

BIOETHICAL PUBLIC POLICY AND THE MAKING OF THE 1997 JAPANESE LONG-TERM CARE INSURANCE LAW

KIMURA Rihito

1. INTRODUCTION

An epoch-making new law, *Kaigo hoken-hō* [Long-Term Care Insurance Law], passed the Japanese Diet on December 9, 1997. The law came into effect and was fully implemented on April 1, 2000. Some media referred to this new law as *kōteki* [i.e., public] *kaigo hoken*, drawing on the public and social elements of the new long-term care system, in which around 50% of the expenses are “publicly funded” by central and local governments.¹ In international publications, *Kaigo hoken-hō* is usually translated as “Long-Term Care Insurance Law”, emphasizing the concern for public care and replacing the traditional family-supported care system. Tremendous efforts were made by Japanese citizens as well as by the government to prepare this new system as it became the new foundation for institutional and functional care for the elderly.

Beginning in the early 1990s, extensive public discussions and wide coverage in the media took place calling for a need to address care requirements of the elderly as traditional family-supported care slowly became obsolete and difficult to maintain due to an increasing number of nuclear families. The new law was a response to the social re-evaluation reflecting the reality of an aging society in Japan. This realization drew attention to the necessity of an integrated system of welfare policy for the elderly, and an official recommendation was proposed for the establishment of a publicly funded long-term care insurance system by the RŌJIN HOKEN FUKUSHI SHINGIKAI (Senior Citizens’ Health and Welfare Council) on April 23, 1996.

The Ministry of Health and Welfare, the government body responsible for formulating the new law, worked hard to stress the positive elements and introduced the law on November 29, 1996. However, many individuals, from welfare professionals to local governments officials, continued

¹ See *Kaigo hoken-hō*, Articles 121–128. The publicly funded share is split; 25% is paid by the central government, and 12.5% is paid each by the prefectural governments and the municipalities. According to TOCHIMOTO (1997: 126–127), this sharing system is different from the one adopted in Germany.

to be skeptical about the implementation of the law and future plans for the care of elderly people under this new system (*Yomiuri Shinbun* 13.12.1997: 29).

This paper will analyze the background leading up to the enactment of *Kaigo hoken-hō*. It will raise some critical aspects of the law, examining thereby the socio-cultural context of Japanese society from a bioethical point of view. Moreover, it will suggest that there were several positive consequences that emerged during the process of public policy-making leading to the enactment of this law.²

2. SHIFTS IN WELFARE POLICY LEADING TO *KAIGO HOKEN-HŌ*

During the 1990s, there were ongoing debates to establish some integrated system to provide care for the elderly in Japan. The White Paper issued by the Ministry of Health and Welfare (KŌSEISHŌ 1997a: 171–191) indicated that the need for proper elderly care is constantly regarded as one of the greatest tasks of an “aging society” (*kōreika shakai*) as Japan enters into the 21st century.

The reasons for proposing the *Kaigo hoken-hō* were as follows: First, with a rapid increase in the number of elderly, the number of people who will need care will also naturally increase. As people live longer, the level of care required will be more intense and long-term. Second, the change in the “traditional” role of the family in caring for the elderly has made it now more difficult to support the elderly than before. The general public is aware of this insecurity and expresses its concern about being able to meet the care requirements of the elderly. Third, care of the elderly could mean an excessive financial and physical burden for many families. Fourth, close to 80% of the Japanese people surveyed want to see the establishment of a new unified system of assisted care for the elderly. Many complained that limited access in the traditional system made it difficult to choose an individual style of service and care (KŌSEISHŌ 1997b).

The aim of the new law can be summarized as follows: First, regardless of family situation and income level, elderly people should be entitled to utilize home care services and institutional services according to their own needs and wishes. In addition, the independence of the elderly should be fully supported by this new system. Second, the two existing

² This paper was originally written based on the presentation made by the author at a conference hosted by the German Institute for Japanese Studies in 1997. Minor changes were made due to the enforcement of *Kaigo hoken-hō* in April 1, 2000.

systems – the elderly welfare system and the national medical insurance system for the elderly – should be integrated in the new law in order to create a unified care system for all elderly people above the age of 64. Third, the law should encourage the private sector to play an active role as a service provider. Traditionally, these services were supported by the public and semi-public sectors. Fourth, the idea of “care management”, a new notion in Japanese health care, should be introduced in order to provide a variety of services required by the elderly (IHARA and AMAIKE 1997: 2–3).

