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Between Family Obligation and Social Care—the Significance of Institutional Care for the Elderly in Japan

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The multifaceted significance of institutional care for elderly people in contemporary Japan is analyzed. An overview of the changes in the demographic structure in Japan is provided. Changes in the social environment of care for elderly people in the postwar period are discussed. In regard to the recent trends of welfare policy for elderly people, development of the variety of institutional care for the elderly is briefly described. By providing concrete examples of cases observed at an institution where the first author of this article has been working for many years, analysis is made of what causes individuals to opt for institutional care instead of other alternatives, such as family care. In all, we hope to enhance the understanding of the meanings of institutional care for the elderly by exploring the interface between family obligation and social care in the changing social environment of contemporary Japan.

Longevity and the Aging of Society in Contemporary Japan

A life of 80 years - jinsei hachijū-nen - has become common as an expression for average life expectancy in contemporary Japan. The first Annual Report of the Ministry of Health and Welfare (MHW) reports that in 1947 the average life expectancy of women
was 53.96 years and men 50.06 years. In 1992 the corresponding figures were 82.22 and 76.09. In September 1991 there were 3,625 centenarians or older. Japanese society is aging at a pace unequalled throughout the world, as the proportion of those aged 65 and over exceeded seven per cent in 1970, and is estimated to reach 14 per cent by 1995, only 25 years. The same demographic change took longer in other societies: in France 115 years (1865–1980), in Sweden 85 years (1890–1975), in Britain 50 years (1930–1980), and in what was then West Germany 45 years (1930–1975). (Management and Coordination Agency, 1994) In Japan in October 1993 the number of those aged 65 and over reached 16.9 million, making up 13.5 per cent of the whole population, and in 2000 the percentage of those of and over 65 years is anticipated to be 17 per cent and in 2020 as high as 25.5 per cent.

The aging of society has been manifested in Japan by on-going phenomena like the prolonged average life expectancy and the decline of birth rate particularly since the late 1980s. In 1991 a woman gives birth on average to only 1.53 children. This is one of the world’s lowest birth rate (MHW, 1993, p. 143). As these phenomena are often seen as ‘problems’, the aging of society tends to be understood as a source of visible and invisible stress on individuals and on society, and as a crucial challenge to social development. We do not by this mean to regard elderly people, especially the very old, as a problem group or a burden. Instead, what seems problematic in Japan is a sense of uncertainty surrounding all the efforts to cope with concerns related to the aging of society, or more precisely, to aged society. Over half of those aged 65 and over have some health problem and the numbers of bedridden elderly people and of the senile are both rising constantly. In 1990 there were about 700,000 bedridden elderly, making 4.6 per cent of those aged 65 and over, and about one million senile, making 6.7 per cent: The numbers are expected to increase towards the beginning of the 21st century (MHW, 1993, p. 282).

In 1990, of about one million senile, total of 255,000 are sheltered either in hospitals or care institutions: The large majority are to be found in at hospitals, namely 60,000 in ordinary hospitals, 54,000 in hospitals specialized in elderly care, 33,000 in mental hospitals (MWH, 1993, p. 283). This may be partly because social
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mores endorse expert health care for the ailing. Behind this, however, there seems also to be reluctance to seek help or advice in time from the institution for elderly, no matter how that reluctance should be identified—either a filial sense of family obligation or prejudice against social care. For those sheltered elderly people, hospitalization is often long-term, over a year for one third of patients aged 65 or over.

In Japan, the aging of society and its social impacts have been discussed in terms of ‘aging of society’ (kôrei shakai) and also of ‘longevity society’ (chôju shakai). These terms marking ‘aging’ (kôrei) or ‘long life’ (chôju) both refer to basic anticipation for increase of care required for the elderly in the ‘aged society’ (kôrei shakai). The expression of ‘longevity society’ has been used since the mid 1980s mainly by the governmental agencies in attempting to discuss in more a positive sense how to make socio-economic systems more flexible for an age when human life lasts eighty years (see Miyajima, 1993, p. 7). In fact, longevity should itself be good news both for individuals and for society, because it implies the physical and mental vitality of individuals and improved living standard in a society. In the first place, a long life for an individual is an achievement to be celebrated rather than a worry in Japan, as it is the case with many other societies.

