The Attitudes towards Formal and Informal Care among Japanese Young-Old in Rural Japan*

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1. Purpose of the study

Japan has been aging rapidly for these two decades and Japan is now one of the most aged populations in the world with the percentage of aged 65 and over among the whole population totaling more than 20% in 2005. This rapid aging of Japan will continue to 2030, and it is estimated that the percentage of older people will be 30 percent in 2030. Because of this rapid aging, Japan will confront many problems such as an increase in the very old, a decrease in the number of children, a decline in family care and mutual help in the community, and a lack of social welfare or care services for the disabled and cognitive impaired elderly.

The Public Long-Term Care Insurance Program (LTCI) in Japan started in April 2000 in order to cope with the rapid aging and rapid increase in care needs. Five years have passed since it started. A reformed LTCI will start in April, 2006. We have found through this five-year experience of LTCI that formal care such as LTCI and other services based on the welfare laws might not be sufficient to cope with all needs of physical, instrumental, and psycho-social care. The appropriate combination of formal care and informal care has become a critical policy issue to meet care needs after the implementation of the Public Long-term Care Insurance in Japan.

Thus, there are two purposes for this study; one is to describe the characteristics of attitudes toward care preferences for informal and formal care, as well as care responsibility among young-old people aged 60 to 74 in a rural area in Japan. The other is to try to establish a framework for an appropriate combination of formal care and informal care.

2. Methods

Definitions of informal care and formal care in this study are as follows;

1) Formal Care:

Formal care is care provided by governments, for-profit and/or non-profit organizations on the basis of tax, social insurance and/or market mechanisms.

2) Informal Care:

Informal care is unpaid care provided by family members, relatives, friends, neighbors, and volunteers.

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3) Sample

A total of 1059 young-old people aged 60 through 74, who were not in need of care, were selected by random sampling from the Resident Registries in Chino City, Nagano Prefecture, Japan. Data were obtained by interviewing and a total of 810 interviews were completed successfully. This survey was conducted from November through December, 2003.

4) Measurement

(1) Social Networks:

Social networks were measured by two sub-scales of which consisted of three items. One sub-scale was network size (the number of close relatives, friends, and neighbors), and the other sub-scale was contact frequency (contact with close relatives, friends, and neighbors).

(2)Anxiety toward Care in Old Age

There were three items regarding anxiety toward care in Old Age. Each item was measured by a dichotomous scale of "yes" or "no". Items were anxiety toward family care, expense of care, and institutionalization.

(3)Expectations toward Formal Care

There were four items regarding formal care; in-home care services such as bathing, feeding, and toileting, home help services such as cooking, cleaning, and shopping, assisted housing services including group home for dementia, and institutional services such as nursing homes.

(4)Attitude toward Care Responsibility

There were four items with regard to attitude toward care responsibility to evaluate children's responsibility for their parents. Each item was measured by a 4-point scale; strongly agree, somewhat agree, somewhat disagree, and strongly disagree. We used added scores of the four items as a scale score (Average Score=9.25, Cronbach α =.817). These four questions are as follows;

(1) Children must take care of their parents when they need physical care.
(2) Elder sons or heirs must take care of their parents.
(3) Children must live together with their parents.
(4) Daughters-in-law must take care of their parents.

(5)Care Preference:

Care preferences for formal care and informal care consisted of 4 items and each item was ranked on a 7-point scale (Average Score=16.6, Cronbach α =.897). This is a linear scale in which the higher the score, the greater the preference for formal care and lower the score, the greater the preference for informal care. These items included: care for physical needs such as feeding, bathing, and toileting, help with daily living tasks such as cooking, laundry, and so forth, emotional support (advice), and social contacts (called "koekake").

3. Results

Sample characteristics are shown in Table1.