It could be said that *Kaigo hoken-hō* introduced shifts in the traditional concepts of social welfare that can be viewed positively, but with some notable reservations. The following phrases indicate some symbolic changes in this new system of care for the elderly.

“From status to contract”

This phrase was originally coined by a legal historian named Sir Henry S. MAINE (1888: 165). He used this phrase to explain changes in the legal status of individuals in society from ancient to modern times through social trends. Indeed, in this sense, the *Kaigo hoken* Law denotes an actual shift of the individual elderly from “status to contract”.

The former *Rōjin fukushi-hō* [Law for the Welfare of the Elderly], promulgated in 1963, provided “administrative measures” (*sochi*) for the care of the elderly. These measures made arrangements for various welfare services such as homehelp services, day-care services, and short-stay services for the elderly. It included the provision or rental of special equipment such as wheelchairs, canes, or hearing aides for daily use. *Sochi* was also used to admit elderly persons into institutions. *Sochi* was mainly determined by local authorities. Legally as well as administratively, the request for services or institutionalization was not regarded as a claim or right of an elderly person (see OGASAWARA *et al.* 1997: 52–53). In order to receive the benefits of *sochi*, personal information regarding family relations, income, and other private data had to be disclosed. The elderly who required *sochi* were treated as “objects” that had to be taken care of by the social welfare system. In *Rōjin fukushi-hō*, tax monies were used to provide for disadvantaged people. However, people were reluctant to obtain this “status” which was accompanied by the stigma of being cared for by a policy intended for the poor.³ The new *Kaigo hoken-hō* abolished this

³ See *Rōjin fukushi-hō* [Law for the Welfare of the Elderly], Chapter II (*Fukushi no sochi*), Article 10, Section 3 (11.07.1963). A health and welfare activist and member of the House of Representatives, Ms. Ishige Eiko, points out the negative notion of *sochi* and proposes a “Citizen-Type of Welfare” as a new

notion of *sochi*. By establishing a mutual support system that includes compulsory payment from those aged 40 years or older, a shift from state obligation in a particular individual category (*status*) and as an administrative object to more individual care (*contract*) can be seen in this law.

“From family to society”

For many years, care and social assistance provided by the Japanese welfare system had negative connotations and faced difficulties because of the traditional emphasis on family care. Those who received welfare services were categorized as poor and lacking family support. Thus, people were reluctant to have “recipient status” and become “objects” of socialized welfare service. Until recently, families living in cities and – even still today – in rural areas were responsible for the care of their elderly members (KIMURA 1988: 175–186). It was shameful for many elderly to receive public welfare services, particularly if they lived alone and were separated from their family.

A series of feature articles on elderly life published in the *Asahi Shinbun* (16.12.1997: 26; 17.12.1997: 34) reported strong ethical and moral sentiments of the elderly against utilizing social welfare services. Those interviewed expressed the more traditional notion that “parents should be cared for by their children’s family members, particularly by the wife of the eldest married son”. However, in reality, changes in the composition of the nuclear family and the move to urban areas have made it difficult, both in urban and rural communities, to care for elderly family members. Moreover, demographic data reveal that there has been a rapid increase not only in the number of elderly parents but also in the number of elderly children.

The new law stresses the idea of insurance as a mutual assistance framework. It attempts to remove the stigma and reluctance of being a care recipient. All citizens beyond the age of 40 are required to pay premiums from their income. This premium funds a part of the cost of care that may be required after an individual reaches 65 years of age. This is a practical solution to deal with a possible increase in the number of elderly citizens who may not be cared for by his or her family.

model to provide welfare services by conscious citizen’s mutual support and participation (ISHIGE 1997: 256–278). By contrast, even though *sochi* has quite a negative connotation and some bureaucratic, administrative implications, AIZAWA (1996: 79) holds that there have been some cases where the contents of *sochi* services had been gradually forced to change due to claims made by local citizens.

