The Rhetoric of Reform: On the Institutionalization and De-Institutionalization of Old Age

Sabine Frühstück

1. Setting of the Problem

During the late 1970s and early 1980s, the question of whether Japan cares well enough for its institutionalized senior citizens was discussed with more rigor than ever before. Most agreed that this was not the case. Public nursing homes met severe criticism from both within and without. The quest for their reform was supported by almost 50% of 24- to 74-year-olds in an opinion poll of 1986 (Naikaku Sōri Daijin Kanbō Kōhōshitsu 1987: 189), at a time when a major turn was underway. Community care programs as an alternative to the problematic and rather closed institutions was one of the options most discussed among bureaucrats concerned with the Japanese welfare system.

When more than 5,000 Japanese men and women were asked in 1978 what kind of life they would like to lead when they are no longer able to work, only 4% said that they would live in a nursing home. Only 2.2% of elderly respondents in 1984, but 9.7% in 1990, agreed that living in a nursing home was the ideal living arrangement in old age (Linhart 1997: 309, Tab. 13). By 1990, the percentage had more than doubled, reaching 8.8% (Linhart 1997: 30, Tab. 14). In 1989, up to 13% of respondents in a national poll were willing to put their elderly relatives into a nursing home if they were no longer able to live alone (Linhart 1997: 299, Tab. 1).

In this article, I will describe the two major areas of conflict regarding the turn from institutionalized care toward community care for the elderly in Japan which took place during the 1980s, prior to the "Gold Plan" and the introduction of the long-term care insurance. First, I look at nursing homes themselves and analyze their internal problems (section 2). Second, I discuss the community care programs and examine in what ways they influenced the reorganization of nursing homes on the one hand, and the transfer of responsibility and financial burden from institutions and the state to the community and female caregivers on the other hand (section 3).

The turn in social policy for the elderly was accompanied by mixed feelings among a number of involved groups and was confronted by rather diverse reactions. Originally, it was propagated by the Japanese

health administration, enthusiastically embraced by prefectural and local rhetoric touting the new "light-hearted and happy" city XY, and only moderately criticized by women's groups who did not want to envision themselves at home, caring again not only for their children and husbands, but for parents and parents-in-law as they had for generations. The major criticism of existing nursing homes, however, did not bring about their radical reform but instead led to the creation of new types of more open institutions that were organized and financed differently and which catered to a different range of elderly people.

2. The State of Nursing Homes in Japan During the 1980s

2.1 The inmates

By the time Hata Hiroaki published his book *Rōjin to wa nan da! Shitsurei na* ([What is an "Old Person"? How Rude!]; 1985), the word *rōjin* [old person] for Japan's elderly had come to have a negative connotation. While in direct interaction within the boundaries of the family or the local community, the elderly are addressed with terms such as *jiji*, *ojīchan*, or *ojīsan* [grandpa], *baba*, *obāsan* or *obāchan* [grandma]. *Rōjin* is used in the official language of health and social welfare administrators, as in *rōjin mondai* [problem of old people], *rōjin fukushi sābisu* [welfare services for old people], or *rōjin hōmu* [old people's home], all of which commonly appear in problematic contexts. Institutions for the care of the elderly managed by national, prefectural, or municipal administrative bodies which were founded after the enactment of the "Old Age Welfare Act" (*Rōjin fukushi-hō*) on August 1, 1963, continued to be called *yōgo rōjin hōmu* [nursing home for old people], *tokubetsu yōgo rōjin hōmu* [special nursing home for old people], *keihi rōjin hōmu* [home with reduced fees for old people], or *rōjin fukushi sentā* [social welfare center for old people], while more recent private institutions were founded by using euphemistic names such as "silver home". Institutionalized elderly in nursing homes were termed *zashosha* [residents] or *nyūshoin* [inmates]. In the following, I will use the word "inmates" when I refer to those elderly who live in nursing homes. Contrary to "residents" and other euphemistic terms it makes clear that we are dealing with a relatively closed or "total institution", a term that had been coined by Erving Goffman (1973). "Total institutions" are characterized by a number of core features, namely, the merging of formerly separate areas of living, the administration of life by a bureaucratic organization, deculturation processes, attacks against the self, and particular adaptation strategies of the inmates.

In 1983, 4.3% of the population over 64 was institutionalized, but only 3% were inmates of nursing homes such as nursing homes for old people (*yōgo rōjin hōmu;* in the following abbreviated as *yōgo*) and special nursing homes for old people (*tokubetsu yōgo rōjin hōmu;* in the following abbreviated as *tokuyō*) (KARGL 1987: 370). Although the group of people who live in nursing homes is rather heterogeneous in nature, inmates of both institutions share a number of characteristics with regard to their age, sex, physical constitution, income, social background, and living arrangements.

Table 1: **Age of inmates in nursing homes, 1982 (%)**

Age group	Special nursing home for old people (*tokubetsu yōgo rōjin hōmu*)	Nursing home for old people (*yōgo rōjin hōmu*)
younger than 70 years	16.3	20.1
between 70 and 80 years	40.1	45.7
80 years and older	43.6	34.3

Source: ZSFKK (1986: 41, Table 1/3).

As for the age composition of the inmates (see Table 1), it can clearly be shown that the strongest group is those aged 80 years and older. Throughout the 1970s and 1980s, with slight variations from institution to institution, at least two-thirds of the inmates were females and one-third was male (SOEDA *et al.* 1977: 13; ESKS 1987: 350). This imbalance can be explained in a threefold manner: First, women's life expectancy is more than six years higher than that of men. Second, elderly women are less often taken care of by relatives. In other words, women who have raised their children, who have taken care of their husbands, their parents, and very often their parents-in-law for most of their lives, prefer not to become burdens for their relatives when they need help themselves (SHIMADA 1983: 146). They know from their own experience that for every single year a bedridden person[1] lives and is taken care of by a daughter or daughter-in-law, the life of the caregiver is shortened by one year (GETREUER-KARGL 1990a: 157). Care at home might become even more difficult when the caregiver grows older and suffers from chronic diseases herself (SHIBATA 1988: 55). Third, women become bedridden later in their lives. Only in the group of those 80 years and older are women more numerous (KARGL 1987: 380).

With regard to their familial situation, the difference between women and men is significant. Although the majority or 80 to 90% of inmates is

[1] According to Kargl, "bedridden" (*netakiri*) usually refers to a person that had been bound to her or his bed for more than six months (KARGL 1987: 371).

widowed, the number of widowed women is 20% higher than men in *tokuyō* and 10% higher in *yōgo*, while the number of widowed men is 17% higher in *tokuyō* than it is in *yōgo*. While 66% of *tokuyō* inmates have children, only 46% of *yōgo* inmates do (ZSFKK 1986: 48–49).

More than 80% of all inmates needs daily medication and suffers from more than one disease. About half of the inmates are bedridden and another half are incontinent (Arioka 1990: 4). More than 50% of them needs treatment they would normally receive in a hospital and even patients who need to be taken care of 24 hours a day, including weekends and holidays, are not rare (Miura 1982: 159). However, a nursing home is by law not a medical institution. It is not equipped in the same manner as a hospital and is unable to provide certain services that are nevertheless needed. Thus the personnel sometimes feels they would be better off in a hospital (*iryō kikan de hataraite ita hō ga yokatta*), while the more concerned inmates fear for their lives: "For the elderly in nursing homes, medical treatment is a luxury; hence they die" (Nakagawa 1979: 35).

The lack of mental agility is another significant characteristic of many inmates. Whereas 4.5% of the elderly who live at home are estimated to be senile (*chihōsei rōjin*) (Ikuta and Fujita 1986: 105), more than half of *tokuyō* inmates and at least one-third of *yōgo* inmates are described as senile due to behavior such as for being forgetful, hallucinating, not understanding what the personnel is saying to them, the inability to perform simple tasks in everyday life although they are physically capable of doing so, insomnia, making noise, uncleanliness, or violence (ZSFKK 1986: 96). Most of the elderly defined as "senile", however, were taken care of at home (*Tōkyō Shinbun* 21.11.1990: 14; Miura 1989: 39). It is estimated for the year 2008 that the number of bedridden or senile elderly will equal the number of full-time housewives. It was feared that, without changing the institutional setting, half of all women between the age of 40 and 50 would have to take care of one bedridden or senile elderly person. Considering that the number of working women of that age group was likely to rise significantly, it became clear that soon women would not be available to take care of the elderly in the same ways and to the same extent as they used to. The extension of existing institutions in order to relieve these women, and the reorganization of these institutions so that new inmates would not primarily feel isolated, excluded, and locked up were two aims of the critique the system faced during the 1980s (Ogawa 1990b: 22). According to a forecast, the number of senile over-64-year-olds will increase and reach 2.16 million by 2025. Similarly, the number of bedridden over-64-year-olds is estimated to rise to 1.96 million (Ogawa 1990a: 15).

Many publications describe elderly Japanese as rather well off (Ishii 1991: 11; Ogasawara 1985: 92). However, most of those elderly who live with their children in urban areas are financially dependent on them, and six out of ten of them lived below the poverty line before they moved in with their children (Honma 1985: 42). In fact, a weak financial situation is no longer a reason for entering a nursing home. The elderly are more likely to enter a nursing home because of an unsatisfactory familial situation rather than for financial reasons (ZSFKK 1986: 193). In any case, there were rather few if any well-off elderly who chose to enter a nursing home during the 1980s.

The income of inmates of nursing homes is significantly lower than of those elderly who are not institutionalized. Institutionalized elderly clearly belong to the poorest group among the elderly in Japan. According to the Public Assistance Act (*Seikatsu hogo-hō*), children have the obligation to provide maintenance for their parents in case they are not able to support themselves sufficiently. Only a minority of elderly over the age of 60, however, feel comfortable about being financially supported by their children. More than half of them would prefer to be able to look after themselves and a considerable third thinks that it is the responsibility of the state to provide the social network (ESKS 1987: 601). But for the elderly who are institutionalized in *tokuyō* and *yōgo*, reality looks quite different. Nine out of ten elderly receive financial support from their children, partners, siblings, and other relatives as well as from friends and acquaintances (ZSFKK 1986: 61).

