare regime. Women particularly, as the main informal caretakers could profit from care burdens being redistributed. Up to this point, however, it shows that the elderly in rural regions are experiencing greater inclusionary effects through community support than their urban counterparts.

While we have gained a glimpse into the changes to the Japanese welfare system and their effects on individuals and welfare institutions, numerous issues and questions remain unresolved and unanswered and still need to be researched further. Among many interesting questions, the basic idea of two welfare regimes in one welfare state is overly appealing and needs further elaboration. Hints in literature allow us to assume that care services might have started to replace public works in rural regions as a 'functional equivalent' to welfare creation and economic subsidies. In addition to that, how far the reforms by the Ministry of Health, Labour and Welfare in the so-called "integrated community care system" have succeeded in including local communities in welfare creation and to what extent locality plays a role four years after the latest reform are of great interest to me. The first reports (Tsutsui, 2014) showed ambivalent results as the incentives and aims were not communicated properly and could thus not be implemented in the desired way. Despite reaching communities being a communicative issue, the indication is also that the top-down administrative and policy approaches might be problematic.
Finally, as the economic partnership agreements for care migration were rather unsuccessful in attracting care personnel, recent developments and the economic policy of the Abe administration aim at the utilisation of care robotics, ranging from low-tech to high-tech levels. These developments need further research as they combine technology use in an ethically complex environment, but depict that the Japanese agenda for care for the elderly is set on an inevitable course.
アンケートの質問
施設について
1. 御社の施設は何の県にありますか？施設にある町/村の人口はいくらですか？
2. 施設はどんな施設ですか？（私立、区立？デイケア、施設介護、両方。。。？）
3. 施設の定員はどのくらいですか？分譲はどうですか？（例：デイケア10人）
4. スタッフが何人ぐらいですか？
5. ボランティア活動がありますか？
6. 県や国からの補助は十分ですか？具体的にはその補助とはどういう内容のものですか？例：金銭、職員。。。）
高齢者について
7. 高齢者の年齢幅と平均年齢はいくらですか？
8. 男女の割合はどのぐらいですか？
9. 施設でデイケアがある場合：
   a) デイケアを使う高齢者はどの世帯に住んでいますか？（一人暮らし？同居？）
   b) デイケアを一週間に何度も利用しますか？
ボランティア活動について
10. どんなボランティア活動がありますか？（例：活花、歌う、傾聴。。。）
11. ボランティア達は、全人数と男女割合はいくらぐらいですか。
12. 10年前をみると、ボランティアの人数と活動はどうやって変化しましたか。
13. 一般的に、介護施設ではボランティア達がいなかったら、どうのような影響があろうと考えますか？ボランティア活動についてどう思いますか？
一般的な質問
14. 新聞などのメディアや研究論文などで、高齢化と高齢社会の問題について様々なことが述べられていますが、貴所ではいかがでしょうですか？どう考えますか？
15. 御社の施設以外高齢者をサポートするインフラや隣組/隣保などがありますか？
16. 女性の平均寿命が男性の平均寿命より長くなって、高齢時代のジェンダー問題が出てきていますが、何か特別な対応をおされていますか？
17. 高齢者の視点から見ると、貴所では何か問題があるとお考えですか？
Appendix

B Interview guide: patient interviews

Biographical Questions
1. ○さんは、いつごろから早川町・伊豆市に住んでおられますか。よそから転入されて来られましたか。
2. お生まれはどちらですか。
3. 生まれ年はいつですか。
4. 結婚されていますか。

Occupation
5. 今、どんなお仕事をされていまか。
6. 以前はどんなお仕事をされていましたか。
7. 農業をなさっていますか？自営業ですか？それとも年金生活をされていますか。
8. 働き始めたのは何歳くらいのときからですか。
9. 基本年金などが小さくて/低くて、生活消費には十分じゃないと思いますが、XYさん、どうお考えですか。 老後の生活をまかなうのに年金は十分ですか（年金が足りますか？）

