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A Look Towards the Future of Eldercare: Lessons Learned from Social Care Models in Japan

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A LOOK TOWARDS THE FUTURE OF ELDERCARE: LESSONS LEARNED FROM SOCIAL CARE MODELS IN JAPAN

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ABSTRACT

CAROLINE STEIL: A Look Towards the Future of Eldercare: Lessons Learned from Social Care Models in Japan
(Under the direction of Dr. Sarah Moses)

The rapidly accelerating trend of population aging is redefining the state of eldercare globally, as every country is currently or will soon face a gap in the excess demand for care versus the scarce supply of caregivers, both formal and informal. Specifically, there is a decrease in the number of elders seeking care through a family member as well as less caregivers in institutions to provide care for elders. Japan is at the vanguard of this caregiving gap, and thus provides key lessons, particularly from two innovative models of eldercare: Ibasho, a grass-roots, non-profit organization, and Japan's Long-Term Care Insurance System. These models are exemplary in adapting to the demographic pattern of population aging, as they both center an elder's care around the community. This thesis explores what values are foundational in creating ethical care systems for this increasing number of elders worldwide by analyzing these two social care models. The Ibasho organization exemplifies the values of reciprocity and integration, as elders are given opportunities to produce social and economic capital as well as spend time with community members of all ages. Likewise, Japan's Long-Term Care Insurance system demonstrates how elders can maintain independence through policy that is elder-focused and economical. I advocate for the reciprocity, integration, and independence of elders as we face these new demographic changes, and stress the universality of these values as we continue to create care systems across the world.

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Chapter One: Introduction

Aging is a fundamental aspect of the human experience. Regardless of whether we age from childhood to adolescence, or from adulthood to elderhood, this process is a universal truth of life. In fact, theories such as the cellular theory of aging suggest that as soon as our cells reach the stage of senescence, usually at the age of 20 years, we begin to experience aging at the molecular level. Given that most of us will experience aging for the majority of our life, this topic merits recognition. To place this universal truth into the context of today, more people are reaching old age than ever before in human history. In combination, the demographic pattern of a decline in the fertility rate is producing an emerging aging population that we must provide care for. However, simultaneously there exists a gap between the capacity of caregivers, both formal and informal, or paid and non-paid, and the elders who need care. It is this caregiving gap in combination with population aging that has motivated the discussion of this thesis: to analyze universal characteristics of caregiving methods for the future of eldercare. Collective discourse surrounding this topic opens the door for us to ponder what we innately desire and enjoy in life as we create and design care systems for an increasing number of elders. As we enter an era of aging, I argue that the characteristics of elder reciprocity, integration and independence can be universally applied to the care of elders across the world.

My personal interest in aging largely rose from the COVID-19 pandemic, a catastrophic event that uncovered and exposed many of the pressure points in our care systems worldwide. Amidst devastating loss, one positive area of discussion that surfaced was increased attention to elders and their care, as well as proposed methods for improving eldercare. My enrollment in Medical Humanities and “COVID-19 and the Elderly” courses with Dr. Moses sparked my pursuit to help better eldercare, as I saw an abundantly evident need to mobilize. In this thesis, I

identify specific characteristics necessary to the future of eldercare through an analysis of two institutions of care in Japan: Ibasho, a grass-roots, non-profit organization, and the Long-Term Care Insurance System (LTCI), a governmental, policy-driven approach.

I focus on Japan's models of eldercare due to the fact that the country is at the vanguard of population aging, with the highest proportion of elders to their population in the world. Later discussion in Chapter Two will comprehensively discuss population aging as Japan has been experiencing. Nevertheless, it must be emphasized that other countries will soon follow this demographic transition in the future, and at present the entire world is facing a heightened increase in their aging populations. The presented models in Japan possess key features which are universally applicable and replicable for countries to utilize as we enter an era of aging.

Population Aging

Population aging is a relatively new demographic trend that has captured the attention of the world. Throughout the majority of human history, to reach old age was an exceptional feat. Today, advancements in modern medicine and technology have made it more feasible to live a longer life, and hence society has begun to reevaluate how "old" is defined. The United Nations gives the case of a man turning 60 years old in Western Europe to elucidate these perspectives on aging.[1] Can society consider him old? Even though 93 percent of men survive to the age of 60 today, nearly 150 years ago less than 25 percent did. These statistics reveal the burgeoning era our world is just beginning to experience: an era of global population aging. In fact, the twenty-

[1] Scherbov, Sergei, and Warren Sanderson. "New Measures of Population Ageing." 2019. https://www.un.org/development/desa/pd/sites/www.un.org.development.desa.pd/files/unpd_egm_201902_s1_sergeischerbov.pdf.

first century will most likely witness a worldwide demographic shift from population growth to population aging.[2]

According to the United Nations, population aging is defined as the "increasing proportion of older persons in a population."[3] This demographic trend is on the rise, as one in six people will be 60 years of age or older by 2030.[4] Furthermore, between 2015 and 2050, the world's population over 60 years is projected to nearly double from 12 percent to 22 percent.[5] For the sake of continuity, this thesis will define an elder as being aged 65 or older.

Humanity's aging is explained by the World Health Organization as being caused by a declining fertility rate and increased longevity. A replacement level fertility rate is roughly 2.1 children per woman.[6] However, the United Nations World Fertility Report states that more than half of the world's population, located in 83 countries, are experiencing a below-replacement fertility rate.[7] This trend in combination with improvements in longevity due to modern medicine and technology, have produced our aging world. Today, elders account for more than ⅕ of the population in 17 countries across the globe.[8] It is important to note that within the phenomenon of global population aging exists many facets. For example, the rate at which certain countries

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[2] Tuljapurkar, Shripad, Naohiro Ogawa, and Anne H. Gauthier. *Ageing in Advanced Industrial States*. Heidelberg ; New York : Springer Verlag, 2010., ix.
[3] United Nations, Department of Economic and Social Affairs, and Population Division. World Population Ageing: 2017 Highlights, 2017. https://www.un.org/en/development/desa/population/publications/pdf/ageing/WPA2017_Highlights.pdf.
[4] "Ageing and Health." Accessed October 19, 2021. https://www.who.int/news-room/fact-sheets/detail/ageing-and-health.
[5] "Ageing and Health." Accessed April 17, 2022. https://www.who.int/news-room/fact-sheets/detail/ageing-and-health.
[6] Searchinger, Tim, Craig Hanson, Richard Waite, Brian Lipinski, and George Leeson. "Achieving Replacement Level Fertility," July 8, 2013. https://www.wri.org/research/achieving-replacement-level-fertility.
[7] "World Fertility Report 2015 Highlights." United Nations, 2017. https://www.un.org/development/desa/pd/sites/www.un.org.development.desa.pd/files/files/documents/2020/Feb/un_2015_worldfertilityreport_highlights.pdf., 2.
[8] United Nations, Department of Economic and Social Affairs, and Population Division. *World Population Ageing, 2019 Highlights.*, 2020.

across the world are aging differs greatly. Accordingly, eldercare approaches must be tailored to the needs of individual countries and communities, and this will be explored later through an analysis of the Ibasho organization.

Though the principal focus of this thesis is concerned with the humanitarian facet of caregiving, it is also worth noting that population aging affects a myriad of socio-economic dimensions, for example the labor supply, capital formation and net savings, gross domestic product, and the sustainability of medical care programs. Thus, this intense demographic pattern is significant to not just our elders but society as a whole.[9] An analysis of both the Ibasho organization and Japan's LTCI provide key lessons as to how to adapt to population aging, by not only improving the quality of care for elders themselves, but also allowing our society to adjust to a new demographic reality.

Research Methods

The research method employed in this thesis was the qualitative data analysis of social care models in Japan, both the Ibasho organization as well as Japan's LTCI. First, I begin with a qualitative analysis of the Ibasho organization to illuminate the means by which a private, informal method of caregiving has supported elders and their communities across the globe. I draw from data on past projects, specifically in Japan and the Ivory Coast, to highlight the importance of incorporating opportunities for reciprocity and intergenerational integration in eldercare.

An important facet in the discussion of Ibasho is the organization's work in least developed countries (LDCs) as defined by the United Nations. This history underscores the

[9] Tuljapurkar, et al., *Ageing in Advanced Industrial States*., x.

universal nature of the organization's values and principles. The principal data pertaining to the Ibasho organization was collected from the organization's website archives as well as lectures presented by Dr. Emi Kiyota, an environmental gerontologist and the founder of Ibasho. Additional scholarly research was gathered to present the key elements of eldercare that the Ibasho organization models.