Table 2: **Living arrangements of inmates prior to their institutionalization (%)**

Living arrangement	Special nursing home for old people (*tokubetsu yōgo rōjin hōmu*)	Nursing home for old people (*yōgo rōjin hōmu*)
with children	35.4	19.6
with other relatives	7.1	14.8
as couple	6.6	7.1
alone	12.1	36.3
in another institution, i.e., hospital or other nursing home	35.6	12.1
other	3.2	--
unknown	1.0	--

Source: ZSFKK (1986: 53, Tab. 2/6).

From Table 2, some interesting facts regarding the household situation of the elderly prior to their institutionalization become apparent. While more than 35% of *tokuyō* inmates lived with their children before their institutionalization, only about half or 19% of *yōgo* inmates did so. While slightly less than half of both groups lived with either children, partners, or relatives, the difference between the two groups in regard to other living arrangements is significant. Of *tokuyō* inmates, 35.6% came from other institutions such as a hospital or another nursing home. The opposite applies to *yōgo* inmates. While 36.3% had lived alone, only 12.1% came from another institution.

2.2 Institutionalization and the adaptation process

Although it is advised by the Japanese social welfare authorities, very few families consult one of the consultation bureaus for social welfare or visit a nursing home before deciding to put their elderly relative into one (ZSFKK 1986: 51). Permission for institutionalization is given by the bureau of social welfare on the basis of a formal application. Criteria for acceptance in a nursing home involve three factors: First, the person concerned must be a receiver of social welfare or receive an income below the taxable minimum. Second, she or he must to a considerable degree be physically or mentally disabled. Third, she or he must be unable to live at home (Kōseishō 1990: 238). *Tokuyō* presuppose a serious physical disability or bedriddenness. Although the lack of financial resources is not necessarily a precondition, many elderly apply for acceptance based on financial reasons (Soeda *et al.* 1977: 18). According to §2–11 of the Old Age Welfare Act (*Rōjin fukushi-hō*), only people with serious physical and/or psychological disabilities (*kurushii kekkan*) are accepted at *tokuyō*. But even if qualification criteria are met, many elderly have to wait for years before there is finally a vacancy. This waiting period increased especially since the enactment of a committee in 1984 which was founded in order to keep administrative costs down and to moderate the speed at which new homes were founded (Teruoka 1985: 33). According to a study carried out in 1984, there were 366,000 bedridden people, but only 111,970 places in *tokuyō* (Miura 1987: 130).

What does *kurushii kekkan* mean exactly? Nakagawa Masateru (1979: 25) explains that originally *tokuyō* were built for old people with *kurushii kekkan* in order to separate them from other sick people, emphasizing that *tokuyō* were not hospitals. According to the Law for Medical Treatment (*Iryō-hō*), hospitals have to be equipped with a certain number of personnel in relation to patients: for 100 patients

there have to be at least 3 physicians and 34 nurses. Legal matters for *tokuyō* are formulated in the Old Age Welfare Act which provides only 1 physician and 5 nurses for 300 inmates. Consequently, the motto for nursing homes that "a nursing home is no hospital" proves to be efficient from a financial viewpoint but dangerously fateful for the quality and the potential of nursing. Hence, according to public policy, those elderly who become sick in a nursing home would have to be transferred to a hospital. In reality, however, hospitals are overcrowded, the elderly themselves are reluctant to move from one institution to another, and they are considered "uninvited guests" (*manekarezaru kyaku*) because they cause high treatment costs (Anton 1989: 36; Nakagawa 1979: 35).

Discriminatory practices seem to be common. As Teruoka Itsuko has found, the elderly are often dismissed from hospitals even though their condition may not have improved and are either sent back home or – in case there are no caregivers available – put into a nursing home. When long waiting periods are expected, some elderly end up in psychiatric wards no matter what their mental state (Teruoka 1985: 33; Getreuer-Kargl 1990a: 168).

About half of those who apply for entering a nursing home are accepted. Most of them stay for three to five years in a *tokuyō* or for five to seven years in a *yōgo* (ZSFKK 1986: 192). Those who leave the nursing home are mainly transferred to a hospital or die. More than 70% die in a *tokuyō*, as opposed to more than one-third of inmates of *yōgo*. The rest of the *tokuyō* inmates are transferred to a hospital or to their homes while the other *yōgo* inmates are usually transferred to *tokuyō* or to hospitals (ZSFKK 1986: 67). One out of four *tokuyō* inmates who are transferred to their homes return to die (ZSFKK 1986: 70).

Death is omnipresent in nursing homes. Hence, they are named "place of death" (*shi no ba*) or "last place" (*saigo no ba*). Nevertheless, the topic of death seems to be taboo. The Conference of the Society for Research on Dying and Death (Shi no Rinshō Kenkyūkai) attributes this taboo to the fact that more and more people die in institutions not only in Western European countries and in North America (Ariès 1980: 736), but also in Japan where 70% of all deaths take place in institutions (*Asahi Shinbun* [Sapporo edition], 27.09.1990). In advice columns of magazines for women or the family, one finds many indicators that women worry about the aging of Japanese society, but there, too, problems concerning death are hardly mentioned (Eijingu 1984: 38). This might be taken as another indicator for what Norbert Elias called the far-reaching "hiding and repressing of death, that is to say of the singularity and finality of human existence" (1982: 56).

Reasons for institutionalization are manifold and vary. An analysis of the social background provides a first glance at which factors play a role when an elderly person or her or his family considers institutionalization. Soeda Yoshiya interviewed 144 inmates[2] and placed them into two categories: the general class (*ippan kaisō*) and the unstable class (*fuantei kaisō*). Almost 70% of the 144 respondents belonged to the unstable class, and more men than women. The material situation of institutionalized elderly is significantly worse than that of workers in general, of whom only 20% belong to the unstable class, as defined by Soeda and his collaborators. Class careers differ depending on sex. Most females belonged to the unstable class for a long time before their institutionalization or had descended to the unstable class during the last few years before their institutionalization. The most important reason for the deterioration of their material situation is the separation from their husbands through death or divorce. The fact that the job situation of an elderly woman hardly has any effect on her material situation in old age suggests that most of them were financially dependent on their husbands when they reached old age. Most of the male inmates belonged to the unstable class for all or at least most of their lives. In regard to their material background, we see a significant difference between *tokuyō* and *yōgo*. While almost 80% of *yōgo* inmates belong to the unstable class, only half of the *tokuyō* inmates do so. *Yōgo* are the follower institutions of *yōrōin*, which were built in Japan from 1895 onward and have never gotten rid of their image as institutions for the poor (Frühstück 1991: 20; Campbell 1984: 78; Oberländer 1997: 92–93).

Another reason for institutionalization is an unsatisfactory familial situation. A quarter of all respondents of a study carried out in 1985 said that they did not get along with their daughter-in-law, their son nagged all the time, or they felt more welcome in a nursing home than at home (Ogasawara 1985: 91). The familial situation seems to have become an increasingly important factor for the decision to enter a nursing home. From all the consultations that take place in bureaus for social welfare, in centers for the elderly, or other consulting offices for the elderly, more than 60% of the problems verbalized and taken into account in relation to institutionalization were related to conflicts in the family (Shimada 1983: 149). As can be gathered from Table 3, the reasons are quite different

[2] Of respondents, 33.3% were male and 66.7% were female; 66 people or 45.8% lived in *yōgo*, and 78 people or 54.2% in *tokuyō*; 18.1% were younger than 70 years, 36.8% were between 70 and 80 years old, and 44.5% were 80 years and older (Soeda *et al.* 1977: 3–27).

among inmates of *yōgo* compared to those of *tokuyō*. The major reasons are familial situation (30%) and material situation (20%). Physical weaknesses or disabilities play a minor role as compared to the inmates of *tokuyō*. In general it is important to keep in mind that more than one unfavorable factor leads to institutionalization (ZSFKK 1986: 58). What is more, the elderly are usually not the decision-makers. Only 4.7% of *tokuyō* inmates and 13% of *yōgo* inmates said that it was their own decision to be institutionalized.

Table 3: **Reasons for entering a *tokuyō* or *yōgo* (%)**

Reason	Special nursing home for old people (*tokubetsu yōgo rōjin hōmu*)	Nursing home for old people (*yōgo rōjin hōmu*)
physical weakness	54.0	10.8
familial situation	25.8	29.9
decision of the inmate	4.7	13.0
mental weakness	4.3	4.1
material situation	3.0	20.0
living circumstances	2.6	9.2
other reasons	4.4	6.8

Source: ZSFKK (1986: 58, Table 2/10).

Very often the decision to enter a nursing home is not carefully considered. Rather, it is the result of an acute crisis or made when the burden of care at home no longer seems bearable to the caregiver and her or his family (Ogasawara 1985: 85). Women especially decide to enter a nursing home after a life of caring for their children, their husband, and sometimes his parents or their own parents out of exhaustion after their husband's death (Getreuer-Kargl 1990a: 157). Others make the decision out of a feeling of loneliness or because they are not (any longer) able to take care of themselves or live alone despite a good physical condition (Teruoka 1978: 240).

While in North America the family of the person concerned is the main decision-maker when institutionalization is considered (Brody 1977: 49), the same is only true of *tokuyō* inmates for whom 59.1% of all cases were decided by the family (see Table 4; first survey). The second most important decision-maker is an administrative body, and only 14.9% of the decisions were taken by the person concerned.

Table 4: **Decision-makers for institutionalization in a *tokuyō*, 1981 (%)**

Decision-maker	First survey	Second survey
family	59.1	32.0
administrative body	53.1	28.7
hospital	16.4	8.9
person concerned	14.9	8.0
social worker	13.9	7.5
other relatives	13.6	7.3
other nursing home	11.4	6.2
other	2.0	1.1

Note: Both surveys were undertaken in 1981 and involved interviews with elderly living in *tokuyō*. The sample of the first survey consisted of 23,116 people. More than one answer could be given and therefore co-decisions were taken into account. The sample of the second survey consisted of 42,778 elderly. Here only one answer could be given.