Changing Social Environment and Its Impacts on the Family

Welfare of the aged can be understood through two major categories: first, for those who are at home and second, for those receiving care in an institution. The first alternative has been the family taking care of the old person with practically no support from outside. While even the elderly of tomorrow are still going to live with their offspring to some extent, the care of the whole family is also becoming a new target of welfare for the aged. The more Japanese society ages, the more the social practice in which cultural codes are embodied is challenged by changes in social environment. In relation to the cultural codes concerning the care for elderly people, it is important to review the impacts of changed social environment on the family.

Before 1945 it was exclusively the family that ensured the care for the elderly in Japan. In those days institutional care was
one of the most disgraceful alternatives for the elderly and their families, because to enter such an institution was regarded as an explicit sign of unsuccessful family life. Such a prejudicial attitude towards the institutional care for the elderly is compatible with the family-duty-oriented idea that family and relatives should take care of each other. An aged person in particular should be looked after by her/his family, according to hierarchical relationships among family members. It may partly still be maintained by some of those who are now themselves 'elderly people' in Japan.

The idea of family obligation is expressed in the legislation like the Civil Code: Article 730 says, "Lineal relatives by blood and the relatives living together shall mutually cooperate" (Law Bulletin Series, 1992, p. FAA 123). In our discussions, however, the family obligation in question is essentially concerned with a moral code of family obligation rather than as a matter of legal 'rights and duties'. According to the prewar-style family practice, it was spouse of the eldest son who should do care-giving work for her parents-in-law. In the prewar family system this idea was materialized through the succession of family property and of status of 'head of the family' from father to eldest son. Today, due to legislative reform, there is no longer such status of head of the family to succeed to, except for inheritance of property. Although a woman as a spouse of the eldest son may be still expected to engage in care-giving work to some extent in contemporary Japan, such expectation is at the level of practice but not of law.

What happened to the Japanese family in postwar period represents a fairly ordinary impact of industrialization accompanied by a process of defunctionalization of the family which is no more than a last resort for emotional comfort for the individuals (Linhart, 1984, p. 55). Before the rapid economic growth between the mid 1960s and early 1970s, the family was often central for individuals even in an economic sense, functioning as a place of work. As 'salaried' labor has prevailed in Japan since around 1960, the function of family was reduced to reproduction and maintenance of man-power (Ueno, 1990, p. 195).

Simultaneously, the size of family has become smaller in postwar Japan, as in 1990 the average number of persons in a household was 2.99, having declined from 3.23 in 1985, 4.05 in 1965, and 4.97 in 1955. (Mitsuyoshi, 1992) Moreover, nuclear family has
become most typical, referring to a type of family which consists of either a (married) couple or a couple with unmarried children. The National Census of 1990 indicates that nuclear family households account for 59.5 per cent of all households and single-person households for 23.1 per cent. In practice, these changes mean that elderly people increasingly live alone. Of all households including person(s) of and over 65 years, nuclear family households accounted for 31.3 per cent and single-person households for 12.7 in 1985, while in 1990 the corresponding figures were 35.4 and 15.1 per cent.

In the meantime, the wish to cohabit with the family of one's own child is often presented by opinion polls emphasizing it as a distinctive feature in Japan in comparison with other industrialized societies. Whereas in 1960 nearly 90 per cent of those over 65 lived with the families of their married children, in 1985 the figure was 65.6 per cent. The estimate for the year 2000 is 60.3 per cent and for the year 2025, 52.1 per cent (Hashimoto, 1990b). These changes in social environment and their impacts on the family are all irreversible making it very hard to regain such close ties and extensive functions of family kinship and local community as before as a sole source of securing the welfare of the aged and their families (Naoi, 1990, p. 11–15). When mental and physical health is no longer intact, the idealistic view on the care by family means testing the limits in the capacity of families in contemporary Japan.

For individual cases, the care for the elderly at home is realized through human relationships between family members rather than according to a manual given under the title of ‘filial piety’. To be cared for at home or to be involved in care-giving work for aged family is far from a static state for individuals. Rather, it is constantly questioned whether the individuals involved have a common understanding on a favorable state of life. When such understanding is missing, discrepancy is displayed implicitly or explicitly and satisfactory results are not always guaranteed, even though the care for aged person(s) is provided in the framework of family obligation.