Similarly, in Chapter Four I provide a qualitative analysis of the Long-Term Care Insurance (LTCI) system in Japan to analyze recent governmental approaches to eldercare. An analysis of the LTCI provides key lessons for particularly nations with an already advanced aging population, namely Western Europe and Northern America,[10] but these lessons will still prove useful as the world continues to age. The chief data related to the LTCI of Japan was sourced from the Ministry of Health, Labour and Welfare (MHLW) of Japan. Additionally, it was necessary to gain further insight into the bureaucratic sphere of long-term care insurance through analyzing scholarly articles that have detailed key data and information regarding the LTCI and its revisions.

The amalgamation of private and public methods of eldercare share the stage of eldercare in Japan, and provide lessons to the world for the future of eldercare. The Ibasho organization and Japan's Long-Term Care Insurance system (LTCI) represent a socialization of care, specifically referring to the notion that elders receive care through community efforts rather than a sole family caregiver. This dispersion of care into a community is what the world is currently turning to as we enter a new era of aging.

The central argument of this thesis is that these models, and their valuable characteristics, should be replicated and tailored to countries and their communities across the world as

[10] United Nations, Department of Economic and Social Affairs, and Population Division. *World Population Ageing, 2019 Highlights.*, 2020., 12.

population aging accelerates. Specifically, the Ibasho organization provides a compelling model of utilizing universal values of eldercare, and tailoring eldercare models to the needs of individual countries and communities. On the other hand, the LTCI is particularly useful for examining countries that will soon catch up to the demographic reality of Japan today, namely the United States as I will note in Chapter Five. Still, Japan's LTCI prioritizes the independence of elders themselves, which I argue is a universal trait of eldercare, though it can manifest itself in different ways. This analysis will call attention to the mechanisms that make these institutions sustainable, as well as allow these institutions to generate opportunities for reciprocity, integrate elders with other generations, and prioritize the voice of the elders themselves, facilitating a more equitable and supportive eldercare arrangement.

This thesis contains limitations with regard to what research could have been collected beyond the presented material. I chose the two care institutions of Ibasho and the LTCI mainly due to the availability of information in English, which presents a key limitation: the language barrier. By only analyzing data available in English, this potentially could have produced a somewhat skewed narrative. Though I was not able to analyze data in Japanese, I selected multiple articles which are provided in both Japanese and English to attempt to help expand this information. In addition, there is an evident absence of quantitative and qualitative data in this analysis of eldercare in Japan. If I were to conduct this type of research again, I would focus on gathering more quantitative data, and I believe that individual interviews could be useful in bolstering the information presented in this thesis.

I encountered limitations in the research I did conduct as well. For example, the analyzed information from Ibasho was sourced mainly from the website's archives. These posts were not very detailed, nor did they contain equal amounts of information per project. For example, I was

able to analyze the natural disaster relief projects from the Ibasho website because there was a substantial amount of information. However, the eldercare project posts did not contain enough evidence. Furthermore, the MHLW website contained a brief overview of the LTCI, but there is a considerable amount of logistical insurance information that this thesis lacks. Thus, the qualitative analysis performed did not necessarily answer my research question completely, as there was a lack of information in both of my primary sources.

COVID-19 and Ageism

Ageism is undoubtedly an unfortunate reality in the discussion of eldercare. The World Health Organization defines ageism as the "stereotypes, prejudice, and discrimination towards others or oneself based on age."[11] There is paramount meaning in the latter half of this definition, specifically in the fact that elders themselves are influenced by ageist thought. My analyses in Chapters Three and Four will highlight how these two Japanese models seek to promote elders' voices and prioritize their autonomy, potentially working to fight against ageist thought.

Additionally, "ageism affects everyone."[12] From a young age, stereotypes are internalized and compounded with other spheres of society. "Ageism intersects and exacerbates other forms of disadvantage including those related to race, sex and disability." In the World Health Organization's Report on Ageism, the secretary-general expressed:

> "Ageism is widespread in institutions, laws and policies across the world. It damages health and dignity as well as economies and societies writ large. It denies people their human rights and their ability to reach their full potential."[13]

[11] World Health Organization. "Ageing: Ageism."
[12] World Health Organization. "Ageing: Ageism."
[13] World Health Organization. *Global Report on Ageism*. Geneva, 2021.

The report further stressed there is a "need to recognize the multiple roles that older persons have in society- as caregivers, volunteers and community leaders- and underscores the importance of listening to the voices of people of all ages, valuing their contributions and ensuring their meaningful participation in decision making."[14] These aspects underscore the importance of design in eldercare in the sense that we can potentially mobilize against ageism through creating spaces that value and humanize our elders.

Further, ageism is reflected in the field of caregiving, as elders report abuse from their caregivers.[15] Additionally, caregiving is sometimes viewed as undesirable due to difficult hours and low pay. Our world must view caregiving "as a globally admired, valued and respected profession."[16] The Ibasho organization and Japan's LTCI are apt examples of ways to facilitate this thought. In fact, Japan's government distributed bonuses to all formal caregivers during the COVID-19 pandemic.[17] This action sent a signal to not only the formal caregivers themselves, but also to potential caregivers for the future.

Demography and Cultural Anthropology

This thesis draws from the interconnected fields of demography and cultural anthropology to examine and speculate about the future of eldercare. Cultural anthropology is understood as the study of, "how people in different places live and understand the world around

[14] World Health Organization, *Global Report on Ageism*, vii.
[15] Alliance, Family Caregiver. "Caregiver Statistics: Demographics." Family Caregiver Alliance. Accessed April 11, 2022. https://www.caregiver.org/resource/caregiver-statistics-demographics/.
[16] World Health Organization. "Ageing: Ageism." Accessed March 10, 2022. https://www.who.int/news-room/questions-and-answers/item/ageing-ageism.
[17] Kiyota, Emi. "ELDER CARE PROVIDERS & COVID-19." The Global Ageing Network, 2021. https://globalageing.org/wp-content/uploads/2021/02/Global-Ageing-Network-COVID-19-Research-Report.pdf.

them."[18] On the other hand, "Demography is the science of populations."[19] This field is concerned with three main processes: birth, aging (including death), and migration.[20] Thus, how do these three processes affect the ways in which people live and understand the world around them? Bachrach encapsulates this interconnectedness between demography and anthropology by stating, "It is not structure *or* culture, but structure *and* culture that affects our outcomes."[21]

I will use a structural and cultural framework to analyze the Ibasho organization and LTCI in Chapters Three and Four, and further draw the conclusion of what this means for the future of eldercare. Specifically, through an analysis of both organizations, I seek to highlight certain aspects that can be implemented across the world as we look to the future of eldercare. In doing so, I also suggest that these aspects are connected to, and perhaps can aid in reducing ageist thought. The World Health Organization details three strategies to reduce and eliminate ageism: "policy and law, educational activities, and intergenerational interventions." The Ibasho organization promotes the educational and intergenerational intervention side of reducing ageism. Likewise, Japan's globally recognized LTCI could potentially serve as a policy and law method to reduce ageism.

[18] American Anthropological Association. "What Is Anthropology? - Advance Your Career." Accessed December 10, 2021. https://www.americananthro.org/AdvanceYourCareer/Content.aspx?ItemNumber=2150.
[19] Max Plank Institute. "MPIDR - What Is Demography?" Accessed April 17, 2022. https://www.demogr.mpg.de/en/about_us_6113/what_is_demography_6674/.
[20] "MPIDR - What Is Demography?".
[21] Bachrach, Christine A. "Culture and Demography: From Reluctant Bedfellows to Committed Partners." *Demography* 51, no. 1 (February 2014): 3–25. https://doi.org/10.1007/s13524-013-0257-6., 2.

Chapter Two: Japan

Japan is at the vanguard of the demographic trend of population aging, as the country had the highest percentage of people aged 65 and over in the world in 2019, reaching 28.2 percent.[22] As aforementioned, this pattern of population aging is explained by low fertility rate and increased longevity. To quantify this, in comparison with a global average of 2.5 births per woman, Japan's fertility rate has fallen from 1.45 in 2015 to 1.36 in 2019.[23] Moreover, Japan set the precedent in experiencing a 50 percent reduction of the fertility rate in just a decade.[24] In other words, the declining fertility rate is not only sharp, but also rapid.