Source: ZSFKK (1986: 52, Table 1/5).

For *yōgo* inmates, almost half of these cases of institutionalization were decided by an administrative body (first survey), 34.9% by the person concerned, and only in 27.6% of the cases was it the family's decision. Tables 4 and 5 show clearly that differences between institutions in regard to the decision-maker are substantial.

Table 5: **Decision-makers for institutionalization in *yōgo*, 1981 (%)**

Decision-maker	First survey	Second survey
administrative body	49.3	29.4
person concerned	34.9	20.8
family	27.6	16.5
social worker	20.6	10.3
other relatives	17.7	10.6
other nursing home	7.3	4.3
hospital	6.8	4.0
other	3.5	2.1

Source: ZSFKK (1986: 52, Table 1/5).

The *White Paper on Nursing Homes* (ZSFKK 1986) does not analyze the relation of the inmates' sex with the question of who made the decision.

Small-scale surveys[3] suggest, however, that women usually actively and deliberately decide to enter a nursing home, while men more commonly end up in a nursing home because a number of authorities (including the family) decides to put them there (SHIMONAKA 1987: 65–75).

In general, institutionalization provokes a temporary deterioration of the constitution of the institutionalized person (OGASAWARA 1985: 85), which has been explained in different ways. Elaine M. BRODY (1977) ascribes the destabilization to the shock caused by the fact that the person concerned had to leave her or his familiar surroundings and is placed into a nursing home. The expectation of the relocation can have the same effects as the relocation itself. Thus, the feeling of isolation usually appears long before the institutionalization takes place. Sheldon S. TOBIN and Morton A. LIEBERMAN (1976: 22) came to similar conclusions when studying the critical implications of institutionalization of the elderly in the United States. The "discontinuity of their surroundings connected with the loss of familial support as well as the beforehand identification with the other inmates can trigger a feeling of isolation which is only reinforced when entering the institution". On the contrary, Erving GOFFMAN (1973: 24–39) tends to ascribe the deterioration of someone's condition to the effects of the nursing home as a total and "totalizing" institution, although he too concedes that in many cases the institution only destroys something that had already been decaying.

There are very few studies on the risk of institutionalization in nursing homes in Japan. Erdman PALMORE (1976: 504–507) has found that the risk is greatest for people who have lived alone before their institutionalization, for elderly who do not have children, and for women in general. As opposed to Palmore's findings, OGASAWARA (1985: 86) found that the effects of institutionalization are more negative for males than for females and that females also enjoy themselves more in nursing homes than males do. SHIMONAKA Yoshiko (1987: 73) defined as additional factors self-confidence and ego, fear of old age, intensity of social contacts, and physical condition. If the person concerned had few social contacts before entering the nursing home, the adaptation process will be less difficult. Socially rather isolated people tend to enjoy life in a nursing home for its possibilities to make contacts and friends and the possibility to live a more "human life" (*ningen-rashii seikatsu*). Those, however, who had satisfying social relations before, are likely to find life in a nursing home less

[3] SHIMONAKA *et al.* (1987) analyzed case studies of 114 men and 232 women. Excluded were sick and bedridden elderly. Respondents were 76 +/- 6.3 years old. The study was carried out in two nursing homes, one of which was in an urban area and one in a rural area.

enjoyable (Ogasawara 1985: 83). In general, we can conclude that the lifestyle of the elderly before their institutionalization has a considerable impact on how they feel about entering a nursing home and how they feel about being an inmate of a nursing home.

2.3 The personnel

Similar to companies, Japanese nursing homes tend to present the idyllic image of family life in regard to the interaction of inmates and staff (Ogasawara 1985: 83; Hata 1985: 117), thus disguising the fact that relations between them are organized in ways significantly different from familial relationships. Inmates and personnel are related to each other by a dependence which is in certain ways mutual. On the one hand, the inmates are dependent on the personnel and their willingness to provide the right treatment. On the other hand, the personnel are dependent on the inmates' willingness to cooperate. Both parties are subjugated to the regulations and restrictions of time and place which will be discussed below. These regulations and restrictions affect the autonomy of inmates and their activities and mark the boundaries of their *Lebenswelt*. Family, friends, and acquaintances of the personnel guarantee them the ability to leave the "totalizing" atmosphere of the institution.

Among all kinds of welfare institutions, next to social welfare institutions for children and youth (*jidō fukushi shisetsu*) the second largest group of people are employed in the institutions for the elderly (Kōseishō 1990: 326). In 1988, 90,060 of these were working in nursing homes. Although the absolute number of personnel doubled between 1978 and 1988, the ratio of personnel and staff has hardly improved. In *yōgo*, the ratio was 3.48 inmates to one staff member, while ten years earlier it was 3.97. In *tokuyō*, the ratio was 2.01 in 1988 as compared to 2.27 inmates facing one staff member. Although there are national norms for the ratio of inmates and staff, they are in many cases twice as high as provided in the law. In about 12% of all *tokuyō* there are three inmates to one staff member and in almost half of all *yōgo* one staff member faces four or more inmates. When necessary, e.g., on bathing days, all staff members have to work together regardless of whether they are qualified or not.

According to Goffman's model of face-to-face interaction, in every society there are preferred ways of entering an interaction between two people. Each of these "systems to make contact" can be a source of identity, a guideline for ideal behavior, and a precondition for solidarity or disunion. Each system consists of a range of interdependent assumptions which are adjusted to each other and form a model. Through an analysis of the assumptions and ideals of interaction between inmates

and staff, one can learn a lot about the problems of institutions. The most important form in which inmates and staff interact with each other is the relation between one who is served and the other who is serving. In the following I will exclude personnel that do not regularly come into contact with the inmates such as cleaning staff or cooks. I will treat only those personnel that interact on a daily basis with the inmates, that offer services in form of treatment in direct and indirect, medical and non-medical ways. In the course of one day, no less than seven nurses and *ryōbo* [literally: home mother] interact directly with the bedridden elderly (see Table 6).

Table 6: **Schedule of a nursing home for a bedridden inmate**

Time	Treatment/activity	Personnel
8:30– 8:50	meeting of personnel	
8:57– 9:40	excretion care	ryōbo A
9:40– 9:54	treatment of bedsores	nurse B
10:00–10:01	questions concerning physical condition	ryōbo C
10:18–10:19	eye drop treatment	nurse D
10:43–10:59	help with eating	ryōbo E
11:41–11:43	excretion care	ryōbo F
13:25–13:26	taking the inmates' temperature	nurse B
13:29–13:31	meals served	ryōbo A
13:40–13:43	help with eating	ryōbo A
14:11–14:13	taking temperature and pulse	nurse B
14:18–14:19	questions concerning general physical condition	nurse B
15:51–15:54	excretion care	ryōbo A and G
16:13–16:14	placing the inmates in comfortable positions	nurse B
16:35–16:50	help with eating	ryōbo A
16:51–16:52	oral hygiene	ryōbo A

Source: ASANO (1975: 136).

The personnel of a nursing home that is involved in direct and indirect care include a psychological consultant (often a middle-aged man), *ryōbo*, nurses, and physicians. *Ryōbo* do not need professional training and are normally forced to "learn by doing". Many of them are former full-time housewives. Their tasks include direct and indirect caring, i.e., emotional support, and thus they are the hinge joint between medical personnel and inmates. Nurses are fewer in number and very often *ryōbo* do some of their work. The willingness and ability to cooperate and work in a team is essential for the functioning of a nursing home. 90% of all activities that

can be categorized as either *kaigo* [long-term care] or *kaijo* [caring help] are done by *ryōbo*. The psychological consultant takes care of questions and problems and of public relations matters.[4] The income of these three groups vary and is for all of them slightly higher in *yōgo* than in *tokuyō*. Two-thirds of *ryōbo* in *tokuyō* earn between ¥ 120,000 and ¥ 175,000, the majority of the nurses between ¥ 140,000 to ¥ 250,000, and the consultant usually slightly more. A comparison with the average income of women in the service sector shows that the average income of a *ryōbo* is only 65% of that, while the income of a nurse is still 10% lower than average (Sōmuchō Tōkeikyoku 1990: 95).[5] The number of physicians varies greatly from region to region but is often significantly lower than prescribed by the regulations for nursing homes (Yano Tsuneta Kinenkai 1990: 314).

2.4 Organizing space

The architecture of a nursing home is usually discussed when questions of privacy arise (Miura 1982; Ogasawara 1985; ZSFKK 1986) or the pressure to identify with the other inmates is problematized (Tobin and Lieberman 1976: 165). An analysis of space and its utilization in nursing homes between 1961 and 1975 shows that the living space (rooms of inmates) decreased from 55.9% to 22.2%, in relation to common and administrative space. Concerning the rooms for inmates, the following changes can be observed: While older homes provide rooms for four or more inmates, the homes that were built during the 1970s provide more rooms for either one, two, or three people. In order to provide a minimum of privacy, new homes integrated more and more single rooms. Their average size is 19.8 square meters, whereas rooms for seven people were often not larger than 35 square meters (Ogasawara 1985: 92). Hence, the fact that single-person rooms need more space and require higher costs than multiple-person rooms became one of the main arguments for administrators who opposed the construction of rooms for few people.

The costs and the requirement of space itself, however, were not the only problems the administration of nursing homes saw in single rooms. In their view, group rooms would avoid the possibility of the elderly becoming isolated and introverted, which would in turn disturb the adaptation process, especially in the context of group activities (Hayashi

[4] The last point should not be underestimated considering that in 1987 half of the elderly did not even know that *tokuyō* exist, and a fifth had never heard of *yōgo* (ESKS 1987: 105).