Despite such ambivalence concerning the family in contemporary Japan, discourses since the late 1970s on ‘welfare society’—rather than on ‘welfare state’—demonstrates that the family has
repeatedly risen to prominence as playing an essential role in arranging the care for the elderly. As characteristics of the ‘Japanese model of welfare’, special emphasis has been placed on the need to enforce the solidarity in local community and the family (Naoi, 1990, p. 16–9). However, the emphasis on self-help, mutual help and family is not necessarily a unique phenomenon reserved only for Japanese society (Shinkawa, 1993, p. 128). It is pointed out that the family and the community belong to ‘two familiar themes of conservative welfare discourses’ (Bryson, 1992, p. 108). In Japanese welfare discourses, to refer to the family seems to have been effective in rhetoric seeking legitimacy for the ideology of care, leaving the care for the elderly in the capacity of each family.

On the Cultural Approach to the Family

To discuss the care for the elderly in relation to the family tends to unveil discrepancy between cultural codes and realities on various levels. It is not simply a question as to whether family care or social care is the best. Rather, individuals’ ideals and experiences of family life are unique, and their opinions and preferences concerning real arrangements for the needed care may vary much from what is often presented by the opinion surveys. The wish for co-residence as a reason for family care which is generally expressed on enquiry may be incompatible with the real solutions arrived at when faced with a specific situation.

To refer to the filial ideal of the family as one of specialities with Japanese culture is one way to seek a cultural explanation for the reserved attitude of ‘some Japanese’ towards institutional care for the elderly in Japanese society. To emphasize cultural codes in relation to the family is to seek its basic framework from an assumption on the cultural homogeneity of ‘Japanese as monolith’ (Mouer and Sugimoto, 1986, pp. 129–155). Such an approach, often combined with a ‘group model’, starts with an assumption of Japanese ethnicity, is certainly one attempt to understand cultural meanings of phenomena in a society. On the other hand, it tends to be easily manipulated, for example, through presentation of results of opinion polls concerning alternatives of the care for the elderly. The approach with emphasis on distinctive features with Japanese culture has been controversial due to its methodological
limits in social scientific studies targeting contemporary Japan (see e.g. Sugimoto and Mouer, 1989).

In contrast to the trends of increasing human mobilities mainly because of borderless impacts of economy, the present family system contains elements to distinguish individuals between Japanese and non-Japanese through the overlap between family registry and Japanese nationality (Takahashi 1993). In this sense, to refer to the family in the Japanese context means more than to touch the familiar themes of conservative welfare discourses. Although it is out of the primary scope of this paper, cross-cultural perspectives, in addition to cross-national ones, are becoming more meaningful to studies of social welfare and welfare policy in Japan, replacing the assumption on cultural homogeneity with more attention to ethnicity in Japanese society.

Gender in the Care of Elderly People

The care-giving work for the elderly at home is not always referred to explicitly as ‘woman’s work’ in official documents on welfare policy. It is still women—rather than men—whose life sphere is most close to family and local communities and who tend to be involved in the invisible work fulfilling the increasing needs for social welfare services for aged family members or neighbors. In particular, the bedridden elderly and senile living at home are mostly nursed by women: in 35 cases out of 100, it is the daughters-in-law who looked after the well-being of the bedridden elderly in 1984 (see e.g. Kataoka, 1990a, p. 45). The spouse/wife of the bedridden elderly is the next after the daughter-in-law. Woman meets old age three times—her parents (-in-law), her husband and her own (Komatsu, 1993, p. 292).

It is argued that a woman in Japan leaves her working place twice—for bearing children and for looking after her aged relatives (Ichibangase, 1992, p. 87). When a woman is involved in care-giving work for her aged parents, parents-in-law or husband, she often has to give up working outside home (Kataoka, 1990b). On the other hand, in 1991, a total of 26,510,000 women were involved in the labor market, and of them 16,860,000 were married women: The labor force participation rate of women in total was 50.7 and married women 53.2 per cent (Komatsu, 1993, p. 84). From a viewpoint of woman’s lifestyle, there exist two confronting trends, as
the gender divisions of labor prefers woman's care-giving work at home to her working career.

The tension between family obligation and working life grows, especially when the health of an aged family member breaks down. The governmental agencies have been discussing how to realize a law of 'care leave' for those who wish to take care of their aged family member(s) at home in addition to working (Furuhashi, 1993, p. 130). This law of 'care leave', passed at the Diet in 1995, will certainly increase flexibility for family and working life by making family care possible without losing a job, insofar as legislation is properly used in practice. On the other hand, because in legislation it is usually hard to mark the gender of the person in care-giving work—as it is the case with the Law on Leave for Child Care since April 1992, the result may be a reinforcement of the gender divisions of labor in the care of the aged unless an individual is highly motivated to work or encouraged to return to work after the leave (see Takahashi 1994).

