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During the last five decades, family life of the Japanese elderly and long-term care have drastically changed. As a response to the rapid population aging and the increasing difficulty of family care, a new universalistic system of long-term care services is going to be introduced in 2000. The new system, called the Insurance Against Care, acknowledges societal responsibility for long-term care, and guarantees a certain level of provision of care services. While the insurance is a response to the changes in family life of the elderly, symbolized by the decrease of co-residence with adult children, it may further stimulate and complete the changes to family life of the Japanese elderly which began in the 1960s.

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Introduction

Rapid population aging is one of the most salient social changes in today's Japan. Mass media repeatedly report the seriousness of population aging and the burden of long-term care. Further, today's Japanese are rather knowledgeable about the problems of an aged society and life in old age, and thus are anxious about their own and/or their parents' old age. An opinion poll conducted by the Prime Minister's Office in 1993 revealed

that 89.3% of the Japanese, ranging in age from 30 to 59 years, felt some anxiety about their lives in old age; the most frequently mentioned anxiety being the deterioration of health and care in old age (Prime Minister's Office, 1993).

During the last 50 years, Japan has experienced drastic social changes. She rose up from the ruins of a world war and achieved remarkable economic growth. However, economic growth was not the only change that Japan experienced, though it made possible and facilitated other social changes covering almost all facets of life and thought. Due to these changes, the lives of today's Japanese are more Westernized than in the past. Family life of the elderly and long-term care of the disabled elderly have also changed, and are changing.

The traditional living arrangement of the Japanese elderly was the patri-lineal, patri-local stem family. Typically, co-resident family members provided every kind of support. Even if the elderly were completely dependent, their lives seemed secure because co-resident family members were to be "protective" (Hashimoto, 1996). However, long-term family care of the disabled elderly has become more and more difficult through, for example, the reduced number of children and household members, reduced percentages of the self-employed and farmers, higher geographical mobility, the increased labor force participation of women, the aging of caregivers, the extended duration of care, and the increased financial cost of caregiving. Reflecting the difficulty of family care, people's attitudes toward family care has been changing rapidly (see, for example, Elliott & Campbell, 1993).

As a response to the aging population and the increasing difficulty of family care, a completely new system of long-term care services is going to be introduced in the 2000 fiscal year (starting in April, 2000). In this article, the author briefly describes the population aging, changes in the living arrangement of the elderly, and the new system of long-term care and its possible further effects on changes to family.

Population Aging

Population aging started relatively late in Japan. In 1950, Japan was the least aged among today's developed nations: the

percentage of people aged 65 years and older in the total population was only 5.0% in Japan while it was more than 10 % in France, Sweden, and U.K. However, in Japan, the percentage has been more rapidly increasing: it reached 7.0% in 1970, 14.6% in 1995, and is projected to increase continuously. Because of her rapid population aging, Japan will be the most aged among developed nations in the early 21st century.

The rapid population aging has been brought about by the population transition which occurred in the latter half of this century. During the five decades after World War II, the death rate decreased from 1.46 in 1947 to 0.73 in 1997; total fertility rate has declined from 4.54 to 1.39; and the life expectancy at birth has risen 1.5 times, and marked the longest life expectancy in the world (in 1997, 77.19 years for men and 83.82 years for women). These statistics clearly indicate that Japan has completed the population transition within a very short period. Further, the baby boom after the war, which simultaneously occurred with the population transition, accelerates the population aging. When baby boomers enter the aged population, the aging of the Japanese population will reach its peak.

While population aging in Japan may possibly cause several social changes, long-term care of the disabled elderly is generally regarded as the most important issue of the aged society, and the core of societal preparation for the aging of the population is considered to be the expansion of provision of long-term care services. During the last five decades, the percentage of people aged 75 years and older has grown five times and is expected to increase rapidly both in actual number and proportion: for a 30-year period from 1995, the population aged 75 years and older is projected to increase from 5.7% to 15.2%, or 7.2 million to 18.5 million (National Institute of Population and Social Security Research, 1996). The projected increase of people aged 75 years and older implies an increase of the disabled elderly. The Ministry of Health and Welfare (1997) reported that the number of bed-ridden elderly (including those with dementia) would increase from 900 thousand to 2.3 million, and that of demented would rise from 100 thousand to 400 thousand, within the next 30 years.

"Weakening" of Family Support

During the five decades since the war, the family life of the Japanese elderly has drastically changed. Before the end of the war, life in old age was typically found for a retired household head who had already transferred the headship to his eldest son, wife, or widow of the household head. The elderly person lived with the successor's nuclear family within the same household, and was given every kind of support by the successor, his wife, and children. For the successor, co-residing and sharing all assets with elderly parents were legal, as well as moral, obligations. Gratitude and respect, rather than intimacy or affection, were to be attached to the instrumental support, because providing support to elderly parents was an actualization of filial piety.