Table 1　Sample Characteristics

Gender	
Male	48.9% (396)
Female	51.5% (414)
Total	100.0% (N=810)

Age	
60-64	36.2% (293)
65-69	31.9% (258)
40-49	32.0% (259)
Total	100.0% (N=810)

Education	
Junior-High	34.9% (281)
High-school	58.9% (474)
College	6.2% (50)
Total	100.0% (N=805)

Employment	
Employed	49.1% (395)
Not Employed	50.9% (409)
Total	100.0% (N=804)

Spouse	
Have Spouse	83.6% (674)
None	16.3% (132)
Total	100.0% (N=806)

Children	
Have Children	92.0% (745)
None	8.0% (65)
Total	100.0% (N=810)

First of all, we evaluated the respondent's participation in activities. The proportion of participation in community activities such as volunteer activities and community center activities in the past one year was 23%. This is higher than other Japanese young-old people. Based on the 5th International Comparative Study, participation in social welfare activities aged 60 and over was 8.7%. We asked about the possibility of volunteer activities in the future. The percentage of future volunteer activities was 43.8% and about half of the respondents had positive attitudes toward voluntary activities.

The next question was anxiety toward care in old age. There were three items: anxiety toward not having family care, expenses for care and institutionalization. The proportion of family care was 51%, expense of Care was 64%, and institutionalization was 74%. Three-fourth of respondents might be afraid of living in institutions when they need care in the future.

Table 2 Characteristics of Social Networks

Network Size

Number	Relatives	Neighbors	Friends
None	4.2% (34)	12.5%(101)	12.7%(102)
One	5.0% (40)	7.8% (63)	6.0% (48)
Two	12.8%(103)	13.3%(107)	12.1% (97)
Three	12.1% (98)	17.7%(143)	17.4%(140)
Four to Six	31.8%(256)	23.2%(187)	19.8%(159)
Seven to nine	11.2% (90)	7.2% (58)	4.0% (32)
More Than Ten	23.0%(185)	18.2%(147)	28.0%(225)
Average Score	3.88	3.26	3.50

Frequency of Contact

Frequency	Relatives	Neighbors	Friends
One to a few times a year	21.4%(165)	2.3% (16)	25.1%(176)
One to a few times a month	41.0%(316)	17.3%(122)	39.9%(280)
One time a week	18.4%(142)	22.7%(160)	18.5%(130)
Few times a week	11.2% (86)	30.2% (21)	11.3% (79)
Almost everyday	7.9% (61)	27.5%(194)	5.1% (36)
Average Score	2.43	3.63	2.31

With regard to social networks, the proportion of co-residence was 46.7%, and half of the young-old lived together with their parents. This is almost the same result as other surveys in Japan. The mean of the number of children was 1.94 and which is also the same result as for others. Table 2 shows the simple characteristics of social networks of the respondents. There are two network scales; one is network size of relatives, neighbors, and friends and the other is frequency of contact with relatives, neighbors, and friends. Relative network size is larger than other two resources. On the other hand, contact with neighbors is more frequent than others.

Table 3 Results of One-way ANOVA:

Social Networks ***P<.01 *p<.05*

	Size	Contact **
Male	10.6	7.1
Female	10.7	8.0

Network Score By Age Category ***P<.01 *p<.05*

	Size	Contact **
60-64	10.5	7.2
65-69	10.6	7.6
70-74	10.9	7.8

Network Score By Marital Status ***P<.01 *p<.05*

	Size**	Contact *
Living with spouse	10.9	7.5
Living alone	13.7	5.3
Divorced	8.5	7.4
Widowed	10.3	8.1
Never married	5.9	6.2

Network Score By Education ***P<.01 *p<.05*

	Size**	Contact **
Junior-high	9.7	7.1
High-school	11.2	7.9
College	10.8	6.7

Network Score By Ares Characteristics ***P<.01 *p<.05*

	Size**	Contact **
Rural area	11.2	7.8
Old town area	11.1	8.0
New town area	9.7	7.1
Mixed area	9.7	6.4

The next table (Table3) shows the results of a one-way ANOVA of each sub-scale of social networks by socio-demographic variables such as gender, age category, education, marital status, and area characteristics. With regard to gender difference, the results show a significant difference in social contacts between male and female. The mean score for male was 7.1 and 8.0 for female. The results of marital status, education, and area characteristics were also significant. Respondents who lived alone or were widowed had larger network sizes than others. Widowed had significantly more frequents contacts than others. Respondents who graduated from high-schools had significantly larger network sizes and more frequent contacts than the other groups. People who lived in rural areas and old town areas had significantly larger networks and more frequent contacts than other areas. People who lived in rural areas and old town areas resided for a long time in this city and this might indicate that the traditional Japanese close society remains in these areas.