According to the "Report on the Survey Concerning Aging" issued by the Prime Minister's Office in January 1998, 38% of middle-aged people (40–59 years of age), and 46% of the elderly (beyond 60 years) responded that if a family member were to become bedridden, he or she should be cared for by the family. By contrast, 47% of middle-aged people and 31% of the elderly expressed the need to utilize public welfare services, and in some cases institutions, to care for a bedridden family member. In the case of care for healthy elderly, only 9% of middle-aged people and 10% of the elderly responded that he or she needed to be institutionalized (SŌMUCHŌ CHŌKAN KANBŌ KŌREI SHAKAI TAISAKUSHITSU 1998). This suggested a growing interest in utilizing public welfare services within a home environment rather than institutionalization.

The new law recognizes the changes in the traditional concept of family by shifting the responsibility of elderly care from "family to society". The new insurance system has transformed the negative notion of welfare service. Government surveys suggest that the attitude of the public towards receiving welfare services is already shifting toward a more positive direction.

"From state to individual"

According to the *Kaigo hoken-hō*, each individual will be supported in his or her care by community-based local agencies. The emphasis is on each individual to utilize community-based care services after consulting a care manager, and to prevent the government intervening in care services by requiring the application of *sochi*, as mentioned above. Moreover, the law encourages the use of private sector organizations in the community, usually business-oriented welfare services. This new option provides many Japanese citizens with the opportunity to employ services that were previously too expensive.

The shift from welfare as a state obligation to a more individual choice of care providers can be viewed as a positive development. However, critics like SAKAI Sonoko (1997), a social worker at one of the Elderly Home-Care Support Centers in Tōkyō, worries about the downgrading of elderly care as a result of the new insurance law system. While this law signifies a dramatic change in Japanese welfare legislation, there is also the possibility of a decrease in the quality of care for the elderly due to both a lack of human resources for care services and the difficulty of determining a standard criteria to evaluate the level of care requirements.

“From bureaucrats to the people”

Traditionally, bureaucrats in Japan have been viewed as paternalistic and unsympathetic to individual citizens. The official statement issued by the Ministry of Health and Welfare read that as soon as people understand the new long-term care system of a mutually assisted insurance mechanism that is supported by local governments and communities, elderly citizens will eagerly claim their rights and utilize this system in a positive way. However, in order for this objective to be realized, there must be a change in the mentality and attitudes of welfare bureaucrats as well as of people in the local community. They must become more compassionate and less paternalistic as this law shifts the concept from receiving welfare to the people's right to utilize care services.

“From tax to cost-sharing insurance”

In order to share the cost of caring for the elderly the new law transfers the expenditure from taxes to insurance. Thus, the major problem people will encounter with this new system is trying to meet costs that are expected to rise in the future. Although people will have to pay premiums for this insurance, they may not be able to tap into this service unless certain criteria are met. Even individuals classified in the standard-care category after an evaluation process have to pay 10% of the total cost as a user fee. This means that for this new insurance system, citizens must now pay an insurance fee and a user fee in addition to their taxes.

Cost-sharing for the benefit of elderly care is generally viewed as a good idea. However, due to the different level of services available based on different criteria in each local community, there is the fear that *hoken atte mo kaigo nashi*, meaning “an insurance system exists but no services are available”. Special efforts must be made to ensure that cost-sharing insurance will not disadvantage others.

3. A BIOETHICAL APPROACH TO THE LONG-TERM CARE INSURANCE LAW

Bioethics is an interdisciplinary subject related to issues of value judgments regarding life and death in the natural, social, and human environment (KIMURA 1986: 248–249). The field of bioethics interweaves traditional disciplines such as biomedical sciences, ethics, law, philosophy, religion, and public policy. Grassroots movements in the 1960s dedicated to civil rights, women's liberation, consumer protection, patient's dignity, and other human rights issues were the creative forces behind the forma-

tion of bioethical ideas. It is important to examine *Kaigo hoken-hō* within this socio-cultural context.

The following bioethical implications can be analyzed in order to study the new law: (1) the public policy perspective; (2) the human rights perspective; (3) the equality perspective; and (4) the “do-no-harm” perspective (KIMURA 1987).

3.1 Public policy

The public policy perspective is often used to analyze the bioethical aspects in making new laws regarding such issues as organ transplants, the definition of brain death, and guidelines for genetic testing. It emphasizes the importance of law-making that includes public debate rather than traditional top-down decision-making procedures of bureaucrats and politicians. How did *Kaigo hoken-hō* utilize this new approach?