Filial piety was regarded as an extremely important moral virtue corresponding to the infinite grace of parents including the grace of bearing, nurturing, and allowing marriage. The norm of filial piety was propagated by the Imperial Japanese Government in combination with loyalty to the Emperor. Ideally, only family and nation were regarded as "formal" organizations, and the nation was conceptualized as a big family, consisting of real families, headed by the Emperor. Thus, filial piety and loyalty to the Emperor were tightly interwoven in the Imperial Japanese ideology.

After the war, as a part of the democratization of Japanese society, the concept of family was completely changed: co-residence with elderly parents was no longer a legal obligation of children, and filial piety has never been taught in classrooms, at least in its original and extreme form of pre-war Japan. Nevertheless, the percentage of the elderly co-residing with adult children was very high (over 85%) for 20 years after the war. It was in the 1960s when the percentage started to decrease. During a 35-year period from 1960, the frequency of co-residence decreased from 86.8% to 55.9%, while that of living alone and living only with spouse increased from 3.8% to 12.0% and from 7.0% to 27.8%, respectively. The percentage of co-residence is generally lower in urban areas, among employees, and younger generations, and is expected to decrease further.

The decrease of co-residence is usually taken seriously as reflecting the weakening of family care. Generally, co-resident family members are the most dependable source of social support (Koyano, Fukawa, Shibata, & Gunji, 1994). Especially, for instrumental support, including long-term caregiving, co-resident family members are almost the only dependable source of support. For the elderly needing care, co-residence with children is still the only way to sustain their lives by obtaining necessary support from family members. A large-scale survey conducted by the Metropolitan Tokyo Government in 1995 found that 88.4% of the disabled elderly were cared for by co-resident family members, and the remaining 5.1% by children or relatives living apart; 31.5% of principal caregivers were wives, 23.0% were daughters, and 22.1% were daughters-in-law (Metropolitan Tokyo, 1996).

Introduction of a New System

Responding to the increase of the disabled elderly, the decrease of co-residence, and increasing difficulties of family care, the Ministry of Health and Welfare has proposed new long-term care policies almost every year (see, for example, Adachi, Lubben, & Tsukada, 1996), and finally proposed establishing a new compulsory social insurance named "Insurance Against Care" (IAC) in 1996. The bill was approved by the Diet in December, 1997, and the law will come into force in April, 2000.

IAC will create drastic changes to the long-term care of the disabled elderly in Japan, because care services under the IAC system are completely different from traditional services. The outlines of IAC are as follows:

The insurance covers 90% of the cost of long-term care services provided either in community (home-help, day care, visiting nursing, etc.) or institution (nursing home, long-term care hospital, etc.).

The insurer is the municipality. The insured are all residents aged 40 years or older (including those who are institutionalized) and are divided into two categories: those aged 65 years or older (Category 1) and those who are 40 to 64 years old (Category 2). For the Category 1 insured, long-term care services are covered by IAC irrespective of the cause of disability. However, for the Category 2 insured, services are covered only if his or her disability

is caused by "geriatric disorders" (such as cerebrovascular stroke or Alzheimer's disease).

The insured needing long-term care services should apply to the insurer (municipality) for assessment of eligibility. If the insured is judged eligible, based on the severity of disability, the person will be assigned to one of six ranks; for each rank, an upper limit of reimbursement is defined. After the assessment, the individual can purchase necessary services by paying 10% of the cost, up to the upper limit of reimbursement of his/her rank. The user can select the kind, amount, and provider(s) of services; the provider may be a private company, non-profit organization, municipality, or any combination. Care management services are available, without any fee, for all eligible persons. If the elderly wish to pay 100% of the cost, they can purchase additional services which exceed the upper limit of reimbursement.

While the insurance acknowledges the societal responsibility for long-term care of the disabled elderly, and guarantees a certain level of provision of care services, care services for the disabled elderly have long been provided mainly in the system of welfare services defined by the Law for the Welfare of the Elderly enacted in 1963. Although they have been gradually weakened during the past 35 years, welfare services for the elderly are selectivistic in nature; long-term care services are provided only for a limited number of the disabled elderly who are regarded as eligible by governmental agencies, while the vast majority of the disabled elderly are cared for informally by family members. Further, even for the users of care services, services provided in the community are far less than sufficient to sustain their lives without additional family care.

Almost all care services under the traditional welfare service system are publicly funded, and users do not need to pay any costs at all, or pay only a very small portion of the cost of services. Some people, especially those who are old and live in rural areas, may feel stigmatized by using care services under the welfare service system.