[5] The average income for women in service occupations in 1989 was ¥ 270,000 for companies with more than 30 employees (Sōmuchō Tōkeikyoku 1990: 95).

and Arizuka 1977: 58). The construction of single rooms would enable the inmate to keep a distance from the all-powerful regulations of the institutions and to withdraw from the observation of other inmates and from the control of the staff.

Group rooms, however, may lead to other side effects significantly not discussed by nursing homes' administrators. Dahms (1985: 35) has argued that the architecture of institutions such as prisons, hospitals, schools, or nursing homes "makes the behavior of inmates susceptible" but also enables without utilizing any restrictive measures to continuously "normalize" and discipline the activities of the inmates. Michel Foucault (1976: 260) described this architecture as follows:

> In order to make constant control possible or at least to let inmates fear this constant control, visibility is necessary. Hence, the architecture is an instrument for the transformation of individuals. […] True subjugation appears mechanically from a fictional relationship so that violent measures are unnecessary in order to force the convict to good behavior, the demented to silence, the worker to work, the student to enthusiasm, and the sick to follow orders.

The effects of control are permanent, and architecture achieves this effect by guaranteeing the visibility of its users at all times, by specifying the traffic roads, by prescribing common rooms, and by dictating their usage (Foucault 1976: 280).

Control (*kanri*) in nursing homes appears as a system-immanent necessity. Arguments against single rooms include the danger of not being able to detect illnesses, accidents, or fires until it is too late, in cases where doors are locked during the night. The lack of personnel would show even more painfully. Sliding doors between the rooms of two inmates seem to provide a compromise or at least the possibility to withdraw oneself from the view of another inmate. More than 70% of inmates always keep these doors closed, either out of "fear of the other person who is unknown and whom they might not want to get to know" or the "feeling of being under continuous observation" (Hayashi and Arizuka 1977: 58). Even if roommates cannot observe each other, they are forced to listen to the noises the other party makes, to her or his soliloquies, and cannot help but hear conversations the other might have with visitors.

Rooms for two or more persons bring about a different set of problems. Again privacy seems to be the main concern and many say that they would rather stay in bed than be observed as soon as they get up (Ogasawara 1985: 98). In these rooms, too, architectural conditions confine the personal freedom of inmates. If we agree with Goffman (1973: 48–50) that a certain amount of space is part of the outer signs of self-

determination, this space is confined to one's own bed. In this context, the physical condition of the person concerned is of great importance. The worse the condition, the smaller the chance of being able to find and keep one's own place. Lovers cannot be alone since double rooms are only for married couples. Inmates feel observed and controlled around the clock by other inmates and by the staff. This was drastically expressed by an inmate who said that "one does not even have enough freedom to hang oneself" (*kubitsuru jiyū mo nai*) or by another who said that "one does not even have enough freedom to jump out of the window" (*mado kara tobioriru jiyū mo nai*) (Ogasawara 1985: 89).

Architectural features become perceptible over and over again, every day and every moment. Changing diapers in the presence of other inmates is a routine that new inmates get used to rather slowly and reluctantly. Statements such as "if I become incontinent I would want to die" (*omutsu ni naru made ni shinitai*), or "diapers that change the heart" (*kokoro o kaeru omutsu*) (ZSFKK 1986: 199) illustrate the fear of requiring care concerning elimination. While in the family it could be considered a private matter, in a nursing home it becomes public. In this way, the architectural conditions turn formerly non-public matters into public controllable ones. Regression, which is partly provoked by this process, promotes *dementia senilis*, which has been interpreted as a psychological escape reflex (Nakagawa 1979: 34). Goffman (1973) emphasizes the de-identifying effects of a total institution in the sense of disturbed privacy and the loss of what he calls "identity equipment". Other researchers have found that an activity such as changing diapers might further the gradual identification of all inmates – including those who are still capable of taking care of their physical functions themselves – with aging and decay. This identification pressure – reinforced by the architectural conditions – not only expresses itself through daily confrontations with the aging and decay of other inmates, but also through the continuous concentration of the personnel on care and treatment (Tobin and Lieberman 1976: 163). Ruth Campbell suggested that this is even more true in Japan where a strong acceptance of dependency exists (1984: 89).

Ikuta Masayuki and Fujita Ayako (1986) have tried to identify the problems in regard to the treatment of senile inmates as opposed to those who they classified as "normal" (*seijō-na rōjin*).[6] There are a few interest-

[6] Apart from the fact that the sample of 96 "senile" inmates is rather small, there are a few other problems involved in such a study. First of all, Ikuta and Fujita do not describe the criteria according to which they have categorized the people in the study. Second, a polarized categorization is always problematic since differences are gradual and people shift slowly from one stage to the other.

ing points the authors make based on their data. Inmates classified as "normal" tend to mobilize their opposition and protest against the personnel more often and in a more radical manner than senile inmates do. They ignore orders of the personnel, react negatively toward the personnel, show less willingness to cooperate in general, and in many cases distrust the staff. Their behavior is also found to be much more egoistic than that of senile inmates. Inmates classified as "senile" oppose the personnel to a lesser degree. They rather wander or loaf about, are unable to differentiate their own belongings from those of others, disturb the sleep of other inmates, and sometimes frighten them. Among those classified as "senile", there are more inmates who wish to return to their family. To a similar degree, both groups oppose the regulations of a nursing home by not eating anything or eating only food they like, by refusing to bathe, or by refusing to change their clothes. All traits of opposing behavior are passive and appear in form of refusal of a specific activity or treatment (Ikuta and Fujita 1986: 105–117).

2.5 Managing time

Restrictions pervade the daily timetable of a nursing home, as I will investigate in this paragraph. A day in a nursing home is regimented according to a timetable that not only normalizes their activities and treatment, but also prescribes in which order, at what time, and for how long the personnel is obligated to perform the treatment and at what time the inmates are allowed to perform certain activities. Ideally, all activities of the inmates are organized in this way by the institution. The schedule for inmates is often determined by the convenience of the personnel who have to perform many activities. Furthermore, acoustic signals and announcements over loudspeakers are also common. To signal the start of new activity a short piece of music is played before an announcement is made, such as "Let's get up and start a fresh day!" or "Ah, today was another good day!". If they are not orders, acoustic signals are often permissions for activities, e.g., drinking alcohol, which the elderly would not normally be able to do without asking for permission (Hata 1985: 86).

The acoustic ritualization of activities spares the personnel from having to personally give permission or orders. In this way, the authority that gives the order becomes anonymous, and to a far greater degree limits the inmates' possibility of opposing the order than would be possible if the authority were personalized. Foucault suggests that power is nothing that can be possessed by one group or an individual, but rather a certain interrelation of forces or a name that is given to a complex strategic situation in society (1977: 114). In this model of power, there is no sover-

eign above society. Instead, there are stable constellations of strategies that operate as social hegemonies either in the form of institutions or of implicit dispositions which form self-evident orientation for the self-definition of individuals and their activities. This becomes obvious when we look at a schedule of a nursing home where most of the daily occurring activities are regulated to a great extent by a fixed timetable (see Table 7).

Table 7: **Regulated activities and treatment according to time (%)**

Activity	Special nursing home for old people (*tokubetsu yōgo rōjin hōmu*)	Nursing home for old people (*yōgo rōjin hōmu*)
breakfast	98.9	98.8
lunch	98.9	98.9
dinner	98.1	98.9
bathing	95.5	95.2
excretion care	87.3	30.2
gymnastics	86.3	93.4
going to bed	81.3	91.0
getting up	70.2	93.0
rehabilitation	66.1	12.8
snack	60.7	32.6
club activities	60.1	61.1
washing themselves	57.3	28.1
cleaning	37.5	55.3
other activities	8.7	7.0

Source: ZSFKK (1986: 105, Table 3/22).

Timetables of nursing homes are commonly discussed in regard to dinner time (which many feel is too early), the frequency of bathing (which is said to be too low) and to excretion care (*haisetsu kaijo*). In most nursing homes, dinner is served between 4:30 p.m. and 6 p.m. In about half of the nursing homes, it is served before 5 p.m. Serving dinner at such an early hour has been criticized, but reasons given for this regulation only make evident how the timetable, in relation to other conditions, allow for no other alternatives. First, the gap between the low number of personnel and the relatively high number of inmates makes it impossible to begin dinner at a later time. Second, cleaning up after dinner takes a considerable amount of time, and again, since the number of staff is insufficient, many of those who are meant to care exclusively for inmates perform

other work, e.g., cleaning up after dinner as well (ZSFKK 1986: 165–167). Some homes, however, have found their own solution, such as a buffet that allows more flexible work time for the personnel and enables inmates to choose what and how much they would like to eat. Even improvements like these, however, disguise the diversity of individual needs. Some of the inmates suffer because they cannot eat anything for thirteen hours between 7 p.m. until 8 a.m., while others would in fact rather start at 4 p.m. because they need help with eating and therefore take longer (Ogasawara 1985: 56).

As mentioned above, excretion care is one of the central problems in the treatment and care of the institutionalized elderly and for the personnel. In regard to excretion care, too, the necessity to adapt individual needs to a strict timetable causes great problems and expresses the "dehumanizing" or "depersonalizing" aspects of the institution (Tobin and Lieberman 1976: 4). To adjust their most basic needs to a timetable made by others leads them feel "treated as objects" (*mono toshite atsukau*) (Yoshida 1980: 22), and many agree that the quality of treatment cannot be exclusively measured by the frequency at which diapers are changed.