From the time *Kaigo hoken-hō* was proposed in the House of Representatives (139th Session) on November 29, 1996, there was considerable discussion in the general public on the long-term implications of this new policy. One criticism was that the law focused too heavily on *elderly* persons who need care, but not enough on someone who might become disabled or require care services at a younger age. According to the law, individuals are required to pay a compulsory premium from the age of 40. However, in principle, benefits can only be provided after undergoing a qualifying evaluation by an expert and after reaching the age of 65. Younger individuals, who become ill or disabled, may receive benefits only in exceptional cases. Therefore, this law could be viewed as unjust from the perspective of the younger generation.

During the year 1997, the public debate focused on the most basic element of the system, i.e., whether benefits should be funded by the insurance or taxation systems. If the principle of mutual support is fundamentally important, it would appear that a taxation system is better suited because it is fairer. However, without much exchange of opinion with the public, policy-makers adopted the insurance system as the better choice. The main reason behind this outcome was that political parties wanted to refrain from raising taxes in face of general elections.

While attempts were made by the public to become involved in the policy-making of the new system, the Long-Term Care Insurance Law became a victim of political compromise. And thus, a great opportunity to reconsider fundamental notions of public policy with regard to mutual care for needy people was lost. The government insisted that persons covered under the Welfare Law for the Disabled would not be integrated into the Long-Term Care Insurance Law. This was a disappointing deci-

sion made by the government as care should be provided as a commitment of the community regardless of age and generation. It should have been based on the needs of disabled people and their families, and not by what is considered convenient for the government.

3.2 Human rights

The human rights perspective can be used to analyze legislation to determine if a certain law will have positive or negative implications regarding the dignity and rights of the people. In the Long-Term Care Insurance Law, key expressions such as “support”, “care”, “welfare”, “choice”, “service”, “mutual support”, “cost-sharing”, and “independence” are repeated throughout the text. But there are no words that indicate the “rights” of the person in need of services. This law still bears the sense of obligation and paternalistic welfare-state attitude traditionally observed in Japanese bureaucracies. If it is important to support the independence of the elderly, as it is specifically stated in this law, policy-makers must first recognize the entitlement of elderly persons to have access to various services as an extension of their constitutional rights.

3.3 Equality

The equality component is essential to judge how the law applies to each individual. The possibility of inequality in services is a reality in *Kaigo hoken-hō* because of differences in the circumstance of local communities. For example, a care manager of a particular community may recommend plans for specific elderly care, but home care or institutional care may not be available due to a lack of human resources. This unequal and unethical situation may result in the creation of a new type of social welfare recipient; one which migrates from one local community to another in search of better services.

Another problem relating to equality is the gender issue. Japan is traditionally a strong male-oriented society where an estimated 85% of family caregivers are still women. Ironically, some Japanese feminist groups rejected the idea of cash payment for full-time care provided by family members at home. They felt that such a cash payment could work against women, confining them to the home and depriving them of their social, business, and professional opportunities.⁴ Moreover, the final de-

⁴ See KŌSEISHŌ (1997c), no. 2, chapter 4: *Kazoku kaigo ni tsuite, (2) genkin kyūfu ni shōkyokuteki-na iken* [On Family Care, (2) Negative Opinions Toward Cash Payment for the Care Services]. OKIFUJI (1997: 61, 210) argues that one of the

cision not to provide cash payment to full-time family caregivers also deprives some family members of receiving full-time care.

The equality principle is clearly in violation of this law. Equal care should be available to all who require services. In addition, if in reality women continue to be the core caregivers in the household, financial assistance should have been provided in order to address the inequality of gender roles.

3.4 "Do-No-Harm"

"Do-No-Harm" is also regarded as one of the criteria in making value judgments on issues related to bioethics. "Do-No-Harm" is a fundamental principle for health care professionals to serve the needs of the client. However, one of the main concerns of this law is that those who have paid insurance premiums may not necessarily receive care services later in life. Ordinarily, insurance means that those who pay premiums to protect them against future setbacks will receive benefits when he or she requires them in the case of sickness, injury, or unemployment. In this definition, the new law is not an insurance policy. This law takes advantage of healthy citizens who expect to receive proper services when they require them. Citizens do not realize that the Long-Term Care Insurance Law does not automatically guarantee them care and it imposes a barrier of qualifying standards. It is not even clear whether an appeal for care can be filed within a particular time limit. In fact, the insurance designed to cover their future needs actually harms prospective recipients with uncertainty.