According to the National Institute of Population and Social Security Research, the percentage of the population aged 65 and over in Japan was 17.4 percent in 2000, yet this statistic is projected to more than double, and rise to over 40 percent in 2055.[25] Such an increase in population is due to the fact that elderly people are living longer, so whilst the population is aging it is simultaneously getting older. These astounding statistics of a decline in the fertility rate and increase in longevity explain the root of the strain on Japan's eldercare institutions. Further, these statistical patterns are projected to continue occurring in countries across the world.[26] Thus, Japan provides key lessons for eldercare, as the country is at the forefront of experiencing a dramatic caregiving gap while also undergoing dramatic population aging.

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[22] Population References Bureau. "Countries With the Oldest Populations in the World." Accessed October 25, 2021. https://www.prb.org/resources/countries-with-the-oldest-populations-in-the-world/.
[23] Statista. "Japan: Fertility Rate 2019." Accessed February 17, 2022. https://www.statista.com/statistics/270088/fertility-rate-in-japan/.
"World Fertility Report 2015 Highlights." United Nations, 2.
[24]OGAWA, NAOHIRO. "Population Aging and Policy Options for a Sustainable Future: The Case of Japan." Genus 61, no. 3/4 (2005): 369–410.
[25] National Institute of Population and Social Security Research. "Population by Age." Accessed December 12, 2021. https://www.ipss.go.jp/p-info/e/psj2008/PSJ2008-02.pdf.
[26] World Health Organization. "Ageing and Health." Accessed April 17, 2022. https://www.who.int/news-room/fact-sheets/detail/ageing-and-health.

Family and Filial Caregiving

In order to understand current shifts in the sphere of Japan's eldercare, it is first important to detail the pre-existing norms that have shaped it, such as the Confucian tradition of filial caregiving in Japan. Tradition regarding elders and their care exists everywhere, yet I detail the aspects of Japan's traditions in order to illustrate how countries operate within the complex social structures of tradition and change when creating methods of care.

The Chinese philosopher Zeng Shen once said, "Now *xiao* is the principle of Heaven, the righteousness of Earth, and the (proper) conduct of people. The principle of Heaven and Earth - people's affairs should follow that principle."[27] *Xiao* is a term derived from the Wade-Giles romanization of the modern Chinese language that translates to filial piety.[28] Filial piety, or *kō* in Japanese, is the "attitude of obedience, devotion, and care toward one's parents and elder family members that is the basis of individual moral conduct and social harmony."[29] Zeng Shen, often referred to as Zengzi, was a disciple, or an apprentice, of Confucius who is best known for reaffirming the principle of *xiao* in Confucianism.[30]

The principle of filial piety rests at the heart of caregiving in Japan, as this is what shaped sentiment surrounding caregiving for generations. In fact, this virtue is "generally assumed as an underlying ideology of the traditional living arrangement of the Japanese elderly, *ie*."[31] *Ie* is a Japanese term which translates to several meanings in English, such as "family, lineage, home,

[27] Rick. "Wujifa: Filial Piety In Our Gongfu." Wujifa (blog), November 11, 2011. http://wujifaliangong.blogspot.com/2011/11/filial-piety-in-our-gongfu.html.
[28] "Wade-Giles Romanization | Chinese Language | Britannica." Accessed March 13, 2022. https://www.britannica.com/topic/Wade-Giles-romanization.
[29] "Xiao | Confucianism | Britannica." Accessed December 13, 2021. https://www.britannica.com/topic/xiao-Confucianism.
[30] Encyclopedia Britannica. "Zengzi | Chinese Philosopher." Accessed November 3, 2021. https://www.britannica.com/biography/Zengzi.
[31] Koyano, W. "Filial Piety and Intergenerational Solidarity in Japan." *Australasian Journal on Aging* 15, no. 2 (n.d.): 51–56.

and house".[32] The *ie* ideology manifests itself in many ways by dedicating responsibilities to certain members of the family based on gender.

In the context of today, this virtue is represented as the eldest son of the family is typically given the status of inheritor, and he is responsible for continuing the ancestral veneration of his family's lineage.[33] Before World War II, elders in Japan were given authority over arranged marriages and primogeniture inheritance through the old Civil Code.[34] After the war, under American occupation a new version of the Civil Code was established, eliminating this legal power of elders. Nevertheless, in addition to a "shame culture," already enforced by society at the time, it is evident that these traditional social norms are not only reflected in the caregiving of elders, but also that they are being challenged as time progresses.[35]

There exists a prevalent gendered dimension to the *ie* and filial piety principles, too. That is, women, especially daughters-in-law, were traditionally viewed as responsible for the care of their spouse's parents. Yamamoto and Wallhagen explain, "For Japanese daughters-in-law, caregiving was an expected career, unlike for American caregivers who were reported to perceive caregiving as an unexpected."[36] In some situations, caring for a spouse's elderly parents was seen as a family business or trade. Tradition is imprinted in such sentiments, as "the older generation's view was portrayed by a strong belief in the housewife's responsibility as a caregiver."[37] This sense of responsibility and traditional virtue would, in the abstract, inspire "daughter-in-law caregivers to tolerate the difficulties of caregiving with pride."[38] I detail these

[32] Koyano, "Filial Piety", 51.
[33] Koyano, "Filial Piety", 52.
[34] Tuljapurkar, et al., *Ageing in Advanced Industrial States*., x.
[35] Tuljapurkar, et al., *Ageing in Advanced Industrial States*., 225.
[36] Yamamoto, Noriko, and Margaret I. Wallhagen. "The Continuation of Family Caregiving in Japan." *Journal of Health and Social Behavior* 38, no. 2 (1997): 164–76. https://doi.org/10.2307/2955423., 169.
[37] Yamamoto and Wallhagen, "The Continuation of Family Caregiving in Japan," 169.
[38] Yamamoto and Wallhagen, "The Continuation of Family Caregiving in Japan," 169.

traditional norms to help give nuance to the conversation of the caregiving gap, and to also highlight that the other countries across the globe are experiencing their own merging of tradition and change. The institutions of eldercare I discuss both operate in this sphere of Japanese tradition, and in the case of Ibasho promote a culturally appropriate and traditionally aware approach to caregiving.

The Caregiving Gap

Though population aging is a marvel of the 21st century, this trend necessitates a re-examination of caregiving at the institutional level as the integral question arises of who will care for our elders? In other words, such an increase in the elderly population as well as other social factors have led to a gap between the level of high demand and low supply of caregivers. In 2012, Japan's Ministry of Health and Welfare's age dependency ratio estimates concluded that 2.6 persons of the ages 20 to 64 supported each elder aged 65 or over, but in 2060 this is projected to decline to 1.2 persons per elder.[39] Moreover, this is simply the statistic of the amount of people aged 20-64 that exist per elder, not the number of actual caregivers.

Already, there exists a scarcity of both professional and informal caregivers in many countries, and as the world enters this new era of aging, alternative methods of care will become increasingly important. It is important to distinguish that a caregiver can refer to those whose professional, paid job is to provide care for an elderly patient, but also an unpaid person, typically a family member, who provides care to an elder. As illustrated with the aforementioned statistics, the actual ratio of young to old is rapidly changing, and thus we must consider to not only alleviate formal and informal caregiving methods, but also to adapt and create alternative

[39] Health and Welfare Bureau for the Elderly. "Long-Term Care Insurance System of Japan." November 2016. https://www.mhlw.go.jp/english/policy/care-welfare/care-welfare-elderly/dl/ltcisj_e.pdf.

caregiving methods. “Closing the gap between supply and demand for home care workers will not be achieved by simply recruiting and training more people. It will also require a dramatic shift in societal understanding of and attitudes toward the caregiving profession.”[40]

The foregoing discussion of a declining fertility rate and increased longevity emphasize the core reasons behind population aging, yet it is population aging in conjunction with a plethora of other societal factors that have created the caregiving shortage or ‘gap.’ Namely, a decline in multigenerational housing and an increase in women’s participation rate in the workforce has shaped this gap, as well as fewer young people themselves in the workforce. It is evident that these changes, though currently most evident in Japan, are beginning to take shape worldwide. To add context, it is critical to be cognizant that these societal factors comprise an interconnected web of tradition, gender, and family, and thus there exists significant nuance behind changes regarding these factors.

Japan provides a compelling case when examining multigenerational housing, as this pattern is still relatively prevalent compared to the West, but also is currently on the decline.[41] To elaborate, fewer adult children are caring for parents in the home, and more elders are living alone or with a spouse. In 1960, 87 percent of Japan’s elders aged 65 or older lived with their adult children; however, in 2005 this percentage dropped to 47 percent.[42] On the other hand, only four percent of elders aged 65 and older lived alone in 1960, but in 2005 this statistic rose to 15 percent. Furthermore, the same trend was applicable to elders living with a spouse, with an increase from seven percent in 1960 to 33 percent in 2005.