Bathing is the most time-consuming care activity that involve personnel help, and bathing days are limited according to the number of staff available. According to national norms, inmates of nursing homes must take a bath more than twice a week. However, according to a national survey in 1977, in every third institution, bathing took place only once a week, and in only half of all homes twice a week. In 1982, almost all *tokuyō* inmates took baths twice a week and in 80% of *yōgo* twice to four times a week. In every fifth *yōgo* however, bathing was only possible once a week. Again, the number of "bathing days" does not necessarily inform us about how often inmates took a bath. In homes with four "bathing days", inmates might be allowed to take a bath only twice a week (ZSFKK 1986: 163). Although taking a shower or washing would take less time and could be done with less personnel, inmates do not consider that a welcome solution since bathing is one of their favorite activities (ZSFKK 1986: 164).[7]

The administrative regulations through control, discipline, and therapy as well as through space and time organize life in a nursing home. For both inmates and staff, life in a nursing home appears to be one "without

[7] Taking part in clubs for the elderly or other individual leisure activities are rather rare. Both became part of the programs which aim at the socialization of the nursing homes and are treated extensively in Linhart's *Organisationsformen alter Menschen in Japan* (1983) and Ben-Ari's *Changing Japanese Suburbia: A Study of Two Present-day Localities* (1991: 125–190).

the right to vote" (*senkyoken no nai seikatsu*), as one of the overworked *ryōbo* said (ZSFKK 1986: 200).

2.6 Conclusions

I have described two types of nursing homes, *tokuyō* and *yōgo*, focusing on their organizational structure. Both institutions, although to differing extents, constitute a rather isolated *Lebenswelt* through strict regulations of time and space, which in turn creates an atmosphere that seriously limits the sphere of action of inmates, intrudes on their privacy, and involves other restrictions of their personal freedom. Inmates deal in various ways with these restrictions and develop different strategies of adaptation and resistance, depending on a number of factors, such as their idea of life in a nursing home before their institutionalization, their reasons for entering a nursing home, the degree to which the decision to continue their life in a nursing home is their own, how they felt about their institutionalization when they entered, and their physical and mental constitutions.

It is precisely the question of strategies of adaptation and resistance that divides academic writing on institutions, methods of analysis, and arguments as well as proposals for reform. The first type focuses on the institution itself, its organizational structure, and its problems and explains the effects of institutionalization on inmates. The weakness of this approach lies in its failure to take into account the reasons for institutionalization and the life histories of inmates prior to their institutionalization. As I have shown, despite their heterogeneity, inmates of *tokuyō* and *yōgo* share a number of characteristics that differentiates them from other elderly who need care. These characteristics include specific features of their life histories, of their personalities and their social backgrounds, their material situations, their physical and mental conditions, and their familial situations, all of which make institutionalization in a nursing home more likely than for other elderly who do not share these characteristics.

The second methodological approach, which is historically speaking a newer one and which appeared in reaction to the first one, puts these before-mentioned features into the center of analysis and tends to underestimate institutional elements in the narrow sense such as the regimentation of time, of activities and treatment, and the regimentation of space, which structures the options for interactions among inmates as well as between inmates and staff. A closer look at the organizational structure of nursing homes, however, shows that such institutional elements have a significant influence on the lives of inmates as well. I have tried to utilize both approaches.

Although it is important to take a few considerations into account – differences between inmates and regional differences between institutions and in the availability of community care services – we can draw the following conclusions: First, the probability of entering a *tokuyō* or a *yōgo* in old age is twice as high for women than it is for men and this gender gap increases with age. Second, to live alone or to have no child(ren), partner, friends, or close acquaintances in old age increases the probability of institutionalization in a *yōgo*. Third, a weak physical constitution, an insecure social situation, and especially poor living conditions increase the chances of institutionalization in either of the nursing homes, although the probability of entering a *tokuyō* when in poor physical health is clearly higher than entering a *yōgo*. Fourth, a stay in a hospital over a long period of time, together with the deterioration of physical condition, increases the probability of institutionalization in a *tokuyō*. Last, we have to keep in mind that it is very rare that only one factor leads to institutionalization. Rather, two or more factors have to come together to lead to institutionalization in a *tokuyō* or a *yōgo*.

Since the beginning of the 1980s, no new *yōgo* have been built, but *tokuyō* increased by about 120 a year (see Table 8).

Table 8: **Number of institutions, personnel, and inmates (1965–1988)**

Year	Institutions		Personnel		Inmates	
	yōgo	*tokuyō*	*yōgo*	*tokuyō*	*yōgo*	*tokuyō*
1965	702	27	— *	—	—	—
1970	810	152	10,466	4,197	60,453	11,573
1975	934	539	14,798	18,005	67,848	43,207
1980	944	1,031	18,318	37,037	66,395	79,499
1981	945	1,165	18,511	41,258	65,944	88,361
1982	946	1,311	18,654	46,111	66,110	97,919
1983	945	1,410	18,560	49,461	66,552	105,459
1984	946	1,505	18,694	52,766	66,707	111,908
1985	944	1,619	18,791	57,262	66,452	118,959
1986	944	1,731	18,686	61,110	66,136	126,332
1987	945	1,855	18,788	65,398	65,826	134,461
1988	945	1,995	18,812	71,248	65,480	143,496

Note: * Up to 1969, neither personnel nor inmates were included in the surveys.
Source: ESKS (1987: 348); KARGL (1987: 94, 375); own calculations based on SŌMUCHŌ TŌKEIKYOKU (1971–1990).

Existing institutions were not extended and the elderly reacted in the following way. Those elderly who had financial resources at their disposal and who decided to enter an institution despite good physical condition, tended to choose a privately-run, more expensive but less restrictive, nursing home rather than a public *yōgo*.

Despite the vehement criticism of the *tokuyō*, which allow hardly any privacy due to their strict regulation of space and time, there is an increasing demand for institutions for the elderly with quasi-medical services which cannot be provided by the family.

3. "Community Care" in Japan

3.1 Preliminary remarks

Although Miura Fumio (1982: 208) claimed in 1982 that the institutions of social welfare had come into being according to social needs and stated optimistically that they would change according to their social function and role, it would be more appropriate to rephrase his "social needs" as "financial considerations of the Japanese government". Only in institutions does the state bear the full cost of caring for dependent adults. From the point of view of public expenditure, institutions are by far the most expensive form of care. These financial considerations ironically concur with two other observations which seem to point in the same direction: First, there is a common wish among Japanese elderly to enjoy old age in their own homes in familiar surroundings and with their families (*rōgo o wagaya de*). Second, they are supported by the criticism of the existing nursing homes as described above.

I will base the following description and critique of the Japanese community care system for the elderly on the assumption that care or nursing is not just one of peripheral phenomena of the social order, but rather a "central crossroad of capital and gender" as defined by H. Graham (1983: 30).

3.2 The socialization of social welfare institutions for the elderly and "community care"

Shisetsu no shakaika [socialization of institutions] or *shisetsu shogū no chiiki-ka* [localization of institutional care] stand for a social policy that had been propagated and slowly taken up by the Japanese administration during the mid-1980s. One of their main foci was smaller collective units, e.g., regions, and the inward-orientation of these units. Within the context of

an explicit de-institutionalization of old age, this liberates the state to a considerable extent from its welfare responsibilities and leaves it to smaller collective units to feel solidarity with those in need, i.e., the indigent elderly. The Japanese state took up this policy at a time when per capita expenses for social security were significantly lower than those of other post-industrial countries.[8] Although in Japan expenses for social security rose from ¥ 288,000 to ¥ 333,000 between the years 1980–1982 and 1985–1987, the per capita expenses equaled only one-third of the Swedish expenses and about half of the French expenses. Even the per capita social security expenses of the United States, Italy, and Great Britain during 1985–1987 with 59%, 29%, and 17%, respectively, were higher than those of Japan (YANO TSUNETA KINENKAI 1990: 325).

Another focus was the restabilization of the social status of women and their place at home, since caring for the elderly (and others in need), whether it is paid or unpaid, whether it takes place inside the boundaries of an institution or in a private home, whether it is done in private or in public, is first of all women's work. Most of the nurses, *ryōbo*, or home-helpers (*hōmu herupā*) are women. Women work in day-care centers. Women organize themselves in volunteer groups and prepare and deliver food. Nursing homes, hospitals, and private homes are cleaned by women. Two-thirds of the personnel of nursing homes are women. What J. FINCH and D. GROVES (1983: 494) concluded in regard to the United States is also true for Japan: "In practice community care equals care by the family, and in practice care by the family equals care by women".

In 1982, the International Association of Gerontology (IAG) – a worldwide organization of scientists who study old age – invited gerontologists from all over the world to develop and formulate guidelines for social policy for the elderly. Among other important recommendations, the IAG insisted that besides rehabilitation centers, day-care hospitals, day-care centers, nursing homes, and institutions for long-term care, comprehensible systems must be implemented to enable the integration of medical and social services as well as of the family and other people and organizations. In this context it should be brought to the attention of decision-makers that traditionally, caregivers are women. On the basis of the changes in the status of women in society, it is necessary to prepare women *and* men for the tasks of caregiving and nursing (IAG 1982: 82). What had been suggested by the IAG was labeled "community care" and taken up by Japanese administrators as well. Gillian PASCALL (1986: 86) comments as follows:

[8] As calculated from the GNP, expenses for social security in 1985/1987 were 8% lower than during the years 1980–1982.

> An ideology that romanticizes caring for the elderly and handicapped seems more improbable than one that romanticizes motherhood. However, the idea of "community care", while less developed than romanticized notions of motherhood, fulfills a very similar function in legitimating minimal state activity in the private sphere of home and family. It also disguises minimal men's activity. […] The notion of "community care" belongs to social policy documents rather than to women. It does not have the widespread allegiance of "maternal deprivation"; nor is it in any sense "needed" to persuade women to look after dependent relatives and friends. Its use has been in justifying low government spending on the elderly and handicapped, and in disguising policies whose real effects are to burden and isolate individuals. […] An expression which appears warmly to encompass everyone disguises the fact that, whether as paid workers or as relatives, it is generally women who do the "caring".

Despite the fact that the Japanese state never really developed a system of welfare institutions for the elderly that could be compared in both quantity and quality to those of Germany or other Western European nations, it took over the rhetoric of "community care" and further radicalized the situation for those who were in need of care as well as for non-professional caregivers in families. It thus restabilized the view that there is no alternative to either total institutions or women caring themselves.