An additional problem in caring for the elderly can be seen in the traditional arrangement where many hospitals admit elderly patients who encounter difficulties in living alone. This hospitalization for the elderly often occurs due to a lack of vacancies in appropriate elderly institutions and is called "social hospitalization" (*shakaiteki nyūin*). Hospitalization, in this case, is not meant to cure a disease, but rather to care for an elderly patient in an institutional setting. This leads to a great drainage of medical resources (KŌSEISHŌ 1997a: 175). With the implementation of the Long-Term Care Insurance Law, these patients will eventually have to be discharged. This will cause tremendous problems not only to elderly patients, but also to their families. Therefore, this new system can actually "harm" the intended beneficiaries without providing for a proper structure to prepare for the care of these elderly.

negative impacts of the delay in long-term care policy in Japan is the problem that men do not recognize care issues as men's issues. Today, in 85% of all cases women provide "family care".

4. THE KAIGO HOKEN-HŌ IN THE PUBLIC POLICY PROCESS: THE CITIZEN'S POSITIVE ROLE IN MAKING PROPOSALS

The bioethical public policy perspective mentioned above played a vital part in the making of the Long-Term Care Insurance Law. There was a high degree of open debate and public policy-making with regard to this law. The debate on *Kaigo hoken-hō* caught the attention of the public because it was believed to have implications in political, economic, social, and family settings as Japan entered the 21st century. This section will examine how the activities of civic action groups contributed to the process of making this law.

The media was an active participant in the debate of *Kaigo hoken-hō*. By and large, coverage of topics related to elderly citizens was covered in the "Social" or "Family and Women" feature sections. However, articles written to support or criticize *Kaigo hoken-hō* also appeared on the front pages of national newspapers. The topic topped the news on radio and television programs with reports on the political, economic, financial, and government issues surrounding this bill.

As the legislative body, the Diet held a series of special sessions, inviting experts from Welfare and Health Committees to speak on issues related to long-term care. Moreover, special public hearings were held in cities outside the capital region. The subject evolved into one of the most crucial political issues in Japan integrating all existing systems for welfare and medical care in local communities.

However, even more remarkable was the formation of a citizens' social action group in order to support the fundamental idea of long-term care insurance. A group was established in 1996 that called themselves *Kaigo no Shakaika o Susumeru Ichimannin Shimin linkai* (Ten Thousand Citizens' Committee to Realize a Public Long-term Care System; abbreviated in the following as KSSISI). The name of the group, KSSISI, reflects the purpose of this organization. The founding members planned to gather 10,000 citizens to join this committee with a membership fee of ¥ 10,000. They suggested that this national organization would raise a fund worth ¥ 100 million to support activities that allowed ordinary Japanese citizens to put forward suggestions for the law regarding the care of the elderly. As of February 10, 1998, KSSISI claimed 2,320 members of which around 60% were women, 37% men, and 3% associations. It made tremendous efforts to put forward concrete and positive proposals to the new law. Among other things, the group presented policy alternatives, it submitted recommendations, administered surveys on elderly care, dispatched questionnaires to Diet members on the proposed law, and collected resources, documents, and drafts related to the law.

In the founding statement of KSSISI, the emphasis was on the citizens' input to influence law-making procedures and to present positive proposals on various points such as the following: 1) citizen's participation in the policy-making process to plan for care-related infrastructure; 2) assurance of receiving services by setting a target age in order to avoid the situation of compulsory insurance payments without receiving benefits; 3) insurance fee payments from age 20; 4) deletion of the provision stating "necessity of care caused by the aging process" and expansion of benefits to all people with disabilities including younger people; and 5) the establishment of a Care Insurance Managing Council consisting of an equal number of male and female representatives of the insured in order to protect the human rights of the insured. This council was also willing to provide an "ombudsman" function so that it would have the power of "investigation, recommendation, and public disclosure" (KSSISI 15.09.1996: 7-8).