The next topic concerned care responsibility. We tried to examine changes in attitudes toward care responsibility, which is part of the traditional Japanese culture (children must take care of their parents; as it were "filial piety"). Here, 67% of respondents thought that they had to take care of their parents when in need of physical care. On the other hand, 35% thought elder sons had to take care of them. One-third of the respondents answered that daughters-in-law had to take care of them. These results might show a change in traditional family care in Japan. .

The results of a one-way ANOVA for care responsibility by socio-demographic variables are shown in Table 4. There was a significant gender difference. Males tend to take more care responsibility than females. We determined the linear relationships among age cohorts. The older the respondents are, the more they tend to take responsibility for their parents. With regard to differences in living area, people who lived in new town area were more likely not to think that they had to assume care in the future than other areas.

Table 4: Resuls of One-way ANOVA of Care Responsibility

Care Responsibility	Care Preference ***
High	18.3
Law	14.6

p<0.05;p<0.01;***p<0.001.*

Gender	Care Responsibility ***
Male	9.8
Female	8.8

p<0.05;p<0.01;***p<0.001.*

Age Category	Care Responsibility *
60-64 yrs old	8.9
65-69 yrs old	9.4
70-74 yrs old	9.6

p<0.05;p<0.01;***p<0.001.*

Education	Care Responsibility
Junior-High	9.5
High-School	9.2
College and University	8.6

p<0.05;p<0.01;***p<0.001.*

Area Characteristics	Care Responsibility **
Rural Area	9.6
Old Town Area	9.3
New Town Area	8.5
Mixed Area	9.8

p<0.05;p<0.01;***p<0.001.*

The final analyses concerned care preference. As I mentioned earlier, formal care services might not be enough to cope with increasing needs for care in Japan. To deal with this problem, we have to strengthen informal care from families, relatives, neighbors, and volunteers. We also have to try to examine the optimal combination of formal and informal care. This is a kind of pilot study to try to evaluate this appropriate combination.

The question was : Which combination of informal care and formal care do you prefer?

1) Physical care: In need of physical care such as bathing, feeding, and toileting.
2) Help with daily tasks: In need of help of daily

tasks such as cooking, cleaning, and shopping.

3) Advice when needed: In need of advice for making decisions.
4) Social Contacts: Social contacts such as casual visits, and telephoning.

The scale of care preference was on Figure 1. It is a 7-point scale. The lower the, the greater the preference for informal care and vice-versa.