> It does seem necessary to explain the widespread failure to "share" care, to support women who do caring work, to found any real middle way between the total institution and the woman alone. A conspiratorial interpretation would suggest that such policies are "meant" to keep women in their place. But the idea of the state as a coherent entity with a coherent policy on women's place is not very compelling. I would argue that policies for "sharing" care involve a threat to traditional notions of the family and woman's role, and that the fear of undermining women's commitment to caring work lies near the surface. The quantity and cost of such work, especially in an era of increasing dependency, must reinforce wariness about drawing it into public expenditure. Thus, the interest of government departments in maintaining traditional family patterns is a pervasive underlying element, if it does not amount to a policy for women (Pascall 1986: 96).

Community care programs should on the one hand dissolve the polarity formed by the state and the family, and on the other hand develop a social

network that integrates all members of a regional community in one way or another. Consequently, information pamphlets of local governments of rural municipalities and prefectures appeal to the solidarity of the community, thus attempting to mobilize a solidarity that restabilizes society as a whole, since "the more people work themselves up to a rage in regard to conflicts that developed out of the community, the less they will question the basic institutions of this society" (Sennett 1983: 390). A look at the information pamphlets on the policies of a city or prefecture can further illustrate how appeals to the solidarity of smaller collectives in society function. Two examples, of which one is taken from the "Charter of Kanazawa's citizens" (*Kanazawa shimin kenshō*) and the other from the "Charter of Yashiro's citizens" (*Yashiro jūmin kenshō*), make the following appeals:

> We who love Kanazawa, […] let's hold out our hands to each other in order to build our city" (Kanazawa-shi Fukushi-bu 1987: 5).
>
> We, citizens of Yashiro, let's build families full of cheerfulness and warmth. In mutual agreement and friendship we shall do our best to create a region full of love and order with the youth who carries the future on their shoulders. We shall support their dreams (Yashiro-chō 1974: 1).

The pamphlet of Yashiro even communicates the hope that "social solidarity" will increase the sense of morals (*dōtokushin*) (Yashiro-chō 1974: 18). A myriad of other examples could be quoted which illuminate the rhetoric of "community care" for the elderly by referring in specifically appealing ways to the family, regional solidarity, and the education of the region's youth. In regard to the education of youth, the then Prime Minister Kaifu Toshiki stated in a speech given in parliament on March 2, 1990:

> The stagnating birth rate poses a lot of questions concerning the future of this country. Focusing on tomorrow, we must strengthen in our youth the wish to have children (Arioka 1990: 51).

Pointing in the same direction, the president of the Japan Federation of Employers' Associations, Suzuki Eiji, went a step further and suggested that men should cut their time playing golf or mahjong and instead spend more time with their wives (Arioka 1990: 51). These thoughts are commonly underpinned by forecasts on the number of elderly, which for 2015 will reach about a quarter of the total population (Sōmuchō Tōkeikyoku 1989: 25). Hence, the view that Japan's youth should procreate at a higher rate in order to balance the population pyramid is widely shared among policy-makers (Eijingu 1989: 2). Women themselves, however, have differ-

ent views of procreation. In a 1990 *Mainichi Shinbun* survey, 80% of 5,000 women said that they consider child bearing a private matter and that they do not see a reason to change their opinion in response to the government's policy (Arioka 1990: 52).

While "institutionalized social welfare" had dominated during the 1970s, Japan's social policy of the 1980s shifted its priority toward community care or, more precisely, toward "welfare at home" (*zaitaku fukushi*). The ambivalence of this development becomes clear when considering that already at the beginning of the 1980s, the building of *yōgo* stagnated, while community care programs were not yet fully organized but only propagated as a cheaper solution. From a strategic point of view, this development seems to complement policies taken up in another area of social welfare, namely welfare for the disabled. Until 1984, the budget for the welfare of the disabled had been increasing every year. In 1985, however, the budget was abruptly cut based on the suggestions of the Commission on Administrative Reform to the Prime Minister. These suggestions included the following paragraph:

> […] [W]elfare measures must be reduced to the minimum level, by retaining only those measures that are truly indispensable for the welfare of the population, while fully safeguarding the private sector's free activities in the field of welfare services (Nishida 1991: 139).

The cuts concerned first of all institutions such as rehabilitation centers and other institutions for stationary care. The turn concerning welfare institutions for the disabled complements the propagation of community care programs for the elderly: away from institutions and toward care services that can be performed at home. Despite extensions of community care programs and facilities, the total budget was cut considerably. Instead of setting new priorities for social welfare for the disabled, the government sought to cut the budget and reorganize it to the advantage of those areas which support "independence and self-help" (Nishida 1991: 143). Furthermore, it slashed government outlays for the welfare of the disabled, mainly those for facilities and institutions, while forcing local governments to bear greater financial burdens for ensuing their welfare (Nishida 1991: 150).

Private initiatives were welcomed in the welfare for the elderly sector as well. Many of them met the criteria for relatively open institutions and offered quite good services. However, their geographic distribution was uneven, with a good supply in urban areas and a poor supply in rural areas where they are needed most because of the unbalanced dissemination of the elderly (see Lützeler (1997) for demographic details). Further-

more, they failed to provide services at a price that was affordable for many elderly and very often only accepted elderly in good physical condition (GETREUER-KARGL 1990b: 157). Organizations such as Kōseikai in Tōkyō, which built apartments especially equipped for elderly, received ¥ 10 million at first and then ¥ 10,000 to ¥ 20,000 per month. Similar organizations required the entire inheritance in case the person concerned dies (KIM 1991: 14).[9] In a survey on behalf of the then Prime Minister Takeshita Noboru, more than half of the respondents said that the high costs of private institutions would be unfortunate, while only a fifth said that they met their needs (NAIKAKU SŌRI DAIJIN KANBŌ KŌHŌSHITSU 1987: 150–151). That – as late as in 1987 – two-thirds of the respondents in another survey held in Saitama Prefecture did not even know what "community care" was must be taken as a further indicator for the insufficiency of the system at that time (NAIKAKU SŌRI DAIJIN KANBŌ KŌHŌSHITSU 1987: 212).

This policy was not specifically Japanese. The Italian movement *Psychiatria Democrazia*, which was organized in 1973, was probably the first organization that called for the opening of total institutions (there, psychiatric wards) and served as a model for many other similar movements in other European countries with similar institutions (METZGER 1980: 825). The governments of Great Britain and the United States also propagated community care at a time when social welfare networks were not sufficiently developed (SCULL 1988: 80). The same is true for former West Germany where the construction of new nursing homes slowed down considerably after the implementation of new laws concerning social welfare for the elderly which, on the one hand, humanized the existing institutions, but, on the other hand, almost stopped the creation of new beds (HUMMEL 1982: 45). Swiss gerontologists developed a model for the *nouvelle geriatrie* and demanded that geriatric hospitals must be "open to the outside world, a part of intensive collaboration of physicians, a network for care at home, other social and medical organizations, and prevention policies" (GILLIAND and FRAGNIÈRE 1988: 25–26).

[9] On a similar program in the city of Musashino (suburban Tōkyō), see LINHART (1995: 36–37).

3.3 Socialization policies and programs

Ambulant care services that were offered at *tokuyō* and *yōgo* were meant to open up these institutions. Other services were provided for use at home to postpone institutionalization as long as possible. Since 1979, day services (*dē sābisu*) were offered in day-care centers which were usually built as extensions of *tokuyō* or *yōgo*. So-called short stays (*shōto sutei*) at nursing homes were possible for over-64-year-olds who needed care for up to seven days and had to be applied for at the local bureau for social welfare. Costs for a short stay varied depending on whether the person was put there for "private" (more expensive) or "social" reasons. Social reasons included illness of the caregiver, births, weddings, funerals, accidents, and responsibilities at school. All other reasons, including the need for the caregiver to rest, were considered private (KKSFK 1988: 25). However, in 1989 there were still only 4,274 beds available for this service. Short-stay services included bathing, eating, physical training, or training for caregivers on how to take care of elderly at home. In 1987, there were 57 *tokuyō* that offered training on caring for the senile elderly. The training is done by *ryōbo* (Kōseishō 1988: 290).

Such services as cleaning of laundry, food catering, and bathing were also provided at home (Getreuer-Kargl 1990b: 57; Oberländer 1997: 96–97). They were, however, not available on call but only on certain days at certain times. For example, municipal *tokuyō* and *yōgo* in the city of Itami offered food catering only on Tuesdays and bathing only on Fridays between one and three o'clock (Itami-shi 1986: 9). Apart from the inconvenience of limited availability, day-care centers also presupposed that there was a person available to take the elderly from their home to the institution and back. It goes without saying that this was considered the responsibility of female caregivers and thus relieved them only temporarily and partially.

Short-stay services presented quite a few problems to both the institutions and the people at home involved. Table 9 shows which were the main problems when formerly relatively closed institutions such as *tokuyō* and *yōgo* tried to establish themselves as day-care centers. The most pressing problems were the lack of staff, of financial resources, and of material equipment. These insufficiencies are seen most clearly in the context of bathing or rehabilitation training but also when means of transportation were needed.

Table 9: **Problems concerning the socialization of nursing homes (%)**

Nature of problems	Special nursing home for old people (*tokubetsu yōgo rōjin hōmu*)	Nursing home for old people (*yōgo rōjin hōmu*)
a number of problems	25.0	45.0
lack of personnel	24.3	40.0
overwork	8.1	10.0
lack of financial resources	29.7	6.0
lack of material equipment	10.8	24.0
accidents	2.7	–
traffic/transport	–	6.0
training of volunteers	8.1	–
lack of professionals	8.1	–
other	8.2	14.0

Source: Miura (1982: 257, Tab. 3/25).

The policies for the socialization of nursing homes as described above did not have a significant effect on those who were already institutionalized, but they bore the potential to postpone the institutionalization of other elderly.