KSSISI received a great deal of attention during the first two years of its establishment. They appeared in the news whenever symposiums, seminars, and general assemblies were held. One remarkable feature of this process was the publication of newsletters that carried valuable information on survey results, data, and proposals. In issues 1 to 7 (including an extra issue published immediately after the passing of the bill in the Health and Welfare Committee of the House of Councilors on December 2, 1997), the group put forward very positive proposals and even exerted strong pressure to consider amendments in the final process of law-making (KSSISI 02.12.1997: 2-3).⁵

On May 22, 1997, the House of Representatives passed the Long-Term Care Insurance Law that included the following amendment: "Local municipalities should be given the necessary administrative discretion in order to get feedback from the insured whenever they make a plan or intend to change services provided by the care insurance policy" (KSSISI, 01.06.1997: 1-3).⁶ The actual content and meaning of "administrative discretion" was suggested as: "1) the establishment of a planning policy committee, consisting of experts from the fields of health, medicine, welfare, and insurance; and 2) a public hearing or briefing including the

⁵ Concretely, it was decided to include the phrase "policies and other necessary measures to secure the system for providing health and medical services", relating to the responsibility of central and local governments, in Article 5.

⁶ This amendment endorsed public participation in reflecting the insured's opinion when the municipalities need to establish or change its care insurance service plans. The idea of "citizen participation in the care planning process" may be considered as one of the fundamental proposals made by the KSSISI.

insured should be held" (KŌSEISHŌ KAIGO HOKEN SEIDO JISSHI SUIISHIN HONBU 1998: 35).

This amendment shows the actual influence of KSSISI's movement. Its role in the public policy process for the new care insurance system cannot be denied. The entire process of making *Kaigo hoken-hō* gave new hope to many citizens as government bureaucrats and politicians seriously considered KSSISI proposals for amendments. KSSISI's role as a citizen's public policy-making body was, for the first time in Japan, accepted by government policy-makers, candidates for the Diet at the time of the 1996 general election, and by the Japanese people in general.

5. CONCLUDING REMARKS: DISAPPOINTMENTS AND HOPES FOR THE FUTURE

The public debate that surrounded the making of *Kaigo hoken-hō* was in many respects the first of its kind in Japan. However, many Japanese have not recognized the importance of addressing bioethical concerns in the public policy-making process. Democratic efforts were made through nationwide public hearings held in certain prefectures, such as Okayama, Fukushima, Hokkaidō, and Niigata, organized by the Welfare Committee of the House of Representatives, and in the prefectures of Yamanashi, Kōchi, Ōita, and Aichi, organized by the Health and Welfare Committee of the House of Councilors. The most encouraging approach of public participation was the formation of special citizens' interest groups on the care issue.

Nonetheless, citizens' groups were unable to influence the legislators on the fundamental issue regarding which people are entitled to receive care. The *Kaigo hoken-hō* clearly stipulates that citizens are eligible for benefits according to the care category in which they are classified. They must have certain symptoms of disability or a condition caused by the "aging process". It is important to note that the original draft of the law did not have such a restrictive wording of *kōrei ni tomonatte shō-zuru* [caused by the aging process] but had a more inclusive *kaigo o hitsuyō to suru hito* [those who need care]. In spite of the efforts to keep the original wording in the law, the law was passed using the more restrictive phrase. KSSISI and the majority of the public consider this phrase ridiculous. There was also concern about the serious implications this phrase may have for those who require care because they suffer from symptoms or disease unrelated to the aging process.

While problems existed in the making of *Kaigo hoken-hō*, this was one of the first instances where the public experienced direct participation in the

democratic political process by submitting concrete proposals and amendments to the law. Because of an increasing number of people in need of care, many citizens felt direct connection to the issue as it related to their own life within the community. This law-making process led to changes in the idea of mutual caring, the family, welfare, and medical services. This new trend in Japan will have positive implications in realizing the global agenda "Health for All in the Year 2000", which was initiated by the World Health Organization (WHO) of the United Nations.

In order to determine the necessary level of care for people in need, international comparisons should be made and concerted efforts initiated to address these issues. In many cases, new approaches to solve difficult problems can be found by investigating and looking at the issues from different socio-cultural and bioethical perspectives. This is not meant to discourage traditional values that emphasize care in the family and community as some societies move towards socializing care for the disabled. Rather, it is important to note that Japan is attempting to enter a new era of care and support with additional mechanisms influenced by bioethical guidelines brought forth within the course of a public policy-making process.

Continuous cooperation is necessary for all participants in the public policy process to address national, generational, and gender disparities. In addition, there is a need to respect the autonomous decision of those people who need care. Participation by citizens including those in need of care, the commitment of health care professionals and policy-makers are critical when making public policies based on bioethical beliefs of building communities where humane care is fully realized.

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