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[40] Global Coalition on Aging. “Building the Caregiving Workforce Our Aging World Needs,” n.d. https://globalcoalitiononaging.com/wp-content/uploads/2021/06/GCOA_HI_Building-the-Caregiving-Workforce-Our-Aging-World-Needs_REPORT-FINAL_July-2021.pdf., 14.
[41] Tuljapurkar, et al., *Ageing in Advanced Industrial States*., 224.
[42] “Global Health and Aging.” World Health Organization, n.d. https://www.nia.nih.gov/sites/default/files/2017-06/global_health_aging.pdf., 27.

There exists a debate between the root causes of the decline in multigenerational co-residence. Scholars such as Ogawa et al. argue that the growing social security system is a contributing factor in the "erosion of traditional family values," and thus assume social welfare as a factor in the decline of multigenerational co-residence.[43] Conversely, it can be argued that the changing societal and caregiving norms paved the road for new social welfare policy for eldercare to take shape. Whether the expansion of social welfare benefits encouraged elders to live alone or not, the statistic of declining multigenerational co-residence still stands and can be attributed to the caregiving gap at present.

Further, some suggest a decline in multigenerational co-residence can be attributed to a delay in multigenerational housing, perhaps until the elder feels a greater need for care.[44] Nevertheless, these theories lead to the inference that care structures are changing, and there are lessons to be learned about what values and principles can shape them. It is important to note Japan's strong welfare state exists amidst this shift in traditional caregiving sentiment and structures as this proves there already exists an underlying sentiment of social solidarity in the country. This concept will become increasingly important in Chapters Three and Four, as this will help give context to the analyzed organizations.

According to the World Bank, the percentage of women in Japan's workforce rose over two percent in just a decade, from 41.63 percent in 2009 to 44.24 percent in 2019.[45] It is certain that "Coresidence with parents or parents-in-law has a powerful effect on women's employment patterns," yet the direction of causation once again is debated.[46] Ogawa et al. argue that

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[43] Tuljapurkar, et al., *Ageing in Advanced Industrial States*., 225.
[44] Martin, L. G. "The Graying of Japan." *Population Bulletin* 44, no. 2 (July 1989): 1–43., 14.
[45] "Labor Force, Female (% of Total Labor Force) - Japan | Data." Accessed March 9, 2022. https://data.worldbank.org/indicator/SL.TLF.TOTL.FE.ZS?locations=JP.
[46] Ogawa, Naohiro, and John F. Ermisch. "Family Structure, Home Time Demands, and the Employment Patterns of Japanese Married Women." *Journal of Labor Economics* 14, no. 4 (1996): 677–702., 692.

caregiving responsibility influences Japanese women's participation in the workforce. On the other hand, some scholars state that the workforce participation rate influences caregiving availability. The sole statistic of an increase in the participation rate of women in Japan's workforce is not a lone aspect or the sole argument presented. Rather, this statistic is a facet of other social and cultural factors, such as increase in education or access to contraceptives, for example.[47] Still, this statistic helps to illustrate and quantify the pre-existing social patterns that helped shape it.

Finally, amidst an increase in the aged population, there is a stark decrease in the younger population, thus adding to the caregiving gap. Needless to say, this can largely be attributed to a declining fertility rate. However, I further emphasize that there is a decline in the working-age population, which is defined as persons between the ages of 15 and 64. In fact, ever since this population's peak of 87.26 million in Japan's 1995 Population Census, there has been a decline which is projected to continue, dropping to as low as 45.29 million in 2065.[48] To illustrate the ratio of these numbers, different projected fertility rates suggest that the population share of this age group in 2065 in Japan could fall anywhere between 52.2 percent to as low as 50.5 percent.[49]

[47] Ogawa and Ermisch, "Family Structure, Home Time Demands, and the Employment Patterns.", 679.
[48] National Institute of Population and Social Security Research. "Population Projections for Japan : 2016-2065 |National Institute of Population and Social Security Research." Accessed March 9, 2022. https://www.ipss.go.jp/pp-zenkoku/e/zenkoku_e2017/pp_zenkoku2017e_gaiyou.html.
[49] National Institute of Population and Social Security Research, "Population Projections for Japan".

Chapter Three: Ibasho

Ibasho is a Japanese term that translates to "a place where one feels a sense of belonging and purpose, and is accepted as oneself."[50] Dr. Emi Kiyota created the Ibasho organization in 2010 in order to facilitate spaces that provide *ibasho* for everyone as they age. The organization operates around eight central principles: elder wisdom, the maintenance of normalcy, communal ownership, intergenerational integration, demarginalization, cultural recognition, resilience, and imperfectness.[51] Each principle is integral to the Ibasho mission: to partner with locals to create "socially integrated and sustainable communities that value their elders."[52] This is done through a unique process of elders leading and owning the projects, which will be discussed in later sections.

This organization seeks, promotes, and facilitates communal collaboration with elders. Dr. Kiyota describes the importance of elder-led design in her lecture at the Body and Soul Symposium, drawing the analogy of the community as a hand, and the Ibasho organization helps to create the glove. Therefore, a given community must know what kind of glove they want in order for it to fit. Ibasho takes a dual-edged approach to their mission and philosophy through detailing the organization's physical and social attributes. Elder involvement with development, community presence, a non-institutional abode, and the embracement of imperfection are the four core physical characteristics. Likewise, elder ownership and governance, non-profit, non-institutional, multi-generational relationships are the four main social characteristics.[53]

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[50] ReliefWeb. "Elders Leading the Way to Resilience - Japan." Accessed January 25, 2022. https://reliefweb.int/report/japan/elders-leading-way-resilience.
[51] Ibasho. "Ibasho Principles | Ibasho." Accessed January 25, 2022. https://ibasho.org/ibasho-principles.
[52] Ibasho. "Mission and Values | Ibasho." Accessed January 25, 2022. https://ibasho.org/about-ibasho/mission-and-values.
[53] Kiyota, Emi. "Ibasho Café: Giving Elders a Role to Play in Making Communities More Resilient." In *The Global Age-Friendly Community Movement*, 169–87. Berghahn Books, 2018.

First, I will detail the origins and structure of Ibasho, and then analyze what essential characteristics are applicable for the future of eldercare, noting how they demonstrate the socialization of care. I will give the examples of the Ibasho project in Japan, which best represents elder reciprocity, and the example of the Ivory Coast project, which best depicts elder integration. I want to note that though I select two specific projects to illuminate the aforementioned characteristics, these are not the only projects that possess such traits. Rather, I use these examples because they are the most suitable representations of reciprocity and integration.

Further, Ibasho exemplifies the universality of eldercare, as the organization has facilitated project sites in six countries: Japan, the Philippines, Nepal, Bhutan, the Ivory Coast, and Sri Lanka. Their approach to facilitating sites in different areas is molded to the specific needs of the given community, yet is guided by the eight core principles. This corroborates with the notion that eldercare must be tailored to individual community needs, yet also possesses a certain form of universality. In reference to the aforementioned metaphor of Dr. Kiyota, the purpose of the Ibasho organization is to be the facilitator of the creation of the glove, and this glove is different for each different community, yet ultimately, a glove is still required. Though Ibasho does not provide a formal method of caregiving, this organization does provide crucial insight into values that must be applied to eldercare methods as we enter this new demographic era of aging.