Housing & Social
10. ○○さんのご家族もここに住んでいらっしゃいますか
11. 一人暮らしですか。それとも同居されていますか。
12. ご家族は、一ヶ月に何度くらい○○さんのところに来られますか。
13. ここでの近所付き合いはどんな感じですか。隣組/隣保などはありませんか。

Infrastructure
14. 町内/市内の施設や設備（インフラ）に満足されていますか。
15. 最寄の医療施設はどうですか。
16. 介護サービスを希望すれば受けられますか。
17. ○○さんの経歴や人生経験を振り返られてどう思われますか。
18. かお望みがおありですか。)

C Interview guide: expert interviews

1. 新聞などのメディアや研究論文などで、高齢化と高齢社会の問題について様々なことが述べられていますが、特別地域の町と町村ではどうか。先生は、どう思いますか。
2. ○○市でも高齢者割合は全国と比べるとちょっと上がっていますよね、高齢化が○○市ではどの影響をあたえますか。
3. 先生、一般的に地域看護の主な問題は何でしょうか。
4. ○○市に住んでいる高齢者の生活実態を教えていただけませんか。
5. ○○市は高齢者の自立や生活支援のためにどのようなことをされていますか。幾つか例を挙げていただければありがたいです。
6. ○○市ではデイサービス、グループホーム、在宅介護など色々な高齢者施設がありますが、そして駒ヶ根市が地域町の典型的な例はないでしょうか。
7. 女性の平均寿命が男性の平均寿命より長くなって、高齢時代のジェンダー問題が出てきていますが、駒ヶ根市ではどうでしょうか。何か特別な対応をされていませんか。
8. 地域看護の教育を都会看護教育を見るとどの違いがありますか。
9. 先生、高齢者の視点から見ると、こちらの市では何か問題があるとお考えですか。
10.2000年に施行された介護保険は、これまで○○市と地域看護ではどのような経緯/経過/結果をたどっていますか。

D Overview of patients and sociodemographic data

Table A-1: Overview of interviewed patients and sociodemographic data
### Overview of patients and sociodemographic data

#### Table A-1: Overview of interviewed patients and sociodemographic data

<table>
<thead>
<tr>
<th>Patients</th>
<th>Unit</th>
<th>Age</th>
<th>Sex</th>
<th>Education</th>
<th>Familial status</th>
<th>Marital status</th>
<th>Former occupation</th>
</tr>
</thead>
<tbody>
<tr>
<td>#1</td>
<td>Day Care</td>
<td>101</td>
<td>w</td>
<td>Secondary</td>
<td>Lives alone</td>
<td>Widowed</td>
<td>Housewife</td>
</tr>
<tr>
<td>#2</td>
<td>Day Care</td>
<td>85</td>
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<td>Housewife</td>
</tr>
<tr>
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<td>Housewife</td>
</tr>
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<td>#4</td>
<td>Day Care</td>
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<td>m</td>
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<td>Employee</td>
</tr>
<tr>
<td>#5</td>
<td>Day Care</td>
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<td>Secondary</td>
<td>Cohabitation</td>
<td>Widowed</td>
<td>Housewife</td>
</tr>
<tr>
<td>#6</td>
<td>Day Care</td>
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<td>Cohabitation</td>
<td>Widowed</td>
<td>Employee</td>
</tr>
<tr>
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<td>Housewife</td>
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<td>Employee</td>
</tr>
<tr>
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<td>Widowed</td>
<td>Employee</td>
</tr>
<tr>
<td>#11</td>
<td>Day Care</td>
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<td>Secondary</td>
<td>Lives alone</td>
<td>Widowed</td>
<td>Housewife</td>
</tr>
<tr>
<td>#12</td>
<td>Day Care</td>
<td>75</td>
<td>m</td>
<td>Secondary</td>
<td>Cohabitation</td>
<td>Widowed</td>
<td>Employee</td>
</tr>
<tr>
<td>#13</td>
<td>Institutional</td>
<td>80-90</td>
<td>w</td>
<td>Secondary</td>
<td>Institutionalized</td>
<td>Widowed</td>
<td>Housewife</td>
</tr>
<tr>
<td>#14</td>
<td>Institutional</td>
<td>85</td>
<td>w</td>
<td>Secondary</td>
<td>Institutionalized</td>
<td>Widowed</td>
<td>Secretary/ Housewife</td>
</tr>
</tbody>
</table>