Recent Trends in Social Welfare
Policy for Elderly People in Japan

Article 25 of the Japanese Constitution states that "All people shall have the right to maintain the minimum standards of wholesome and cultured living", and that "The State shall use its endeavors for the promotion and extension of social welfare and security and of public health" (Law Bulletin Series, 1992, p. AA 6). It can be understood from this that the state has the duty and obligation in principle, while in practice it is the local authorities (the prefectoral and municipal governments) which have done a great deal of the 'work'.

Without any doubt, pensions have a profound impact on the economic life of the elderly. Japan’s pensions are basically on a par with those of Britain and the Nordic countries, but for many elderly widows or divorcees who never drew a salary or had any other independent source of income, the pension level is usually low and in some cases these women are not entitled to a pension at all. The amendment of the Pension Law of 1985 established the right of married women (including widowed and divorced women) to receive their own pensions.
Generally speaking, at state level the MHW has the last word and responsibility at the level of residential institutions for the aged and other services. However, in the revision of the Law for the Welfare of the Aged in 1990, both the responsibility and realization of various services were delegated to the local governments. The *Welfare Vision*, a strategy for constructing such a society where “the elderly can lead a happy and care-free life”, as was declared by the Japanese government in October 1988, is on the way to accomplishment, being followed by another declaration of December 1989, the *Ten-Year Strategy on Health and Welfare of the Aged*, or, the *Gold Plan* to cope especially with the ever growing number of bedridden or senile old people. (see e.g. Campbell, 1992, p. 244–6) This ‘ten years’ refers to the decade between 1991 and 2000. The *Gold Plan* includes the ‘Three Important Pillars’ that would make possible the care of the elderly at home. These pillars are (1) a home help service, (2) a short stay in residential care service, and (3) a day care service.

In particular, the home help service, which comprises the important work of home helpers, seems to be still in its infancy in contemporary Japan. In a country with a population of 123.25 million there were only 31,405 home helpers in 1989. In 1992 their number was increased to 46,405, while the whole population was 124.52 million. The target of the *Gold Plan* is to increase this number to 100,000 by the end of the century. As for the short stay in residential care service, the plan is to increase the number of beds from 4,274 in 1989 (15,674 in 1992) to 50,000 by the year 2000. As far as the day care service is concerned, the government is planning to increase the number of day care centers from 1,080 in 1989 (3,480 in 1992) to 10,000 by the end of this century. Counselling services for families with aged persons will also be a major target of increase. (MHW, 1992)

The efficient realization of the *Gold Plan* ultimately relies on recruitment and training of sufficient human resources for the welfare sector. It is estimated that until the year 2000 this sector will need 3,460,000 persons (2,350,000 for health and medical care, 1,110,000 for social welfare) (MHW, 1993, p. 163). MHW presents two scenarios how the share of welfare sector will grow in the whole labor force. In one estimation based on the recent trend in the labor market in Japan, the welfare sector will make 5.1 per cent
of the labor force in 2000. In the other case that ‘women and those aged over 60’ will be available for the labor market in maximum, the welfare sector is assumed to have its share of 4.7 per cent of the labor force. (Ibid., p. 164)

These estimations do not immediately manifest that women and those aged over 60 are those who are expected to make contributions to the Gold Plan, nor specify whether the labor is meant to be exclusively ‘Japanese’ or not. ‘Women, the aged or foreign workers’ are those groups who tend to remain in peripheries in the labor market due to their gender, age and ethnicity, provided with less benefits than those who—mainly men—are in the major core in the labor market. In regard to the labor force in welfare sector in Japan, until today little attention is paid to the issue on foreign workers, while their number has been increasing since the late 1980s primarily in construction work or the services not specified to welfare sector. In brief, the urgent recruitment of more labor to welfare sector may not be easy to be carried out without sufficient coordination of the labor and welfare policies.