The Rate of Aging

Prior to analyzing the characteristics of Ibasho, I will highlight the compelling model that this organization provides for global population aging. Ibasho has facilitated projects in middle

to low income countries, which helps demonstrate the universality of the organization. This is of particular importance, since the United Nations World Population Prospects report indicates that least and lesser developing countries are aging at a much faster rate than developed countries.[54] Though the term "developing country" is vague and negligent, in this context it is highly useful to use this concept as a lens to illustrate the patterns of global population aging. The United Nations defines LDCs as "low-income countries confronting severe structural impediments to sustainable development" that are "highly vulnerable to economic and environmental shocks and have low levels of human assets."[55]

In 2017 LDCs had nearly 1000 million citizens aged 60 years or older, and this number is projected to soar to over 2000 million in 2050. On the other hand, more developed countries had about 250 million citizens aged 60 years or older in 2017, with this increasing to about 300 million in 2050. Even more, Africa is projected to experience a 228.5 percent change between 2017 and 2050 in the number of persons aged 60 years or older. Meanwhile, Europe is expected to experience only a 35.1 percent change.[56]

Ibasho's eldercare project in Bhutan provides a brief example of the organization's work in LDCs.[57] This project sought to create a community for retired elderly monks and was initiated by Dr. Mary Ann Tsao, and partnered with the Bhutan Central Monastic Body. The objectives of this project were to "offer opportunities to practice Buddhism" and "employ resident directed care."[58] I emphasize that the Bhutan project provides a compelling example of how to approach

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[54] United Nations, Department of Economic and Social Affairs, and Population Division. *World Population Ageing, 2017 Highlights*, 2017., 4.
[55] United Nations. "Least Developed Countries (LDCs) | Department of Economic and Social Affairs." Accessed March 3, 2022. https://www.un.org/development/desa/dpad/least-developed-country-category.html.
[56] United Nations, *World Population Ageing, 2017 Highlights*., 5.
[57] United Nations. "UN List of Least Developed Countries | UNCTAD." Accessed April 7, 2022. https://unctad.org/topic/least-developed-countries/list.
[58] Ibasho. "Bhutan | Ibasho." Accessed April 6, 2022. https://ibasho.org/projects/ibasho-elder-care/bhutan.

such forceful projected patterns of demographic aging, given that these areas will soon face a rapid rate of increase in their elderly populations.

Origins

Dr. Emi Kiyota's passion for elders began early in her life. Growing up in a multigenerational household in Japan shaped this sentiment, as she was always seeking wisdom from her grandparents and great-grandparents. When Dr. Kiyota's grandmother began to experience memory issues, she checked herself into a nursing home in fear of being too "burdensome" to the family. After Dr. Kiyota first visited, she found that the staff did not even know her grandmother was a patient at the facility. For Dr. Kiyota, her wise grandmother always came first, yet for the nursing home staff, her grandmother was reduced to a diagnosis followed by a room number on a medical chart. Dr. Kiyota had never actually "seen that world."[59] Months passed at the nursing home, and after another visit, it was time to part ways. However, her grandmother, not able to speak much at all, still pleaded "don't go."[60] These were her last words. Dr. Kiyota realized a change needed to happen, and decided to resign from her job and go to the United States to study aging in graduate school.

During her time at graduate school, Dr. Kiyota lived in a long-term care facility for three weeks alongside elders to conduct research. She wanted to put herself into the shoes of residents in order to better understand ways to improve the design of long-term care institutions such as the one her grandmother lived in. For example, Dr. Kiyota committed to being wheelchair bound, having her teeth brushed for her, as well as showering with assistance. Her focused study

[59] Ryan, Susan. "Ibasho & Elder-Led Design." Elevate Eldercare, 2020.
[60] Kiyota, Emi. "'Body & Soul' Symposium - Emi Kiyota on Vimeo." 2013. https://vimeo.com/55685206.

of elders coincides with her philosophy of always listening to the input of elders, first and foremost.

Often, we "treat older people as a commodity," and this strips elders of their human dignity and respect later in life.[61] During her time at the long-term care facility, Dr. Kiyota encountered many design flaws that treated elderly patients as such. In her lecture at the Body and Soul Symposium, she described how the design structure of the home influenced her physical and emotional wellbeing as a 'patient.' For example, though the nursing home was filled with plants and pleasant decorations, this did not necessarily translate to an enjoyable experience. She recalled the dysfunctional design that impeded her daily routine when attempting to simulate an elderly resident's experience. Activity rooms and living rooms "parked people," demonstrating a counterintuitive approach to leisure time.[62] She noted the irony in the poor accessibility of the nursing home and illogical design. For example, the countertops of desks were too high to even see over, much less converse with the staff behind the counter. Most notably, it was some of the smallest details that created significant obstacles to everyday maneuvers, such as medical carts or trash cans. Foul smelling trash cans would meet residents at eye-level, and medical carts would consistently clutter hallways. Everything was closed off, and Dr. Kiyota stressed that residents, especially those with dementia, were likely to perceive their nursing home as a hostile, scary space, not as their welcoming home.

Dr. Kiyota's compelling remarks describe how this experience allowed her to physically see the importance of purposeful design in long-term care. This design, however, did not necessarily equate to luxurious carpets or intricate decor, but rather she references a design that creates opportunity for meaning. She argued that environment means more than just paint choice

[61] Kiyota, "Body & Soul".
[62] Kiyota, "Body & Soul".

or incorporation of nature and plants, it also means putting yourself in the shoes of elders and continuing to ask more questions and communicate with them to create meaningful design.

General Overview

Dr. Kiyota continued her driven pursuit in eldercare, motivated to create change, and founded the Ibasho organization in May of 2010, then gaining their tax-exempt status with a 501(c)(3c) the following December of that year. Ibasho has a Board of Directors of nine members, each serving a vital role to the organization. Dr. Emi Kiyota, an environmental gerontologist, is the founder and director of Ibasho. In addition, Britta Berge, Catherina Celosse, JD, Susan Mende, MPH, Dr. Taryn Patterson, Carrie Rich, Dr. Robyn I. Stone, Sharyn Yorio, FSMPS, and Ann Wyatt, M.S.W. comprise the rest of the board.

The organization identifies three principal problems and their solutions that they seek to solve in the Ibasho Toolkit. Economic burden, natural disaster risk, and social isolation are major problems that impede the lives of elders. However, Ibasho provides answers, as elders lead and own the sites, giving them economic security and purpose. Secondly, Ibasho centers double as evacuation centers, and practice disaster drills to help prepare elders, who are disproportionately affected by these events, for dangerous situations. Finally, Ibasho creates opportunities for elder empowerment and social integration by creating the opportunity to foster strong social relationships on Ibasho sites.[63] The organization aims to solve these three chief problems through their project process of facilitating Ibasho sites.

[63] Kiyota, Emi, Margaret Arnorld, Yasuhiro Tanaka, Kirsetn Bobrow, and Susan Tan. “The Ibasho Toolkit.” Ibasho, 2019. https://ibasho.org/wp-content/uploads/2019/10/191001The-Ibasho-Toolkit.pdf., 8.

Project Process

Ibasho utilizes a methodological process of five steps to carry out projects. First, the Ibasho team performs a pre-project exploration in which they review the application of local groups, composed mainly of elders. Field inquiries are conducted by the community leaders with Ibasho, and the team discusses project goals. The second phase is to establish a shared understanding between Ibasho and the community by reviewing financial and legal responsibility as well as selecting a local coordinator. Once completed, the third phase supplies technical support to elders, specifically the necessary resources to actualize the project. Even though this support is provided, it is crucial to emphasize that the Ibasho team supports elders in making their own decisions, rather than making decisions for them.[64]

There are four workshops held during the third phase. First, the education workshop highlights Ibasho's eight core principles, and then a goal-oriented workshop follows. Third, the team meets to develop operational plans, and finally a design workshop develops these ideas into a blueprint, establishing physical infrastructure design. In addition, the third stage includes establishing the local organization to sponsor the project, training elders on how to sustain this project (both financially and legally), training Ibasho ambassadors, creating sustainable jobs (both environmentally and socially), and impact evaluation. [65] The Ibasho team and community leaders enter the fourth phase with the goal of assisting elders in producing the physical product, which entails mainly construction and physical development of the particular Ibasho site.

Finally, the project concludes in a fifth phase with Ibasho coordinators stepping away and allowing the community project to come to fruition. The fifth stage of the Ibasho process signifies the ability of these projects to be sustainable, which I maintain is vital to communal

[64] Kiyota, et al. "The Ibasho Toolkit.", 18.
[65] Kiyota, et al. "The Ibasho Toolkit."

eldercare development. Additionally, as this stage represents the Ibasho principle of cultural appropriateness, I also extend the case that Ibasho is a global model of eldercare. Particularly, the organization enables individual communities and cultures to create spaces to accommodate the specific needs of their elders while simultaneously advancing their eight core principles to institute ethical eldercare across the globe.

Projects and Training Programs

Ibasho has completed multiple projects with this process since its inception in 2010, and each of these projects are carried out with the purpose of addressing the needs of each specific site. Specifically, Ibasho has completed natural disaster relief projects in Japan, the Philippines, and Nepal as well as eldercare projects in Bhutan, the Ivory Coast, and Sri Lanka.

It must be noted that Ibasho's natural disaster relief projects were still born out of a desire to assist and empower elders in natural disasters, as they are the most vulnerable population. The relief project in Japan was the first Ibasho project, beginning in May of 2012, and the project included the creation of the Ibasho Café, noodle shop, vegetable farm, farmer's market and community resource center. I will further detail this project later in my analysis of elder reciprocity.