#### Komagane - Honobono (04/2013-07/2013)

<table>
<thead>
<tr>
<th>Patients</th>
<th>Unit</th>
<th>Age</th>
<th>Sex</th>
<th>Education</th>
<th>Familial status</th>
<th>Marital status</th>
<th>Former occupation</th>
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</thead>
<tbody>
<tr>
<td>#15</td>
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<td>75</td>
<td>m</td>
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<td>Cohabitation</td>
<td>Married</td>
<td>Farmer</td>
</tr>
<tr>
<td>#16</td>
<td>Pre-Day Care</td>
<td>80</td>
<td>m</td>
<td>Elementary</td>
<td>Cohabitation</td>
<td>Married</td>
<td>Farmer</td>
</tr>
<tr>
<td>#17</td>
<td>Pre-Day Care</td>
<td>80</td>
<td>m</td>
<td>Elementary</td>
<td>Lives alone</td>
<td>Never married</td>
<td>Construction worker</td>
</tr>
<tr>
<td>#18</td>
<td>Pre-Day Care</td>
<td>93</td>
<td>w</td>
<td>Elementary</td>
<td>Cohabitation</td>
<td>Widowed</td>
<td>Housewife / Farmer</td>
</tr>
<tr>
<td>#19</td>
<td>Pre-Day Care</td>
<td>85</td>
<td>w</td>
<td>Elementary</td>
<td>Lives alone</td>
<td>Widowed</td>
<td>Housewife / Farmer</td>
</tr>
<tr>
<td>#20</td>
<td>Pre-Day Care</td>
<td>88</td>
<td>w</td>
<td>Elementary</td>
<td>Lives alone</td>
<td>Widowed</td>
<td>Housewife / Farmer</td>
</tr>
<tr>
<td>#21</td>
<td>Pre-Day Care</td>
<td>80</td>
<td>w</td>
<td>Elementary</td>
<td>Cohabitation</td>
<td>Widowed</td>
<td>Housewife / Farmer</td>
</tr>
<tr>
<td>#22</td>
<td>Pre-Day Care</td>
<td>85</td>
<td>w</td>
<td>Elementary</td>
<td>Cohabitation</td>
<td>Widowed</td>
<td>Restaurant owner</td>
</tr>
<tr>
<td>#23</td>
<td>Pre-Day Care</td>
<td>80</td>
<td>w</td>
<td>Elementary</td>
<td>Cohabitation</td>
<td>Married</td>
<td>Cashier in Coop-market</td>
</tr>
<tr>
<td>#24</td>
<td>Pre-Day Care</td>
<td>95</td>
<td>w</td>
<td>Elementary</td>
<td>Lives alone</td>
<td>Widowed</td>
<td>Housewife / Farmer</td>
</tr>
<tr>
<td>#25</td>
<td>Pre-Day Care</td>
<td>85</td>
<td>w</td>
<td>Elementary</td>
<td>Lives alone</td>
<td>Widowed</td>
<td>Housewife / Farmer</td>
</tr>
<tr>
<td>#26</td>
<td>Pre-Day Care</td>
<td>80</td>
<td>w</td>
<td>Elementary</td>
<td>Lives alone</td>
<td>Widowed</td>
<td>Housewife / Farmer</td>
</tr>
<tr>
<td>#27</td>
<td>Pre-Day Care</td>
<td>80</td>
<td>w</td>
<td>Elementary</td>
<td>Cohabitation</td>
<td>Widowed</td>
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#### Komagane - Kodama (04/2013-07/2013)