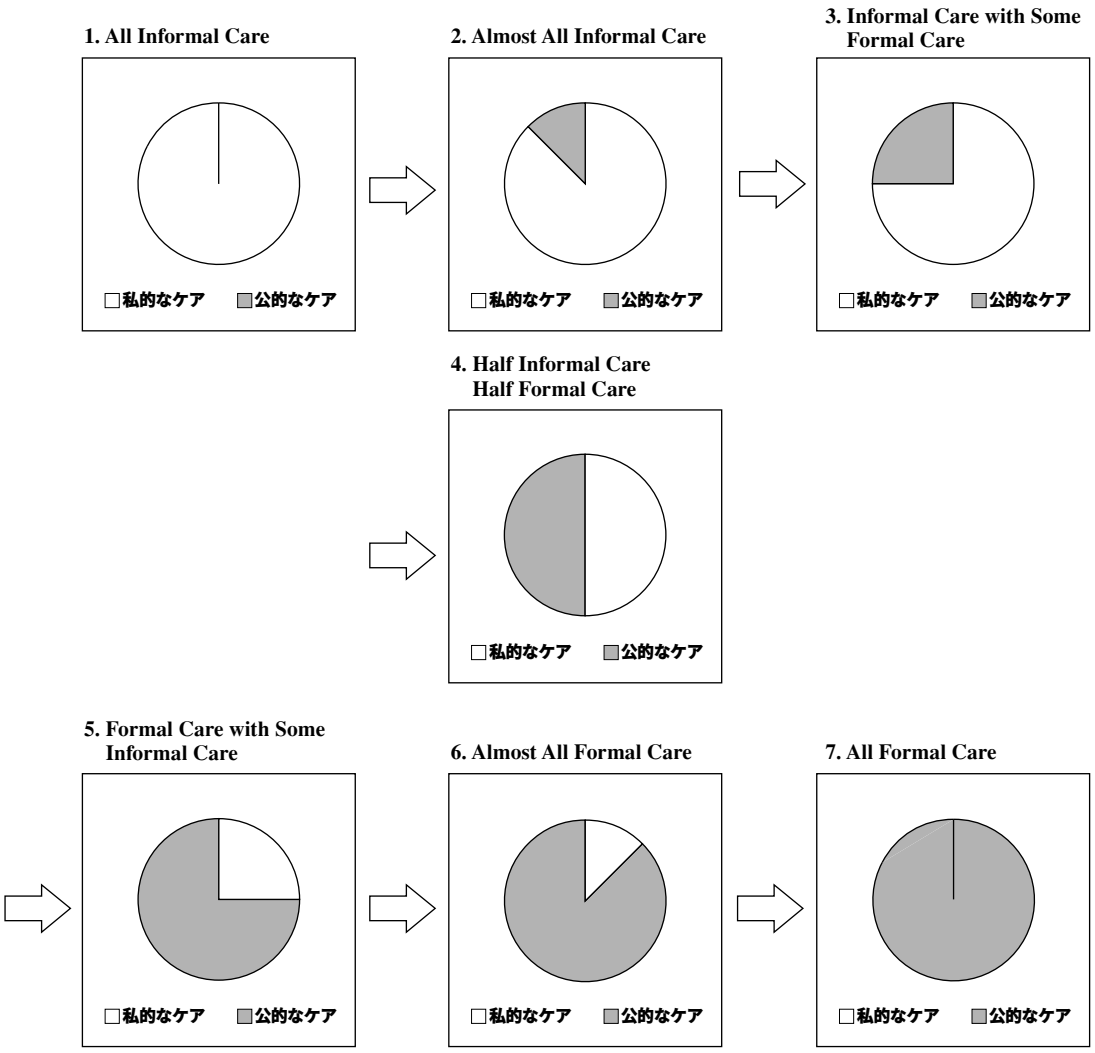

Figure 1 Scale for Care Preference(7-point scale)

These results implicated that respondents tended to prefer formal care for professional or instrumental needs and, on the other hand, they were more likely to select informal care for emotional and autonomous care needs.

The Table 5 shows the results of a one-way ANOVA for care preference by socio_demographic variables such as gender, age category, education, marital status, and area characteristics. There was no significant gender difference. With regard to age category, respondents under 70 years old were more likely to prefer formal care than those aged 70 and more. People who lived alone or were unmarried tend to prefer significantly more formal care than the other categories . Finally, respondents who lived in new

town areas, which means they are free from traditional Japanese society, were more likely to prefer formal care than other areas.

Table 5: Resuls of One-way ANOVA of care Preference

Gender	Care Preference
Male	16.6
Female	16.7

*p<0.05;**p<0.01;***p<0.001.

Age Category	Care Preference ***
60-64 yrs old	16.9
65-69 yrs old	17.6
70-74 yrs old	15.4

*p<0.05;**p<0.01;***p<0.001.

Marital Status	Care Preference **
Living with Spouse	16.5
Living Alone	21.0
Divorced	17.9
Widowed	16.1
Unmarried	23.3

*p<0.05;**p<0.01;***p<0.001.