The Philippines project soon followed in April of 2014 after Typhoon Yolanda in November of 2013. The Ibasho organization and their partner Barangay Bagong Buhay created a community resource center, children's nutrition program, and vegetable farm. Finally, the project in Nepal began in February of 2016 following the Nepal Earthquake in April of 2015. This project created a new form of adaptation, as Ibasho and their partner, the Village of Matatirtha, utilized pre-existing structures and spaces to implement the Ibasho concept at a village level.

Some of the amenities here included: “a vegetable farm, biodynamic composting, flower nursery, handicrafts, pickles, and a multigenerational learning hub.”[66]

In addition to their natural disaster and eldercare projects, Ibasho works to spread the principles and values of the organization through training programs, namely the Iasho Ambassador Training and Peer-to-Peer Knowledge Exchange programs. The Iasho Ambassador Training is a training program for Ibasho elders who seek to delineate the Ibasho concept to other community leaders. The Peer-to-Peer Knowledge Exchange program connects Ibasho elders from different Ibasho sites to learn from each other and form a greater community. These programs represent the organization’s commitment to advancing elder empowerment and connection, and are yet another approach to addressing global population aging. That is, not every location that is faced with eldercare challenges may need the help to create a community resource center, for example. However, through a training program, Ibasho is able to advance the future of eldercare through the spread of ideas and information, in which each community can then adapt these concepts and alter them as needed.

Lessons Learned: Reciprocity

The aforementioned Ibasho Café encapsulates the value of elder reciprocity, which I argue is essential to the future of eldercare. In order to analyze how the Ibasho organization exemplifies this characteristic, I will first detail the circumstances that led to the creation of the site in the community of Ōfunato, Japan. In 2011, Japan suffered the Great East Japan Earthquake and subsequent tsunami, resulting in significant, widespread destruction. The earthquake led to a tsunami, a nuclear power plant accident, power supply failure, and disruption

[66] Kiyota, et al. “The Ibasho Toolkit.”, 27.

of supply chains.[67] Nearly 16,000 people lost their lives, and over 50 percent of the lives lost were those aged 65 and above.[68] One community that suffered some of the worst was a coastal community, Ōfunato. The Ibasho Café was created in response to this tragedy, aiming to give elders a community safeguard, and elders now design, own, and operate a space designated for social connection.[69] One essential caveat: this would not be a space for scheduled visits or a senior center. Rather, the goal was to create a natural environment for elders to give back to their community and foster reciprocal relationships.

In February of 2012, Dr. Kiyota traveled to visit the Tsunami victims, and to discuss the project of the Ibasho Café. The idea originated from a conversation Dr. Kiyota had with an elderly woman, discussing how they (elders) were always the ones to be served tea, rather than serving it, despite the fact that they often know how to make it even better. Dr. Kiyota asked the elderly woman why she would not make the tea, and the elderly woman replied that it was because nobody ever asked. Everybody wants to "feel useful to others," and therefore Ibasho wants to ensure that this includes elders too.[70] The Ibasho Café building permit was approved in January of 2013, and in July of that year, the Ibasho Café opened its doors to the community of Ōfunato. Since then, Ibasho elders have organized 500 events while also welcoming over 18,000

[67] World Bank. "The Great East Japan Earthquake--Learning from Megadisasters : Knowledge Notes, Executive Summary." Washington, DC: World Bank, 2012. https://openknowledge.worldbank.org/handle/10986/17107.
[68] Kiyota, Emi. "WRC2: World Reconstruction Conference 2 | Ibasho." Ibasho, 2014. https://ibasho.org/resources/lectures/140911wrc2., slide 2.
[69] Ibasho. "Ibasho Cafe at Tsunami Disaster Area in Japan | Ibasho." Accessed April 17, 2022. https://ibasho.org/blog/20120212-451.
[70] Kiyota, Emi. "I Lost Everything by the Tsunami, but We Still Have Each Other | Ibasho," February 18, 2012. https://ibasho.org/blog/20120218-486.

visitors.[71] Café patrons typically live within walking distance, and age groups vary from children to the oldest of the old.

Reciprocity is defined as "a mutual exchange of privileges."[72] Often, elders are stereotyped as the weak, vulnerable, and helpless.[73] However, placing elders in such a demeaning and dependent role is counterproductive, as social exchange theory asserts that this an undesirable position for all.[74] In fact, Dwyer et al. suggest that such dependency dwindles resources, meaning that only "currency" elders have is the potentiality to abide by the wishes of others, particularly the nonelderly. The best way to counteract this is by generating opportunities for elders to exchange currency, both socially and economically.

In the example of Ibasho, elder collaboration paved the way for reciprocity. Specifically, while the Ibasho organization provided technical and logistical support, elders provided their invaluable wisdom learned from lived experiences. The Ibasho Café project facilitated this concept of reciprocity by providing elders with different means of currency, not only generating elder economic capital, but social capital as well. Economic capital provides the opportunity for elders to give back to their communities by allowing them to directly exchange goods and services. Elders own and operate the café, which places power and capital back into their hands. This characteristic is crucial for the financial freedom of elders, which is strongly tied to the independence of them. Chapter Four's analysis of Japan's LTCI will further detail the role finances play in elder independence.

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[71] Ibasho. "Empowering Elders Through Community Coalitions for Resilience: The Ibasho Approach," 2016. https://ibasho.org/wp-content/uploads/2016/10/160902Empowering-Elders-Through-Community-Coalitions-for-Resilience-The-Ibasho-Approach.pdf.

[72] "Reciprocity Definition & Meaning - Merriam-Webster." Accessed February 14, 2022. https://www.merriam-webster.com/dictionary/reciprocity.

[73] World Health Organization. *Global Report on Ageism*.

[74] Dwyer, Jeffrey W., Gary R. Lee, and Thomas B. Jankowski. "Reciprocity, Elder Satisfaction, and Caregiver Stress and Burden: The Exchange of Aid in the Family Caregiving Relationship." *Journal of Marriage and the Family* 56, no. 1 (1994)., 36.

Social capital facilitates the same sentiment in a different sphere. For instance, elders can sit and share stories or wisdom with each other and younger groups over a cup of coffee. This valuable form of connection is often not provided at senior day care centers or nursing home activity rooms, since these institutions do not typically integrate elders with other generations nor promote natural communication. Furthermore, statistics show that the elderly in Japan are significantly less social than other countries. "According to an international comparative survey, 15 percent of Japanese aged 60 and over report that they often or usually join social gatherings, whereas the proportion is 63 percent in Germany, 60 percent in the United States, and 53 percent in the United Kingdom."[75] There is an apparent need to foster social connection and subsequent social capital, and the Ibasho Café is an example of facilitating such social exchange.

Though the Ibasho Café was born out of disaster relief efforts, the values and insights the organization provides are applicable to nursing homes, assisted living facilities, and communities across the world. We must give more nuance to old age: still seeing elders as those who we must protect, but also those who can protect us, and thus establishing elder reciprocity.

Lessons Learned: Elder Integration

Ibasho's project in Abidjan, Ivory Coast began in 2010 with the objective of integrating elderly priests back into their communities and to continue teaching others. The Saint Joseph d'Arimathie foundation partnered with Ibasho on the project, and local elder Father Raoul Mambo advised the Ibasho team. This project sought to create jobs, build a community resource center, and a technical high school for locals. The community resource center consisted of a

[75] Kosberg, Jordan. *International Handbook on Services for the Elderly*. Westport, Conn. : Greenwood Press, 1994, 240.

library, playground, educational facilities, gathering space, clinic, and a public health education center.

The project's primary goal was to reconnect priests with their communities and is an exemplar for elder integration. One foundational aspect of elder integration is joining perhaps the two most captivating age groups, the old with the young. While one group is just beginning life, the other is entering its conclusion, therefore creating a harmonious opportunity for growth and learning. Dr. Kiyota underscores the importance of this compatibility by stating, "Elders living in grass huts in Africa with children at their feet are often happier than people in beautiful nursing homes with a chandelier over their heads."[76]

Elder integration further fosters social capital, and this is vital to elder well-being as previously mentioned. Dr. Kiyota notes, "If society can embrace this notion of integrated living, it is not only the elderly who benefit. Society as a whole benefits because it is low cost, encourages volunteerism and builds social capital within the community."[77] In other words, by promoting relationships between elders and their community, reciprocity is created and elders are viewed as part of the community rather than apart from the community.