Since 1971, homehelpers could be requested if the elderly person at home was physically or mentally disabled or the caregiver did not feel able to continue at home alone. The maximum amount a homehelper could be serviced was two to three hours on not more than two days of a week between 9 a.m. and 5 p.m. (KKSFK 1988: 21). Until 1982, only households with low incomes were qualified to apply. Since then, such services could be requested for a rather low fee of about ¥ 650 per hour (Kōseishō 1990: 237). However, there were far too few homehelpers available (Hosaka 1988: 56). In 1987 there were 17,486 homehelpers for 60,237 households with elderly and 22,539 other households that were qualified to apply for them (Sōmuchō Tōkeikyoku 1989: 591). In 1989, their number had doubled and reached 31,405 (Kōseishō 1990: 236). Bedridden elderly could lease special beds and mattresses, bath tubs, air cushions against bedsoreness, urinals, emergency telephones, and other expedients for daily use.

Social Welfare Centers for the Elderly (*rōjin fukushi sentā*) had three functions. They informed the elderly of the region on all sorts of questions, advised them on health issues, and offered facilities for recreation. In 1987, there were 1,884 of these centers in operation (Kōseishō 1988: 236).

Volunteer organizations mainly consisting of middle-aged women offered similar services but had difficulty recruiting new members. In

1988, 3.39 million people were active in various ways in volunteer organizations for the elderly. The most well known were the "Visitors of Friendship and Love", the "Group to Create a Better Life for the Aged", as well as a group called "Tearing Down the Wall between Able-bodied People and the Disabled" (Nakamura 1991: 14).

4. Concluding Remarks

In this paper I have attempted to describe the turn in social policies for the elderly in Japan that took form during the 1980s prior to the "Gold Plan" and the introduction of the long-term care insurance. The announcement of the Commission on Administrative Reform in 1983 that national social policies were to be reduced to a minimum and at the same time private initiatives and activities were to be supported was ironically met by the severe criticism of *tokuyō* and *yōgo* articulated at academic and administrative meetings and in discussions among the personnel and inmates of the existing institutions for the elderly as described in the first part of this article. The rapidly rising costs for the care of the elderly and the rising number and proportion of old people brought about a new orientation of the bureaucracy in dealing with financial and social questions. This orientation turned into the aggressive revival of the role of the family in regard to social policy for the elderly.

Public care institutions for the elderly, as the *tokuyō* and *yōgo* depicted in this article, were thus increasingly criticized. This critique was superficially co-opted by political decision-makers, but did not for another ten years lead to substantial reforms of the institutions in matters that went beyond superficial rearrangements. Improvements by way of government interventions were of a gradual nature and could only be recognized on the level of organization. Instead, the criticism served as a powerful rhetorical tool for encouraging community care programs which were cheaper for the state, and put the financial burden on smaller political units, such as prefectures and municipalities, as well as on the families who pay for these services. The co-option of the above-mentioned critique allowed decision-makers to demonstrate moral superiority and thus enabled them to organize their own rejection of the old institutions in contrast to the enthusiasm with which they propagated the new system.

The propagated community care programs did hardly take any form at all, although there were significant regional differences. Interaction between institutions and communities barely took place and certainly had no influence whatsoever on the isolated *Lebenswelt* of the inmates.

The half-hearted and partial realization of these programs did not go hand in hand with the reform of existing institutions. Especially in regard to the isolating character of *tokuyō* and *yōgo* there were hardly any improvements for the institutionalized elderly.

Another alarming feature of the developments during the 1980s and their consequences is the fact that most of the caregivers were women. Through community care programs or rather the lack of their functioning, women's status as caring, nursing, and in any case emotionally, privately, and socially active persons was reinforced. This can be seen as a side effect of the retreat of the Japanese state from its responsibility to take care of its citizens, therefore encouraging private initiatives and activities.

The smaller political entities – prefectures and municipalities – reacted with a massive propagation of a common feeling of solidarity for the welfare of the community. For the families, this development meant that women were more or less left alone with the problems and difficulties that caring for elderly people involved.

References

Anton, Karen Hill (1989): Aging Grace. In: *PHP Intersect* July, pp. 35–38.

Ariès, Philippe (1980): *Geschichte des Todes*. München: Deutscher Taschenbuch Verlag [Orig.: L'homme devant la mort; 1978].

Arioka, Jirō (1990): Kazoku no yōsei de nyūsho chōkika mo [The Possible Extensions of Institutionalization because of the Needs of the Family]. In: *Asahi Shinbun* 30.03.1990, p. 4.

Asahi Shinbun (27.09.1990, Sapporo edition): Sapporo de shi no rinsho kenkyūkai [Society of Clinical Research of Death in Sapporo].

Asano, Hitoshi (1975): Rōjin hōmu shokuin no shokumu naiyō [Job Specifications of the Personnel of Nursing Homes]. In: *Shakai Rōnengaku* 1, pp. 132–138.

Asano, Hitoshi (1977): Rōjin gurūpu wāku [Nursing Group Work]. In: *Shakai Rōnengaku* 5, pp. 14–28.

Ben-Ari, Eyal (1991): *Changing Japanese Suburbia: A Study of Two Present-day Localities*. London and New York: Kegan Paul International.

Brody, Elaine M. (1977): *Long-term Care of Older People*. New York: Human Sciences Press.

Campbell, John Creighton (1979): The Old People Boom and Japanese Policy Making. In: *Journal of Japanese Studies* 5, 2, pp. 321–357.

Campbell, Ruth (1984): Nursing Homes and Long-term Care in Japan. In: *Pacific Affairs* 57, 1, pp. 78–89.

Dahms, Wolfgang (1985): Die subtile Macht der Architektur über den Menschen. In: Dane, Gesa (ed.): *Anschlüsse: Versuche nach Michel Foucault.* Tübingen: edition diskord, pp. 33–38.

Douglas, Mary (1991): *Wie Institutionen denken*. Frankfurt am Main: Suhrkamp [Orig.: How Institutions Think; 1986].

Eijingu (1984): Kōreika to joseitachi [Aging and Women]. In: *Eijingu* 1, pp. 38–41.

Eijingu (1989): Rōjin taisaku ni tsuite no gimon [Doubts about the Policy for the Elderly]. In: *Eijingu* 2, p. 2.

Elias, Norbert (1982): *Über die Einsamkeit der Sterbenden*. Frankfurt am Main: Suhrkamp.

ESKS (= Eijingu Sōgō Kenkyū Sentā Nenkan Henshū Iinkai) (1987): *Kōreika shakai kiso shiryō nenkan* [Yearbook for Basic Materials on the Aging Society]. Tōkyō: Eijingu Sōgō Kenkyū Sentā.

Finch, J. and D. Groves (ed.) (1983): *A Labour of Love: Women, Work and Caring*. London: Routledge & Kegan Paul.

Foucault, Michel (1976): *Überwachen und Strafen. Die Geburt des Gefängnisses*. Frankfurt am Main: Suhrkamp [Orig.: La naissance de la prison; 1976].

Foucault, Michel (1977): *Sexualität und Wahrheit: Der Wille zum Wissen.* Frankfurt am Main: Suhrkamp [Orig.: Histoire de la sexualité. La volonté de savoir; 1976].

Frühstück, Sabine (1991): *Von institutioneller Pflege zu Community Care*. Wien: Universität Wien [Unpubl. M.A. thesis].

Getreuer-Kargl, Ingrid (1990a): Alt-Sein. In: Linhart, Ruth and Fleur Wöss (ed.): *Nippons neue Frauen*. Reinbek: Rowohlt, pp. 152–169.

Getreuer-Kargl, Ingrid (1990b): *Ende der Dynamik? Eine Expertenbefragung zur Alterung der japanischen Gesellschaft.* Wien: Institut für Japanologie (= Beiträge zur Japanologie; 28).

Gilliand, Pierre and Jean Pierre Fragnière (1988): *Dejà une geriatrie nouvelle.* Lausanne: Editions Réalités Sociales.

Goffman, Erving (1973): *Asyle. Über die soziale Situation psychiatrischer Patienten und anderer Insassen*. Frankfurt am Main: Suhrkamp [Orig.: Asylums: Essays on the Situation of Mental Patients and Other Inmates; 1961].

Graham, H. (1983): Caring: A Labour of Love. In: Finch, J. and D. Groves (ed.): *A Labour of Love: Women, Work and Caring*. London: Routledge & Kegan Paul, pp. 13–30.

Hanmer, Jalna and Daphne Statham (1988): *Women and Social Work*. London: Macmillan Education.

Hata, Hiroaki (1985): *Rōjin to wa nan da! Shitsurei na* [What is an "Old Person"? How Rude!]. Kyōto: Mineruba Shobō.

HAYASHI, Tamako and Reiko ARIZUKA (1977): Rōjin hōmu no menseki henka to isshitsu no kōsatsu [Spatial Changes in Nursing Homes and the Examination of One Room]. In: *Shakai Rōnengaku* 6, pp. 50–60.

HONMA, Shingo (1985): Dōkyo setai ni okeru rōjin, kosedai no keizaiteki kyōdō izon kankei ni tsuite [On Economic Cooperation and Dependence of Parents and Child Families Living in the Same House]. In: *Shakai Rōnengaku* 22, pp. 42–62.

HOSAKA, Tetsuya (1988): Public Assistance and Welfare Services. In: *About Japan Series* 17, pp. 45–57.

HUMMEL, Konrad (1982): *Öffnet die Altersheime*. Weinheim and Basel: Beltz Verlag.

IAG (= International Association of Gerontology) (1982): Foundations of a Policy for the Aged in the Eighties and Beyond. In: *Shakai Rōnengaku* 16, pp. 78–85.

IKUTA, Masayuki and Ayako FUJITA (1986): Tokubetsu yōgo rōjin hōmu ni okeru chihōsei rōjin no jittai to sono shogū ni tsuite [On the Situation of Demented Elderly in Special Nursing Homes and Their Treatment]. In: *Rōjin Fukushi Kenkyū* 10, pp. 105–117.