These characteristics of traditional long-term care services might be related to the historical background of the Law for the Welfare of the Elderly. Like other fields of welfare services, care services for the elderly under the law were developed from public

assistance. Considerable numbers of the disabled elderly and their families prefer to use institutional care provided as medical services (such as those provided by long-term care hospitals), because of the sense of stigmatization and/or the shortage of provision of welfare services. However, the long-term care services provided as medical services are generally much too costly for the funds of the national health insurance. Very few people use long-term care services provided by private companies because only a few people can afford such expensive services.

In order to introduce the IAC system smoothly, preparations are being vigorously carried out by each municipality. However, many difficulties are expected; most of them seem rooted in large discrepancies between the IAC system and the tradition of long-term care services as welfare services. For example:

Shortage of service provision: The introduction of IAC may cause a tremendous increase in demand for long-term care services because the use of services is a right of the insured corresponding to their insurance premiums. Major providers of services in the traditional welfare service system (i.e., municipalities and public organizations supported by municipalities) seem incapable of meeting the increased demands for care services. Further, in the IAC system, private companies are assumed to take major roles in the provision of services. However, they are still insufficiently developed because the demands for their services have been very few under the traditional welfare service system.

Regional differences in provision: The provision of services by private companies seems especially difficult in depopulated rural areas. In such areas, demands for services are fewer, residents are poorer, and the cost of service delivery is much higher than in over-populated urban areas. Naturally, companies may hesitate to extend their business into rural areas.

People's attitudes toward expense: Under the traditional welfare service system, users of long-term care services have not been expected to pay for the services. This "tradition" seems to carry with it the concept that care services for the disabled elderly are (or should be) free of expense. Also, this notion may obstruct service use, because each care service has a price, and the users must pay 10% of the cost of their services under the IAC system. Further, people are likely to estimate the costs of care services

as unrealistically low (Dia Foundation for Research on Aging Societies, 1998).

Differences in eligibility: Eligibility in the IAC system is exclusively defined by physical and mental functioning, while socioeconomic conditions have been largely taken into account under the traditional welfare service system. Thus, some of today's users of long-term care services might be regarded as ineligible under the IAC system. For such cases, municipalities should make special arrangements.

Amount of reimbursement: The upper limit of reimbursement seems too low to obtain sufficient care services for the disabled elderly without family care. However, if the upper limit of reimbursement is raised, the insurance premium would also rise, and the insufficiency of service provision would be still greater.

Pilot Study in a Depopulated Rural Area

Pilot studies of long-term care services were conducted, in the 1997 fiscal year, in three depopulated rural areas where transition into the IAC system seemed especially difficult. In the studies, as in the IAC system, services were provided by private companies, and users were asked to pay 10% of the cost of services. Among the three study areas, the most successful results were obtained in Kurihara region, Miyagi Prefecture, an inland rural area in the northeastern part of Honshu Island. The total number of residents in three towns and one village in the Kurihara region in 1996 was 30,255, and 26.4% of them were 65 years of age or older. As in other regions in Japan, long-term care services had been provided by municipalities and/or public organizations funded by municipalities to a limited number of the disabled elderly.

A complete survey of elderly community residents in the Kurihara region was carried out in November, 1997. The response rate was 97.4% for the screening and 95.0% for the detailed surveys. Among the respondents, 522 (6.7%) were regarded as disabled in bed-ridden or semi-bed-ridden conditions. Most of them (71.8%) co-resided with children and/or grandchildren, 96.2% of principal caregivers were co-resident family members or relatives, and 65.5% had not used any long-term care services. Most of the non-users of care services (79.7%) indicated that sufficiency of family care was the main reason of their non-use.

Service provision by a private company started in February, 1998. After extensive efforts of explanation and propagation by social workers of the company and public health nurses of the municipalities, 13 cases decided to use some services by the end of the 1997 fiscal year (May 31, 1998). Compared to the general population characteristics of the disabled elderly in this region as revealed by the complete survey, the users were relatively young but severely disabled (Table 1). A common, striking feature of the users was shown in their living arrangements: eight out of 13 users did not have a co-resident child, while the majority of the disabled elderly in the Kurihara region co-resided with their children.

Although the number of service users increased to 50 by the end of August, 1998, users have not yet reached 10% of the disabled elderly living in the Kurihara region. Users were likely to be limited to the disabled elderly without co-resident children, and most of them did not purchase as many services as care managers recommended and did not pay 20,000 yen or more per month. Nevertheless, researchers, practitioners, and municipal officers were strongly impressed by the fact that they could have *many* users paying *much* money for care services, because they had anticipated more difficulties. After reviewing the cost of service delivery, they concluded that the provision of long-term care services by private companies under the IAC system could be possible even in such a depopulated rural area (Miyagi Prefecture, 1998).