It is important to note, at the core of this argument lies the notion of multigenerational spaces. It is an innate aspect of life to enjoy the presence of those we can learn from. In this case, it is agreed that children of course can learn from elders, but also elders may find themselves learning how to reconnect with the wonder of life that the young have. Though Japan is

[76] KIYOTA, EMI. "Co-Creating Environments: Empowering Elders and Strengthening Communities through Design." *The Hastings Center Report* 48, no. 5 (2018): S46–49., 46.
[77] "From Care to Lifestyle: A City for All Ages." Centre for Livable Cities Singapore, September 13, 2012. https://ibasho.org/wp-content/uploads/2014/01/130913From-Care-to-Lifestyle_A-City-for-all-Ages.pdf., 42.

experiencing a decline in multigenerational homes,[78] Ibasho is fostering the opportunity to create multigenerational environments in the community. In the example of the Ivory Coast project, for example, this can take shape through a community resource center. Nevertheless, it is vital to foster spaces that integrate all age groups, as this can not only help to work against learned ageist stereotypes, but also allow elders themselves to feel one with their community.

Socialization of Care

Reciprocity and integration are elements of care that are vital to holistic eldercare. Though these characteristics of caregiving have traditionally been cultivated in the home, the aforementioned examples demonstrate that there is an evident shift occurring, that is from the sole family to the collective community. This shift is generally driven by the four primary factors behind the caregiving gap: population aging, women's increased participation in the workforce, a decline in the age dependency ratio, and a decline in multigenerational co-residence. Thus, taking this shift into account, it is evident that adaptations to this state of eldercare must generate reciprocity and multigenerational interaction in order to promote the best quality of care for elders.

After the devastating disaster, the community of Ōfunato fostered a café that facilitated the opportunity for elders to give their input, advice, and experience. The Ivory Coast project demonstrates the socialization of care very similarly, but with emphasis on creating spaces for those of all ages. This private, non-profit approach is a fitting solution to the caregiving gap that the world is and will continue to face. The Ibasho organization has made significant progress

[78] World Health Organization, National Institute on Aging, National Institutes of Health, and U.S. Department of Health and Human Services. "Global Health and Aging," 2011. https://www.who.int/ageing/publications/global_health.pdf., Figure 14, 27.

since its inception in 2010. Today, projects exist in six countries across the globe, and training and exchange programs continue to disseminate the message of Ibasho.

I was fortunate to attend a lecture that Dr. Kiyota gave at Georgetown University, in which she explained a concept that aids in summarizing Ibasho and its purpose. As aforementioned, the family has traditionally played a major role in caregiving, yet with a rise in the caregiving gap, it is evident that this tradition is changing. To illustrate, Dr. Kiyota gave the example of mapping elders' support systems in circles. She stated that a traditional mapping of elders' support system would suggest that in a given circle, from outermost to innermost, an elder looks from their government, to their community, to their family, for care. Thus, a decline in family caregiving structures then removes the family from this circle, and an elder immediately looks to the community for caregiving. It is both the community and the following layer of the circle, the government's role in eldercare, that will be able to comprehensively address population aging. The following chapter will discuss this governmental layer of eldercare through an analysis of Japan's LTCI.

Chapter Four: The Long-Term Care Insurance System

In addition to grass-roots methods of care, Japan also provides a governmental model of community-based eldercare through the long-term care insurance system. The Japanese government enacted a mandatory Long-Term Care Insurance (LTCI) system in 1997, and implemented it on April 1, 2000.[79] The LTCI, or *kaigo hoken*, made Japan "the first country in Asia whose government bears essential responsibility for the social care of its elderly citizens."[80] The LTCI is the largest and considered by many to be the most radical, mandatory long-term care insurance program in the world.[81] Such a salient system garners attention and raises important questions of how to approach the future of eldercare.[82] I will first provide a brief history of long-term care insurance in Japan, and then explicate the current LTCI, emphasizing how at the core of this system lies elder independence, a characteristic that is necessary to not only long-term care insurance but eldercare as a whole for societies across the world.

As Yong and Saito note, this piece of legislation "moved the country decisively towards a system of social care for its growing elderly population."[83] Japan already had implemented universal health care in 1961 through the National Health Insurance (NHI) system. Over a decade later, in 1973, the introduction of the Free Medical Care Scheme for the Elderly provided completely free medical care to everyone aged 70 and over, when the proportion of elderly

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[79] Timiya, Nanako, Haruko Noguchi, Akihiro Nishi, Michael R. Reich, Naoki Ikegami, Hideki Hashimoto, Kenji Shibuya, Ichiro Kawachi, and John Creighton Campbell. "Population Ageing and Wellbeing: Lessons from Japan's Long-Term Care Insurance Policy." *Lancet* 378, no. 9797 (2011): 1183–92., 1184.
[80] Yong, Vanessa, and Yasuhiko Saito. "National Long-Term Care Insurance Policy in Japan a Decade after Implementation: Some Lessons for Aging Countries." *Ageing International* 37, no. 3 (September 2012): 271–84. https://doi.org/10.1007/s12126-011-9109-0., 272.
Hiraoka, Koichi. "Long-Term Care Insurance in Japan." In *Handbook of Asian Aging*. Routledge, 2018.
[81] Kavedžija, Iza. *Making Meaningful Lives: Tales from an Aging Japan (Contemporary Ethnography)*. University of Pennsylvania Press, 2019., 22.
[82] Kavedžija, Iza. *Making Meaningful Lives,* 22.
[83] Yong and Saito. "National Long-Term Care Insurance Policy", 272.

requiring medical care was only 5.7 percent.[84] However, from 1960 to 1980, the elderly population (65 and over) nearly doubled from 5.4 million to 10.6 million.[85] With increasing pressure from demographic change, in 1982 the Health and Medical Service Law for the Aged was enacted, ending free medical care and mandating a copayment.[86] Still, anyone aged 70 and over only paid 20 percent of this rate.[87] This legislative process demonstrates the government's extension of care to include elders.

Furthermore, the nuclear family was on the rise in postwar Japan, correlating with a significant change in housing arrangements. Matsunari demonstrated through opinion polls from the time period of 1950 to 1990 a shift in attitudes around caregiving alongside the introduction of old age pension. There is a shocking flip between the percentage of elders who plan to depend on an adult child in old age in 1950 (59.1 percent) to 1990 (17.5 percent). In fact, in 1990 61.7 percent of elders planned to not depend on an adult child in old age.[88] Matsunari attributed this switch in opinion to the old age pension that became effective in 1960, which is when the statistics began to flip. Similarly, evidence from Ogawa et al. in Chapter Two asserted that a heightened social welfare state caused a decline in multigenerational housing, yet it is important to maintain that the direction of causality of these two events is contested.[89]

[84] Sudo, Kyoko, Jun Kobayashi, Shinichiro Noda, Yoshiharu Fukuda, and Kenzo Takahashi. "Japan's Healthcare Policy for the Elderly through the Concepts of Self-Help (Ji-Jo), Mutual Aid (Go-Jo), Social Solidarity Care (Kyo-Jo), and Governmental Care (Ko-Jo)." *BioScience Trends.*, n.d., 5., 8.
[85] Hiraoka, Koichi. "Long-Term Care Insurance in Japan.", 356.
[86] Hiraoka, Koichi. "Long-Term Care Insurance in Japan.", 357.
[87] Sudo et al., "Japan's Healthcare Policy," 8.
[88] Koyano, "Filial Piety", 52.
[89] Tuljapurkar, et al., *Ageing in Advanced Industrial States*.