ISHII, Takemochi (1991): Growing Old. In: *Look Japan* 37, 421, pp. 10–11.

ITAMI-SHI (1986): *Rōjin hōmu nyūkyo no annai* [Admission Guide to Nursing Homes]. Itami: Itami-shi.

JONES, Kathleen and A. J. FOWLES (1984): *Ideas on Institutions*. London: Routledge & Kegan Paul.

KANAZAWA-SHI FUKUSHI-BU (1987): *Kanazawa no fukushi* [Welfare in Kanazawa]. Kanazawa: Kanazawa-shi Fukushi-bu.

KARGL, Ingrid (1987): *Old Age in Japan: Long-term Statistics*. Wien: Institut für Japanologie (= Beiträge zur Japanologie; 24).

KIM, H. Min (1991): Providing Freedom for the Elderly in Japan. In: *Japan Times Weekly* 31, 7, p. 14.

KKSFK (= Kumamoto-ken Shakai Fukushi-ka Kōreisha Taisaku-shitsu) (1988): *O-tassha desu ka* [Are You in Good Health?]. Kumamoto: Kumamoto-ken Shakai Fukushi-ka Kōreisha Taisaku-shitsu.

KŌSEISHŌ (1988): *Kōsei hakusho Shōwa 62-nenban. Shakai hoshō o ninau hitobito – shakai sābisu wa kō tenkai suru* [Welfare Ministry White Paper for 1987. People Who Bear the Destiny of Social Security – Social Service Will Develop in this Way]. Tōkyō: Kōsei Tōkei Kyōkai.

KŌSEISHŌ (1989): *Kōsei hakusho Shōwa 63-nenban. Arata-na kōreisha-zō to katsuryoku aru chōju fukushi shakai o mezashite* [Welfare Ministry White Paper for 1988. Toward a Fresh Image of the Elderly and a Longevity Welfare Society with Vitality]. Tōkyō: Kōsei Tōkei Kyōkai.

KŌSEISHŌ (1990): *Kōsei hakusho Heisei gan-nenban. Chōju shakai ni okeru kodomo – kazoku – chiiki* [Welfare Ministry White Paper for 1989. Chil-

dren, Family, and Locality in a Longevity Society]. Tōkyō: Kōsei Tōkei Kyōkai.

Linhart, Sepp (1983): *Organisationsformen alter Menschen in Japan*. Wien: Institut für Japanologie (= Beiträge zur Japanologie; 19).

Linhart, Sepp (1995): Die Alten Japans im sozialen Wandel der letzten fünfzig Jahre. In: Klose, Hans-Ulrich (ed.): *Japan ergraut.* Bonn: Vorstand der SPD, Referat Produktion und Vertrieb, pp. 17–40 (= forum demographie und politik; 8).

Linhart, Sepp (1997): Does Oyakōkō Still Exist in Present-day Japan? In: Formanek, Susanne and Sepp Linhart (ed.): *Aging: Asian Concepts and Experiences. Past and Present.* Wien: Verlag der Österreichischen Akademie der Wissenschaften, pp. 297–328.

Lützeler, Ralph (1997): Alte Menschen und ihre familiäre Situation in Japan: Demographische Entwicklung, ihre Ursachen und Implikationen für eine bedarfsgerechte Pflegepolitik. In: Oberländer, Christian (ed.): *Altern und Pflegepolitik in Japan*. Berlin and Tōkyō: Deutsches Institut für Japanstudien, pp. 15–54 (= Miscellanea; 15).

Metzger, Hans-Geerd (1980): Psychiatria democrazia und Psychoanalyse. In: *Psyche* 9, p. 825.

Miura, Fumio (1982): *Gendai rōjin hōmu-ron* [On Nursing Homes Today]. Tōkyō: Zenkoku Shakai Fukushi Kyōgikai.

Miura, Fumio (1987): *Zusetsu kōreisha hakusho 1987-nenban* [Illustrated White Paper on the Elderly]. Tōkyō: Zenkoku Shakai Fukushi Kyōgikai.

Miura, Fumio (1989): *Kōreisha hakusho* [White Paper on the Elderly]. Tōkyō: Zenkoku Shakai Fukushi Kyōgikai.

Naikaku Sōri Daijin Kanbō Kōhōshitsu (1987): *Yoron chōsa nenkan Shōwa 61-nenban. Zenkoku yoron chōsa no genkyō* [Public Opinion Yearbook 1986. Present Situation of National Public Opinion Surveys]. Tōkyō: Naikaku Sōri Daijin Kanbō Kōhōshitsu.

Nakagawa, Masateru (1979): Tokubetsu yōgo rōjin hōmu no genjō to mondaiten [Situation and Problems of Special Nursing Homes]. In: *Rōjin Fukushi Kenkyū* 4, pp. 21–37.

Nakajima, Michiko (1979): Ryōbo wa dare ga fuyō suru no ka [Who Supports Home Mothers?]. In: *Onna Erosu* 13, pp. 184–190.

Nakamura, Yoko (1991): Volunteerism Increasing Steadily but Some Are Still Fighting Stigma. In: *Japan Times Weekly* 31, 7, p. 14.

Nishida, Yoshiaki (1991): Reassessment of Welfare Services and the Trend of Welfare Policy for the Disabled. In: *Annals of the Institute of Social Science* 32, pp. 115–151.

Oberländer, Christian (1997): Altern und Pflegepolitik in Japan – Zur Pflege älterer Menschen in der Familie. In: Oberländer, Christian (ed.):

Altern und Pflegepolitik in Japan. Berlin and Tōkyō: Deutsches Institut für Japanstudien, pp. 55–106 (= Miscellanea; 15).

Ogasawara, Yasuhiro (1985): *Rōjin hōmu wa dare no mono?* [For Whom Are the Nursing Homes?]. Tōkyō: Akebi Shobō.

Ogawa, Naohiro (1990a): *Economic Factors Affecting the Health of the Elderly.* Tōkyō: Nihon University Population Research Institute (= NUPRI Reprint Series; 34).

Ogawa, Naohiro (1990b): *Population Aging and Its Impact upon Health Resource Requirements at Government and Familial Levels in Japan*. Tōkyō: Nihon University Population Research Institute (= NUPRI Reprint Series; 35).

Palmore, Erdman (1976): Total Chance of Institutionalization among the Aged. In: *The Gerontologist* 16, pp. 504–507.

Pascall, Gillian (1986): *Social Policy.* London: Tavistock Publications.

Scull, Andrew (1988): *Die Anstalten öffnen?* Frankfurt am Main: Campus Verlag.

Sennett, Richard (1983): *Verfall und Ende des öffentlichen Lebens. Die Tyrannei der Intimität*. Frankfurt am Main: Fischer Taschenbuch Verlag [Orig.: The Fall of Public Man; 1974].

Shibata, Hiroshi (1988): A Ten Year Comprehensive Survey of the Japanese Urban Elderly: The Koganei Study. In: *Shakai Rōnengaku* 27, pp. 68–75.

Shimada, Tomiko (1983): *Kōreika shakai to josei* [Aging Society and Women]. Tōkyō: Kōreika Shakai Shirīzu.

Shimonaka, Yoshiko *et al.* (1987): Tokubetsu yōgo rōjin hōmu ni okeru shisetsu taizai to rōjin no shinriteki tekiō purosesu [The Institutional Stay in a Special Nursing Home and the Psychological Adaptation Process of the Elderly]. In: *Shakai Rōnengaku* 26, pp. 65–75.

Shōgaisha no Hi Kinen Jigyō Jikkō Iinkai (1987): *Akarui ashita o mezashite* [Toward a Bright Tomorrow]. Sapporo: Shōgaisha no Hi Kinen Jigyō Jikkō Iinkai.

Soeda, Yoshiya (1978): Tokubetsu rōjin hōmu no juyōryō [The Demand for Special Nursing Homes]. In: *Shakai Rōnengaku* 8, pp. 85–94.

Soeda, Yoshiya *et al.* (1975): Rōjin hōmu no shakaigaku-teki kenkyū [Sociological Research on Nursing Homes]. In: *Shakai Rōnengaku* 2, pp. 16–42.

Soeda, Yoshiya *et al.* (1977): Rōjin hōmu no riyōsha no keisei katei [The Molding Process of Users of Nursing Homes]. In: *Shakai Rōnengaku* 6, pp. 3–27.

Sōmuchō Tōkeikyoku (1971–1991): *Nihon tōkei nenkan* (Japan Statistical Yearbook). Tōkyō: Nihon Tōkei Kyōkai and Mainichi Shinbunsha.

Teruoka, Itsuko (1978): Josei no jiritsu to rōgo [Independence of Women and Old Age]. In: *Jurisuto, Zōkan Sōgō Tokushū* 11/12, pp. 235–240.

Teruoka, Itsuko (1985): *Yutori no keizai* [Economics of a Comfortable Life]. Tōkyō: Tōyō Keizai Shinpōsha.

Tobin, Sheldon S. and Morton A. Lieberman (1976): *Last Home for the Aged. Critical Implications of Institutionalization*. San Francisco: Jossey Bass Publishers.

Tōkyō Shinbun (21.11.1990): Chihōsei rōjin kaigo ni hisshi no sugata [Frantic Effort for the Care of the Senile Elderly], p. 14.

Yano Tsuneta Kinenkai (1990): *Nippon: A Chartered Survey of Japan*. Tōkyō: Kokuseisha.

Yashiro-chō (1974): *Yashiro* [The Town of Yashiro]. Yashiro: Yashiro-chō.

Yoshida, Tsugeuchi (1980): *Rōjin hōmu wa ima* [Nursing Homes Today]. Kyōto: Mineruba Shobō.

ZSFKK (= Zenkoku Shakai Fukushi Kyōgikai Rōjin Fukushi Shisetsu Kyōgikai) (1986): *Rōjin hōmu hakusho* [White Paper on Nursing Homes]. Tōkyō: Zenkoku Shakai Fukushi Kyōgikai.