<table>
<thead>
<tr>
<th>Patients</th>
<th>Unit</th>
<th>Age</th>
<th>Sex</th>
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<th>Former occupation</th>
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</thead>
<tbody>
<tr>
<td>#28</td>
<td>Day Care</td>
<td>62</td>
<td>m</td>
<td>Secondary</td>
<td>Cohabitation</td>
<td>Married</td>
<td>Office / Farmer</td>
</tr>
<tr>
<td>#29</td>
<td>Day Care</td>
<td>103</td>
<td>w</td>
<td>Elementary</td>
<td>Cohabitation</td>
<td>Widowed</td>
<td>Housewife / Farmer</td>
</tr>
<tr>
<td>#30</td>
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<td>100</td>
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<td>Elementary</td>
<td>Cohabitation</td>
<td>Widowed</td>
<td>Self-employed / Farmer</td>
</tr>
<tr>
<td>#31</td>
<td>Day Care</td>
<td>93</td>
<td>m</td>
<td>Elementary</td>
<td>Lives alone</td>
<td>Widowed</td>
<td>Self-employed / Farmer</td>
</tr>
<tr>
<td>#32</td>
<td>Day Care</td>
<td>90</td>
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<td>Elementary</td>
<td>Lives alone</td>
<td>Widowed</td>
<td>Sericulturist</td>
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<tr>
<td>#33</td>
<td>Day Care</td>
<td>87</td>
<td>w</td>
<td>Elementary</td>
<td>Cohabitation</td>
<td>Widowed</td>
<td>Housewife / Farmer</td>
</tr>
<tr>
<td>#34</td>
<td>Day Care</td>
<td></td>
<td></td>
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#### Komagane - Yamabiko (04/2013-07/2013)

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<th>Sex</th>
<th>Education</th>
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<th>Marital status</th>
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</thead>
<tbody>
<tr>
<td>#35</td>
<td>Day Care</td>
<td>75</td>
<td>w</td>
<td>Elementary</td>
<td>Cohabitation</td>
<td>Widowed</td>
<td>Housewife / Farmer</td>
</tr>
<tr>
<td>#36</td>
<td>Day Care</td>
<td>80</td>
<td>w</td>
<td>Elementary</td>
<td>Cohabitation</td>
<td>Widowed</td>
<td>Housewife / Farmer</td>
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</tbody>
</table>

#### Komagane - Inaho Group Home (05/2013)

<table>
<thead>
<tr>
<th>Patients</th>
<th>Unit</th>
<th>Age</th>
<th>Sex</th>
<th>Education</th>
<th>Familial status</th>
<th>Marital status</th>
<th>Former occupation</th>
</tr>
</thead>
<tbody>
<tr>
<td>#37</td>
<td>Dementia Group Home</td>
<td>92</td>
<td>w</td>
<td>Elementary</td>
<td>Group Home</td>
<td>Widowed</td>
<td>Housewife / Farmer</td>
</tr>
<tr>
<td>#38</td>
<td>Dementia Group Home</td>
<td>87</td>
<td>w</td>
<td>Elementary</td>
<td>Group Home</td>
<td>Widowed</td>
<td>Housewife / Farmer</td>
</tr>
</tbody>
</table>

#### Komagane - Hohoemi (05/2013-07/2013)

<table>
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<tr>
<th>Patients</th>
<th>Unit</th>
<th>Age</th>
<th>Sex</th>
<th>Education</th>
<th>Familial status</th>
<th>Marital status</th>
<th>Former occupation</th>
</tr>
</thead>
<tbody>
<tr>
<td>#39</td>
<td>Dementia Group Home</td>
<td>85</td>
<td>w</td>
<td>Secondary</td>
<td>Group Home</td>
<td>Never married</td>
<td>Accountant at local bank</td>
</tr>
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#### Komagane - Edel Komagane (07/2013)