Effects on Family Life of the Elderly

The results of the pilot study conducted in the Kurihara region seem to clearly indicate that it is the disabled elderly without co-resident children who have the strongest need for long-term care services and for whom the IAC system is especially beneficial. The users of care services in the Kurihara region seem to have received insufficient care because they could not obtain informal family care from co-resident adult children, and could not utilize a sufficient amount of care services under the traditional welfare service system. Therefore, they decided to use the services under the pay for care system. Although they purchased fewer services

Table 1

Characteristics of Service Users and the Disabled Elderly Population in the Kurihara Region

		Users		*Disabled Elderly in General*[a)]
Gender	Men	38.5%	(5)	33.5%
	Women	61.5	(8)	66.5
Age	65–74	15.4	(2)	21.1
	75–84	69.2	(9)	40.0
	85+	15.4	(2)	38.9
Living Arrangement	Living Alone	15.4	(2)	1.0
	Only with Spouse	46.1	(6)	10.2
	With Child(ren)	38.5	(5)	71.8
	Other	0.0	(0)	17.0
Severity of Disability [b)]	Rank 1–2 (mild)	0.0	(0)	31.5
	Rank 3–4	38.5	(5)	40.5
	Rank 5–6 (sever)	61.5	(8)	28.0
Amount of Payment (per month)	−9,999 yen	23.1	(3)	–
	−19,999 yen	53.8	(7)	–
	20,000 yen +	23.1	(3)	–
Total		100.0	(13)	100.0

Note: Figures in parentheses are number of cases.

[a)]Bed-ridden or semi-bed-ridden respondents in the complete survey of the elderly aged 65 years and over (n = 522).

[b)]For users, severity of disability was assessed by a care manager and public health nurses according to the assessment procedure of IAC. For the disabled in general, the severity was estimated by their responses to the questionnaire items.

Source: Miyagi Prefecture, *Report of the Pilot Study on Community Services in Depopulated Area.*

than recommended, the amount of money they paid seems quite high relative to their income level. Ironically, the disabled elderly without co-resident children are still rare in such depopulated rural areas as Kurihara. However, for Japanese society in general, the elderly without co-resident children are rapidly increasing.

The need for long-term care services would arise firstly from such elderly. Thus, IAC is a good means to meet the increased demands for care services in the aged society in the near future, though several problems are still remaining to be solved.

The introduction of IAC is, in a sense, a response to the changes in the family life of the elderly symbolized by the decrease of co-residence with children. At the same time, the insurance may further stimulate changes to the family. In pre-war Japan, two types of instrumental support provided by adult children were greatly stressed as the actualization of filial piety. They were financial aid and long-term care for disabled parents. For most of the elderly at that time, co-residence was not only the normatively approved way of living, but also the only possible way to sustain their lives through receiving financial aid and/or long-term care from children. Such conditions did not change for a few decades after the war. The situation started to change in the 1960s when the old age pension became effective and visible. In opinion polls, from the 1960s, the percentage of people with negative attitudes toward dependence on children in old age became higher than those with positive attitudes (Matsunari, 1991); in census data, the percentage of co-residence started to decrease.

While financial aid has been reduced in importance by the old age pension, long-term family care has long remained important and necessary. Because of the selectivism and the shortage of services under the traditional welfare service system, the vast majority of the disabled elderly have to be cared for by co-resident family members without any formal care services. This situation is widely known and causes anxiety about long-term care in old age to the average Japanese. However, the importance of family care may possibly be reduced by the introduction of IAC, as IAC acknowledges societal responsibility for long-term care of the disabled elderly. It seems possible to say that the growing reduction in the importance and necessity of instrumental support stressed in pre-war Japan would be completed by the introduction of IAC.

The anticipated necessity of family care is not the only factor leading to co-residence with adult children. However, if the IAC system can free family members from the burden of long-term care, just as the old-age pension freed adult children from

financial support for their elderly parents, the introduction of IAC may contribute to the further decrease of co-residence just as did old-age pension.

Due to the changes in family life, including those affected by the old-age pension, today's intergenerational relationships between elderly parents and their adult children are more affection-based, convenience-oriented, and free from the Confucian norms of filial piety than they used to be (see Koyano, 1996; Naoi, Okamura, & Hayashi, 1984; Sakamoto, 1996). With the enactment of IAC at the beginning of the 21st century, there may be witnessed a completion to the changes in the family life of the Japanese elderly which began in the 1960s.

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