Education	Care Preference
Junior-High	16.6
High-School	16.6
College and University	17.5

*p<0.05;**p<0.01;***p<0.001.

Area Characteristics	Care Preference ***
Rural Area	16.4
Old Town Area	15.6
New Town Area	19.2
Mixed Area	15.0

*p<0.05;**p<0.01;***p<0.001.

Summary of the results and discussion

1. First of all, young-old people in Chino-City did considerable volunteer activities over the previous one year compared with other Japanese young-old. Their attitude toward future volunteer activities also seems to be positive. It is reported that social activities are significantly related to social isolation in old age and these activities are important to prevent them from requiring care.
2. Most of the respondents expect formal care for in-home services and home-help services. These services are mainly provided by professionals. This might indicate that the young-old would like to have formal services by professionals when in need of heavy care and have informal care when in need of light or instrumental care.
3. Many investigators have reported that social networks have a strong impact on mortality and mental and physical health. The results of a one-way ANOVA showed that the differences in area characteristics such as rural, old town, new town, and mixed areas was significant and that people who lived in rural and old town areas had larger networks and more frequent contacts than other areas. They might still have traditional Japanese relationships. This result is important. It is said in Japan that many traditional communities have collapsed in urban areas because of westernization and we need to rebuild our communities for a welfare society.
4. Five years have passed since LTCI started in 2000. The purpose of the LTCI was to cope with the rapid increase in care needs and make personal care (children must take care of their parents) social (society has to be in charge of care). The children's responsibility for taking care of their parents will be lighter than five years ago and it will also change their attitudes toward family care. However, the results of our survey showed that two-third of the respondents still think that children have to take care of their parents in need of physical care. There doesn't seem to be a big change in attitudes toward care. On the other hand, the number of service utilization and service users has been dramatically increasing for five years. Attitudes toward care might be changing more slowly than actual service use.

   Males are more likely to take care responsibility than females in the results of a one-way ANOVA. With regard to differences in living areas, people who lived in new town areas were more likely not

to think that they have to assume care in future than other areas.

5. Formal care and informal care have respective strengths and weaknesses. Formal care is appropriate for securing a national or local minimum level of care and providing professional and instrumental care. On the other hand, informal care is more appropriate for emotional and autonomous care but weak in providing professional care. As Professor Shimizu at Sophia University suggested an optimal combination of formal care and informal care for the elderly will ultimately become an influential model for elderly care in Japan and the world in the 21st century. We tried to evaluate the combination of formal care and informal care using our own scales. There results indicated that respondents tended to prefer formal care for physical or instrumental care needs and prefer informal care for emotional and social contact needs. This might suggest that we had better enhance informal care such as families, relatives, neighbors, and volunteers to meet their psycho-social care needs in next decade. The result of a one-way ANOVA showed that people who are living in new town area, which means they are free from traditional Japanese society were more likely to prefer to formal care than other areas. This might suggest that a combination of formal care and informal care will differ by living areas.

Future Tasks

There were two purposes for this study: one was to describe the characteristics of attitudes toward care preferences for informal and formal fare, as well as care responsibility among young-old people aged 60 to 74 in a rural area in Japan. The other was to try to establish a framework for an appropriate combination of formal care and informal care.

There are limited empirical studies on this topic in Japan. This study is a kind of pilot study. Therefore, there are some tasks which need to be examined in the future. First of all, as there are limited studies on this topic in Japan, more studies will be needed. Secondly, with regard to sampling, our study was conducted in a very limited geographic area, Chino City, Nagano Prefecture. We need to have and analyze nation_wide samples in order to generalize the findings.

The final task is the lack of scales and uniformity in the selection of items of social networks, care preference, and so forth. Inadequate measurements remain a major problem with studies concerning the impact of social relationships, as suggested by many researchers. We need to examine the validity and reliability of our own scale in further studies.

It is hoped that this study's attempt to determine an optimal combination of formal care and informal care for the elderly will ultimately become an influential model for elderly care.