Residential Institutions for Elderly People

Of some 3,000 officially subsidized residential institutions for the aged, two thirds are run by private organizations. These non-profit private organizations are expected to continue their work in the field of social welfare. The financial management of these institutions is born half by the state and half by the prefectural and municipal government together. If a private organization wishes to build a new institution, half of the construction costs are born by the state and local governments, one quarter by the prefecture and the rest by the organization itself. There may be differences between areas, and the actual cost paid by the organization is also frequently larger than the numbers written on paper. In return for their support and assistance, the authorities have the right to make regular checks on the financial and other affairs of the homes. We call it ‘miraculous marriage’ between the authorities and private welfare organizations in Japan. As in 1990 about 1.6 per cent (220,000) of the 14 million elderly in Japan, i.e. those over 65 years of age, lived in about 3,000 government-subsidized shelters for the elderly.
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Residential institutions as welfare facilities for the elderly are basically classified into three types. In Japanese terminology, the term hōmu, taken from the English word 'home', ironically refers mostly to residential institutions for the aged but not to one's own home or residence.

1 Yōgo hōmu or institutions for the low income bracket aged are for those over 65 who have difficulties in receiving necessary care at home because of their physical or mental condition or because of the living environment. In 1992 there were 65,163 elderly people living in 948 yōgo hōmu institutions throughout the country: In 1988, there were 65,480 people in 945 yōgo hōmu institutions. Over two thirds (68 per cent) of these were public homes and the rest run by private persons or organizations.

2 Tokubetsu yōgo rōjin hōmu or tokuyō hōmu (special care institutions for the aged) are for those who, due to a major physical or mental disorder, require constant support and supervision which they cannot receive at home. Of the tokuyō hōmu institutions 80 per cent are run by officially subsidized private organizations. In 1992, 181,083 people over 65 years of age lived in the 2,576 tokuyō hōmu institutions: In 1988, there were 118,959 people in 1,619 tokuyō hōmu institutions. The urgent growth of tokuyō hōmu institutions is based on the estimation that the number of bedridden elderly and senile will increase at a rapid pace in the near future (MHW, 1993, p. 153).

3 The keihi rōjin hōmu, low cost institutions for the aged (or hōmu institutions with moderate fees) are for those aged 60 or over who receive less than a certain level of income and who find it difficult to live at home because of family or housing circumstances. In 1988 there were 280 keihi hōmu institutions with 16,139 residents in Japan. Of these 242 were the so-called keihi A type institutions whose 14,712 residents pay only for the actual living costs, while management and other fees are paid by the authorities (MHW, 1991). In the 38 keihi B type institutions all the costs are paid by residents themselves. In keihi B institutions, unlike keihi A, no meals are served; in this case the term 'residential flat' would be more suitable for keihi B institutions. In 1992 there were 337 keihi hōmu with 17,829 residents.
Entrance to an institution for the aged depends on the nature of the home. The *yōgo* and *tokuyō hōmu* institutions are entered by application to the local authorities, mainly the municipal Welfare Board. There are no economic criteria for entering *tokuyō hōmu* institutions, the only criterion is being dependent both mentally and physically. A portion of the total cost of the care of the aged person is required to be paid by the person in question and his family according to their economic situation. The criteria are the same for the *yōgo hōmu* institution: some people pay nothing, while others pay the total cost of care.

In the case of the *keihi hōmu* institutions, the application is sent directly to the home. The fees that the residents pay depend on their income, and the suitability is judged by the home. At present, a typical fee for a *keihi hōmu* institution is around 20,000 yen per month. *Keihi hōmu* institutions are for those who are not rich enough to enter the expensive private institutions. With the improvement of the pension system and thus the greater purchasing power of elderly people, various services outside the public ones have appeared.

In 1985 about 600,000 elderly Japanese needed regular nursing care. Of these 250,000 were hospitalized long-term, 120,000 were looked after in special care institutions (*tokuyō hōmu*) and the rest at their own residences. Many of the elderly were hospitalized not because of an illness but because they could not receive proper care at home. In response to this situation health service facilities for the aged that are halfway between hospitals and welfare institutions were established after 1986. These 'intermediate health care facilities' (*rōjin hoken shisetsu*) have fewer doctors than hospitals, but more than special care institutions. The capacity of the 'intermediate health care facilities' has developed rapidly from 27,811 beds/places in 1989 to 91,811 in 1992, targeting 280,000 before the year 2000. The patients of these facilities are those elderly who, before returning to their homes, need rehabilitation and adaptation together with care.