<table>
<thead>
<tr>
<th>Patients</th>
<th>Unit</th>
<th>Age</th>
<th>Sex</th>
<th>Education</th>
<th>Marital status</th>
<th>Former occupation</th>
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</thead>
<tbody>
<tr>
<td>#40</td>
<td>Assisted living</td>
<td>86</td>
<td>w</td>
<td>Assisted living</td>
<td>Widowed</td>
<td>Housewife / Farmer</td>
</tr>
</tbody>
</table>
## Overview of patients and sociodemographic data

### Tokyo - Shinkatsushika (07/2013 - 08/2013)

<table>
<thead>
<tr>
<th>Patient ID</th>
<th>Service</th>
<th>Age</th>
<th>Gender</th>
<th>Education Level</th>
<th>Relationship Status</th>
<th>Occupation</th>
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</thead>
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<tr>
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<td>m</td>
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<td>Cohabitation</td>
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</tr>
<tr>
<td>#42</td>
<td>Day Care</td>
<td>89</td>
<td>m</td>
<td>Secondary</td>
<td>Cohabitation</td>
<td>Married</td>
</tr>
<tr>
<td>#43</td>
<td>Day Care</td>
<td>80</td>
<td>w</td>
<td>Secondary</td>
<td>Alone</td>
<td>Widowed</td>
</tr>
<tr>
<td>#44</td>
<td>Day Care</td>
<td>80</td>
<td>m</td>
<td>Secondary</td>
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<td>Widowed</td>
</tr>
<tr>
<td>#45</td>
<td>Day Care</td>
<td>83</td>
<td>w</td>
<td>Secondary</td>
<td>Cohabitation</td>
<td>Widowed</td>
</tr>
</tbody>
</table>

### Tokyo - Tokuyō Asakusa (08/2013)

<table>
<thead>
<tr>
<th>Patient ID</th>
<th>Service</th>
<th>Age</th>
<th>Gender</th>
<th>Education Level</th>
<th>Relationship Status</th>
<th>Occupation</th>
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</thead>
<tbody>
<tr>
<td>#46</td>
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<td>Widowed</td>
</tr>
<tr>
<td>#47</td>
<td>Day Care</td>
<td>88</td>
<td>w</td>
<td>Secondary</td>
<td>Lives alone</td>
<td>Widowed</td>
</tr>
<tr>
<td>#48</td>
<td>Day Care</td>
<td>80</td>
<td>w</td>
<td>Secondary</td>
<td>Lives alone</td>
<td>Widowed</td>
</tr>
<tr>
<td>#49</td>
<td>Day Care</td>
<td>91</td>
<td>w</td>
<td>Secondary</td>
<td>Lives alone</td>
<td>Widowed</td>
</tr>
</tbody>
</table>

### Tokyo - Kōreisha Sōgō Sōdan Sentā Horikiri (08/2013) (no interview data)

<table>
<thead>
<tr>
<th>Patient ID</th>
<th>Service</th>
<th>Age</th>
<th>Gender</th>
<th>Education Level</th>
<th>Relationship Status</th>
<th>Occupation</th>
</tr>
</thead>
<tbody>
<tr>
<td>#50</td>
<td>Prevention</td>
<td>84</td>
<td>m</td>
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<td>Cohabitation</td>
<td>Married</td>
</tr>
<tr>
<td>#51</td>
<td>Prevention</td>
<td>93</td>
<td>w</td>
<td>Secondary</td>
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<td>Widowed</td>
</tr>
<tr>
<td>#52</td>
<td>Prevention</td>
<td>82</td>
<td>m</td>
<td>Secondary</td>
<td>Cohabitation</td>
<td>Married</td>
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</tbody>
</table>