The Central Social Welfare Advisory Committee submitted a report in 1989 concerning the situation of homes for aged persons. The Committee recommended the introduction of a type of facility to be called *kea hansu* (responding English words 'care house')—'sheltered accommodation'—where emphasis is on the
quality of both residence and welfare. The kea hausu aims to provide single-room accommodation for aged persons living alone or as a couple. Special attention is paid to residential needs like use of wheelchair and bathing and kitchen facilities in order to ensure the safety of aged residents. Focus is essentially on physical independence of residents who have a slight physically impairment, minimizing unnecessary hospitalization. The kea hausu accommodation started with capacity for 200 persons in 1989 and increased to 9,700 in 1992, targeting 100,000 in the year 2000.

In fact, the most often mentioned reasons for finding it difficult to live at home are the small size and overcrowding of housing especially in metropolitan areas and inconvenient housing facilities. Narrow steps, floors and hallways where wheelchairs cannot be used, inconvenience with kitchen, bathing and toilet facilities and lack of sunlight combine to deprive convalescents of opportunities to move within a house and make it difficult for elderly people to regain physical independence. (Hayakawa, 1990) The inconvenience of housing tends to increase such hospitalization and institutionalized care that are otherwise medically unnecessary. Without better housing conditions, more adequate and satisfactory care at home will not be made possible, and the effects of pensions, medical treatment, and other social security programs and services will be impeded. In this sense, kea hausu accommodation is meaningful as an attempt to respond to the needs of the aged on the level of housing.

In addition, in Japan there are also privately-run homes that offer luxurious facilities at steep prices. This so-called sirubā sangyō (‘silver industry/business’; ‘silver’ meaning ‘aged’), business using old people’s money, is a rapidly growing sector and attracting much attention. The main feature of this business is the expensive residential facilities (yuuryō rojin hōmu): There were 228 of these establishments in 1992. A total of 17,570 people have chosen this luxurious type of living in an institution of which the cost at its highest may rise to tens of millions of yen at admission plus from one to two hundred thousand yen for various services each month.

This business for the elderly in Japan is anticipated to become one of the alternatives for those who have means to buy the services provided by companies and to ease the financial burden.
in the public sector. However, it seems still questionable whether such a business-oriented solution will ever be a total substitute for the welfare of the aged in Japan. In the same way as officially subsidized institutions, the institutions run by the ‘silver business’ have also lately been targeted for inspection and checks because of suspicion of possible malpractices. However, this means that the public sector has in a way approved the co-existence of this alternative in welfare for the aged.

The Case of the Shisei Hômu Institution in Tokyo

The Shisei hômu in Tachikawa city, one hour’s drive from downtown Tokyo, is an example of the cooperation which we have referred to as ‘marriage’ between the authorities and the private welfare organizations. Established in 1951, the Shisei hômu has devoted all its energy to the activities that would duly be expected from a private non-profit institution in Japan. Starting residential services for 30 people only six years after the end of the Second World War under the then Daily Security Law (later changed to the Law for the Welfare of the Aged), the Shisei hômu at present can boast of being a complete service center for the aged in its community with residential services in three different types of residences: yôgo hômu (60 beds), tokuyô hômu (140 beds) and keihi A hômu (50 beds). There are also kea hausu (sheltered accommodation), an apartment house with services and 15 rooms, a day care facility, short stay services providing bathing and meal services, a day service for the senile as well as a medical clinic with 19 beds. The amount of payment for residence is determined by the income of the resident.

The average age of the residents is 81.2 years, depending slightly on the types of facilities; the tokuyô hômu has the oldest residents, the average in 1991 being 82.3 years. The ratio of women to men in the yôgo hômu is 45 to 15, in the keihi hômu 39 to 21 and in the tokuyô hômu 110 to 30. These residents do not even need to go to hospital to die—for most of them, the Shisei kurinikku (clinic) is the place where they die.

A total of 200 competent, mostly young staff cater for the needs of the elderly residents. One quarter of the staff has already taken the qualification for workers of social institutions
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stipulated by the 1988 Certified Social Worker and Certified Care Worker Law. In addition to the staff of 200, including 2 doctors, rehabilitation specialists, nutritionists, who keep the menu for the residents healthy, around 4,500 volunteers per year, mainly middle-aged women, come to the Shisei hômu to lend a hand. The number of elderly volunteers from the community is also increasing. Briefly, the Shisei hômu is itself a complex which covers all kinds of needs of elderly people: It is also in a relationship of cooperation and mutual assistance with Tachikawa City, where it is located, and four other neighbor towns, providing services and, in turn, beds funded by them.

The Case of Mrs. T

Born in 1904, at the age of 18 she got married and gave birth to five children, of whom four survived. When she was 31, her husband died in a traffic accident. The children were 9, 7, 4 and 1 at that time. In order to support her children and herself she tried different kinds of jobs in small business selling commodities. The eldest son died during the Second World War and two of her daughters are still alive. Since Mrs. T had never been on very good terms with her first daughter, Mrs. T hoped to live with her second daughter. However, as the second daughter left home on getting married, Mrs. T did not dare to express her own wish of living together with her second daughter and lived alone for a while until the age of 67. Close to the age of 70, she sold the tiny shop she owned, gave the money to her second daughter and moved in with daughter’s family. In return for having a place to live with her daughter’s family, she helped the family economy by offering her pension as well as the allowance from her son who died in the war.

When Mrs. T was 80, her daughter’s health deteriorated, which finally made Mrs. T visit on her own initiative the local welfare office to ask advice: She asked to be admitted to an institution for the aged. On hearing this the daughter was anxious about her mother’s independent decision. However, five months later, Mrs. T found herself in the Shisei yôgo hômu, and today the relations with her daughter’s family are good. Although seemingly in poor physical condition, Mrs. T is mentally active for her age. She enjoys various activities in the institution as if she were indicating
to the people that she is independent, free and able to do whatever she wishes. Having had only three years’ school education in her childhood, she, although slightly deficient in knowledge, shows a keen interest in learning new things. Among other things she surprised her fellow residents by joining the English conversation course for yōgo hōmu. The feeling that she is independent and not a burden to anyone is important for her.

*The Case of Mrs. M*

Born in 1908, at the age of 28 she was married and gave birth to a son and a daughter. Soon after the Second World War the son died, and as a result of the shock Mrs. M’s hearing was impaired. At the age of 42 she gave birth to another baby boy: It was a difficult delivery. Mrs. M started working again, this time as a conference stenographer, but because of her impaired hearing she had to quit this job soon. After this she tried various jobs such as one in an advertising agency. Retired from factory work in 1971, her husband started a printing press of his own and Mr. and Mrs. M worked together in their own small enterprise until the death of Mr. M in 1974. After her husband’s death Mrs. M continued the family business with her son. She lived alone in a council house apartment, but when her son got married in 1979, she came to live with him. Mainly due to conflicts in the relationship with her daughter-in-law, Mrs. M moved three years later to an apartment which she rented for herself near her daughter’s house.

When Mrs. M noticed that her life alone was becoming difficult, she visited the Shisei hōmu to discuss the possibility of moving into the keihi A hōmu. However, because of her bad hearing and walking problems, she was instead advised to try entrance into the yōgo hōmu. Finally she decided to continue to live in her rented apartment and attend the day care for the aged through which she could have rehabilitation and other activities.

Life went on like this for a year and a half, after which she entered the yōgo hōmu. Even at the yōgo hōmu, she fell into the category of the physically weakest people and eventually sent an application for admission to the tokuyō hōmu. Being independent and unwilling to admit to any weakness, Mrs. M came to her solution to get her legs treated in hospital through an operation on the legs. During the operation, however, she suffered a heart attack and had to stay in hospital for several months. Consequently, she
entered the tokuyô hômu, where she is still an active member of several hobby groups. Her poor hearing, however, makes communication with others difficult.

Mrs. M could not get along with her family members under the same roof, although she was never refused by the family: They were always by her side whatever she decided to do. She takes pride in herself for what she is and what she has done. She wishes to make her own decisions until the very end of life. She hopes to know definitely where she herself stands. She may be one model for those Japanese elderly of the near future who wish to decide where to live and how to live.

The Case of Mr. K

Born in 1907, he lives with his wife and the family of his son, who has one son. Mr. K, a tall man with a charming smile, had a brain hemorrhage some 12 years ago. What is left of that illness is a paralyzed right side of his body, hearing difficulties and a speech defect. After one month in hospital, he has been looked after at home, at the same time receiving rehabilitation and other services at the day care for the aged at the Shisei hômu. Soon after the stroke he attended only bathing services, and gradually transferred to the day care and short-stay programmes. Presently he is quite capable of managing a simple daily routine by himself, for example, of taking a bath at home. Despite difficulties in communicating with people, he eagerly attends the activities of the institution with other elderly colleagues. He joins regular physiotherapy sessions, as well as occupational and speech therapy. His favorite hobby is pottery-making: To watch him handling clay with his left hand in the pottery class is an amazing sight, a real show of courage and latent human energy. He has been able to live at home with his family in spite of his handicap for over a decade, thanks to the warm family relationship, his zest for life, his optimism, those many possibilities which the short-stay and day care institution services bring to the family, and the rehabilitation that strengthens the independence of the individual.