Source: Fieldwork data.
### Municipal discretion in premium settings of the LTCI

#### Table A-2: Municipal discretion in premium settings of the LTCI

<table>
<thead>
<tr>
<th>Level</th>
<th>Eligible persons</th>
<th>Premium</th>
<th>Expected number of those insured</th>
</tr>
</thead>
<tbody>
<tr>
<td>Level 1</td>
<td>Beneficiary of public assistance&lt;br&gt;The insured receiving Old-age Welfare Pension in the municipal-tax exempt household</td>
<td>Standard amount x 0.5</td>
<td>2.7%</td>
</tr>
<tr>
<td>Level 2</td>
<td>The insured with the total income including the pension income of ¥800,000 or less in the municipal-tax exempt household</td>
<td>Standard amount x 0.5</td>
<td>17.0%</td>
</tr>
<tr>
<td>Level 3</td>
<td>The insured in the municipal-tax exempt household who is not in the Level 2 category</td>
<td>Standard amount x 0.75</td>
<td>13.2%</td>
</tr>
<tr>
<td>Level 4</td>
<td>The insured exempt from municipal-tax</td>
<td>Standard amount x 1</td>
<td>30.2%</td>
</tr>
<tr>
<td>Level 5</td>
<td>The insured subject to municipal (total income of the insured is less than ¥1.90 million)</td>
<td>Standard amount x 1.25</td>
<td>21.1%</td>
</tr>
<tr>
<td>Level 6</td>
<td>The insured subject to municipal (total income of the insured is ¥1.90 million or more)</td>
<td>Standard amount x 1.5</td>
<td>15.8%</td>
</tr>
</tbody>
</table>

F LTCI application process

Figure A-1: Application process for care services for the elderly in Japan

<table>
<thead>
<tr>
<th>No.</th>
<th>Name of Institution</th>
<th>Name of Institution (engl.)</th>
<th>Classification</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>駒ヶ根市福祉企業センター</td>
<td>Komaga-ne-shi Fukushi Kigyô Sentâ</td>
<td>招商施設</td>
</tr>
<tr>
<td>2</td>
<td>駒ヶ根 健天寮</td>
<td>Komaga-ne Juntenryô</td>
<td>救護施設</td>
</tr>
<tr>
<td>3</td>
<td>知的障害者総合援助施設 西駒郷</td>
<td>Chi teki-shôgaisha sôgô engo shishetsu Nishi-komakyo</td>
<td>援護施設</td>
</tr>
<tr>
<td>4</td>
<td>駒ヶ根市福祉センター</td>
<td>Komaga-ne-shi fukushi sentâ</td>
<td>総合福祉施設</td>
</tr>
<tr>
<td>5</td>
<td>福寿荘</td>
<td>Fukuju-ô</td>
<td>老人憩の家</td>
</tr>
<tr>
<td>6</td>
<td>千寿園</td>
<td>Senju-en</td>
<td>特別養護老人ホーム</td>
</tr>
<tr>
<td>7</td>
<td>やすらぎ荘</td>
<td>Yasuragi-shô</td>
<td>老人憩の家</td>
</tr>
<tr>
<td>8</td>
<td>観成園</td>
<td>Kansei-en</td>
<td>特別養護老人ホーム</td>
</tr>
<tr>
<td>9</td>
<td>長寿荘</td>
<td>Chôju-shô</td>
<td>老人福祉センター(A)</td>
</tr>
<tr>
<td>10</td>
<td>やまびこ荘</td>
<td>Yamabiko-ô</td>
<td>老人福祉センター(B)</td>
</tr>
<tr>
<td>11</td>
<td>知的障害者更生施設 悠生寮</td>
<td>Chi teki-shôgaisha Kôsei shitsu Yûseiô</td>
<td>知的障害者更生施設</td>
</tr>
<tr>
<td>12</td>
<td>障害者センター高砂園</td>
<td>Shôgaisha sentâ Takasago-en</td>
<td>身体障害者福祉施設</td>
</tr>
<tr>
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Source: Komagane Minsei-bu Hoshō 2012.

Note: Care facilities for the elderly are highlighted in grey.

Appendix

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