Discussion

The elderly people in contemporary Japan are those who were born in the early decades of the twentieth century and have in
their lifetimes experienced such drastic changes that the people who were born and grew in later periods will hardly face: the great earthquake in Tokyo of 1923, the militarism in the 1930s, Japan's defeat in the Pacific War, which was followed by the occupation period between 1945 and 1952, urbanization and industrialization since the late 1950s onwards until today. (see Hashimoto, 1990a) The cases above presented are three persons at similar ages, born in 1904, 1907 and 1908, with the richness of experiences of life. What is common to them, in addition to age group, is some health problems that had essential impact on the change in lifestyle of these aged persons. The case of the Shisei hōmu indicates that there is a high risk of physical impairment for aged persons themselves (in the case of Mrs. M and Mr. K) that to look after the aged at home is not easy work for family of an aged person (in the case of Mrs. T).

The case of the Shisei hōmu highlights that it is their own decision and not necessarily 'being forced or abandoned' that brought themselves to the institutional care for the elderly. The cases of Mrs. M and Mrs. T reveal that to rely on co-residence with the family of one's child is not always the optional solution as regards the level of individual's lifestyle. Moreover, in the case of Mr. K, the short-stay and related services proved that, if an aged person receives proper care, treatment and help from outside, the ideal place for him seems to be his own home, to live there alone or with relatives as long as possible. However, there are still many obstacles to such a state of affairs in contemporary Japan.

The case of the Shisei hōmu certainly represents 'success stories' about the social care. The three cases demonstrate that the social care provided by the Shisei hōmu can well respond to the welfare needs both those who wish to living in an institution and of those staying at home. On the other hand, for those who do not try to share this success, the expression rōjin hōmu referring to residential institutions in general may still have a connotation with the other outdated term yōrōin, a poorly facilitated house to which helpless aged people were abandoned alone. While some have come to accept the idea of social care for the elderly, some seem to be hesitant to take advantage of it. In cases where due to prejudice against institutional care one feels hesitant to use it in any mode and relies exclusively on the care by family of her/his
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child(-in-law), the solution may not be sustainable because of the risk of weakening health.

It is also pointed out that "institutionalization of the elderly highlights the disjuncture between the cultural norm of filial piety (and its expression in the ideal of coresidence) and a changing social reality" (Bethel 1992, p. 109). However, the residential institutions for the elderly seem to display more than passive withdrawal from the ideal of 'filial piety', as the Shisei hômu has become a multi-functional service center for the welfare of the aged and their families in their communities. Those institutions for the aged generally called rôjin hômu, being now more freed from a sanctionizing nuance of shelters for the poor, are becoming places for all the elderly citizens with physical impairment of some sort. The present rôjin hômu needs to be reconsidered from this viewpoint of social context in contemporary Japan (Naoi and Hashimoto, 1990).

Conclusions

Unlike economic recession that arises with little warning, the timing and extent of population aging are rather predictable (see Johnson et al, 1993, p. 254). However, it is not easy to draw a rosy picture for the well-being of the elderly people and their families in the near future in a society. What is most distinctive with Japan's case in the light of the aging of society and of concern with the aged society, is the unusually rapid pace of profound change of social environment throughout the postwar period. Impacts of the social change on the family show that ideal pictures of family life tend to become fast outdated and even illusive in contemporary Japan. Recent trends of social welfare policy for the aged and the concrete cases observed in the Shisei hômu shed light on multifaceted dimensions in exploring the significance of institutional care in contemporary Japan. As the case of the Shisei hômu manifests, institutional care has been extending its scope of functions from the care offered only for those residents within an institution to the care open to those in the local community where the institution is located. The significance of institutional care for the elderly in Japan does not remain to be limited within 'institutionalization'—gathering people into a place removed from society. In supplying
different modes of care and services in community care by involving professional social workers and volunteers, the institutional care for the elderly is meaningful, promoting integration of the local community beyond the dichotomous framework of 'either family obligation or social care'.

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