Social Hospitalization

As a result of the decline in multigenerational co-residence, many elderly sought care through a hospital since their families could not or would not provide care.[90] This initiated a new trend of "social hospitalization," referring to the pattern where elders choose to stay at a hospital for a prolonged period of time, not due to acute medical needs but rather the "social necessities" of long-term care.[91] The aforementioned Health and Medical Service Law for the Aged, which ended free medical care and mandated a copayment, was in part an attempt to deter elders from seeking long-term care at hospitals.[92]

Social hospitalization is integral to understanding the socialization of care that the LTCI expanded upon. It could be argued that this trend of the past demonstrates a shifting mindset that the LTCI has adapted to. Specifically, elders began seeking care outside of the family unit as the family's traditional role in long-term care was declining.[93] This represents a new approach to long-term care in Japan, through an institution such as the hospital. In fact, in 2001 "more than 80 percent of high cost elderly patients (top 5 percent) were long-term inpatients hospitalized for ninety days or more."[94]

Motivations Behind the LTCI

There are several reasons why the LTCI was created. Namely, demographic change, the misuse of hospitals, changing family demographics, assisting women in the workforce, and

[90] Iwagami, Masao, and Nanako Tamiya. "The Long-Term Care Insurance System in Japan: Past, Present, and Future." *JMA Journal* 2, no. 1 (March 4, 2019): 3. https://doi.org/10.31662/jmaij.2018-0015., 67.
[91] Shimizu, Y., and J. Wake. "International Handbook on Services for the Elderly," 1994, 227–43., 236.
[92] Hiraoka, Koichi. "Long-Term Care Insurance in Japan.", 357.
[93] Hiraoka, Koichi. "Long-Term Care Insurance in Japan.", 357,
[94] Ogura, Seiritsu, Toshiaki Tachibanaki, and David A. Wise, eds. *Aging Issues in the United States and Japan*. A National Bureau of Economic Research Conference Report. Chicago: University of Chicago Press, 2001., 221.

revising the welfare system were all principal reasons behind this formation. Yet, it is worth noting these reasons are all closely interconnected and thus have intersected and coalesced with each other to create the situation at present. Further, this myriad of factors each added a layer to the plethora of issues surrounding eldercare and its future.

The first motivation behind the formation of Japan's LTCI was the sharp increase in the elderly population. In 1980, the percentage of elders in Japan's population was 9.1 percent. As of 2020, this number has more than doubled, at 26.7 percent, the largest percentage in the world.[95] This statistic is expected to increase to 39.9 percent by 2060.[96] Such a sharp rise in the elderly population remains at the forefront of the conversation surrounding long-term care, as many of these elders will need some form of care as they age. In fact, the number of elders that need a greater level of care are estimated to increase from 2.8 million in 2000 to 5.2 million in 2025.[97] Even more, about 45 percent of people will need some form of long-term care at some point in their lives.[98] These population demographics necessitate a comprehensive long-term care insurance system.

Additionally, the misuse and subsequent increased costs of hospital care led to widespread inefficiency and inadequacy in long-term care. Thus, in theory Japan's LTCI could not only streamline the process of long-term care, but also reduce cost. Increasing costs can be explained by the trend of "social hospitalization," which placed further pressure on hospitals by misusing resources on elderly patients who did not necessarily need that extent of medical care.

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[95] Health and Welfare Bureau for the Elderly. "Long-Term Care Insurance System of Japan."
[96] Health and Welfare Bureau for the Elderly. "Long-Term Care Insurance System of Japan."
[97] Yong and Saito. "National Long-Term Care Insurance Policy", 272.
*Greater level of care means "The number of older people who are bedridden, have dementia, or need assistance with activities of daily living."
[98] Ministry of Health, Labour and Welfare. "Long-Term Care Insurance in Japan." Accessed February 10, 2022. https://www.mhlw.go.jp/english/topics/elderly/care/1.html.

"Total expenditures for medical care for those ages 70 and older in Japan increased by 5.7 times from 1973 to 1981, and by 79 percent from 1983 to 1990."[99] Furthermore, this trend resulted in low quality care since these hospitals lacked the necessary facilities such as: "dining halls, lounges, and rehabilitation facilities."[100] Through implementing a long-term care insurance system, in theory there would be less desire or need to use hospitals as a form of long-term care. However, as aforementioned there remains substantial nuance to the preference of hospital stays over nursing homes, as there exists an underlying social norm of the elderly in Japan taking preference of the hospital over nursing homes, for example, as a more socially acceptable form of long-term care.[101]

The rise in the nuclear family is closely tied to another motive to form the LTCI. That is, a changing family structure is thought to have led to a decline in multigenerational housing, which has and continues to shift norms surrounding family caregiving. That is, as detailed in Chapter Two, the customary approach of care for elders is filial, typically with the daughter-in-law assuming responsibility for this role, and this is largely based in Confucian tradition.[102] Recently, there is an evident decline in adult children caring for parents, with an increase in elders living alone or with a spouse. To quantify, in 1960, 87 percent of those aged 65 or older lived with their adult children, however in 2005 this percentage dropped to 47 percent.[103]

At the same time, recent trends show the female labor force is growing in Japan, and therefore this paired with a decline in multigenerational housing translates to the overall decline

[99] Hiraoka, Koichi. "Long-Term Care Insurance in Japan.", 358.
[100] Hiraoka, Koichi. "Long-Term Care Insurance in Japan.", 357.
[101] Campbell, Ruth. "Nursing Homes and Long-Term Care in Japan." *Pacific Affairs* 57, no. 1 (1984): 78–89. https://doi.org/10.2307/2758388., 81.
[102] Yamamoto and Wallhagen, "The Continuation of Family Caregiving in Japan".
[103] World Health Organization, National Institute on Aging, National Institutes of Health, and U.S. Department of Health and Human Services. "Global Health and Aging," 2011. https://www.who.int/ageing/publications/global_health.pdf., 27.

in informal caregiving, filial caregiving.[104] Over 85 percent of caretakers of bedridden elders (aged 65 or over) are women.[105] The number of women participating in the labor force has been simultaneously growing, increasing by five percent since 2012, reaching 53.2 percent in 2020. These two trends are at an evident crossroads, and interventions such as the LTCI help to redirect caregiving responsibility to the community.[106]

An additional reason to create the LTCI, and perhaps the most significant, was to address the issues present within the current social welfare system, specifically regarding inclusivity. Japan's pre-existing Social Welfare Law for the Elderly, created in 1963, "was neither comprehensive nor welcoming to most Japanese elderly."[107] Though it included a long-term care program, a multitude of problems made this less accessible to all elders. Specifically, it was essentially only available to low-income elders, making it especially difficult for elders in a middle or upper-income group to pay for care costs out of pocket. Healthcare systems did not coordinate well with the welfare system, adding to the bureaucratic maneuvering necessary to receive care. And, there were long waiting lists for placement into nursing homes, often two to three years.[108]

All things considered, these presented reasons all represent the push towards the responsibility of care lying in the hands of the community. In fact, Ozawa and Nakayama argue, "Perhaps more than any other force that led Japan to launch comprehensive long-term care insurance was the emergence of an ideology that adopted the notion of socialized care for the

[104] Yong and Saito. "National Long-Term Care Insurance Policy", 273.
[105] Health and Welfare Bureau for the Elderly. "Long-Term Care Insurance System of Japan," 3.
[106] Statista. "Japan: Labor Force Participation Rate by Gender 1973-2020." Accessed February 16, 2022. https://www.statista.com/statistics/1233936/japan-labor-force-participation-rate-by-gender/.
[107] Yong and Saito. "National Long-Term Care Insurance Policy", 273.
[108] Ozawa, Martha N., and Shingo Nakayama. "Long-Term Care Insurance in Japan." *Journal of Aging & Social Policy* 17, no. 3 (September 2005): 61–84. https://doi.org/10.1300/J031v17n03_04., 67.

elderly."[109] Thus, it is important to keep in mind that the country was already shifting in this direction prior to the introduction of any real policy. In fact, most often policy is created as a response to the current setting, and thus the LTCI serves as the missing piece of the puzzle.

Goals of the LTCI

Japan's Health and Welfare Bureau for the Elderly, a division of the Ministry of Health, Labour and Welfare (MHLW), outlines four main goals of the LTCI. The first goal, "To facilitate a system in which the society as a whole supports those who are facing the need of long-term care, society's major cause of concern in terms of becoming old," encapsulates the repeated theme of the socialization of care.[110] In addition, a goal of the LTCI was to make the benefit and burden relationship of patient and care provider clear for public understanding. Further, it was necessary to rework the "vertically-divided system" between medical, health, and welfare services, and instead to provide seamless, comprehensive care. Finally, the introduction of the LTCI sought "To separate long-term care from coverage of health care insurance, and to establish a system which aims to decrease cases of "social hospitalization" as the first step toward restructuring the social security system as a whole."[111] These goals of the LTCI help to illuminate where the needs of Japan were, and where the needs of many other countries are headed. In other words, the goals of Japan's LTCI are very similar, if not the same, of the goals of other advanced aging societies.

[109] Ozawa and Nakayama. "Long-Term Care Insurance in Japan.", 67.
[110] Health and Welfare Bureau for the Elderly. "Long-Term Care Insurance System of Japan."
[111] Health and Welfare Bureau for the Elderly. "Long-Term Care Insurance System of Japan."

Enrollment in the LTCI

I first give the background of the general organization of the LTCI to give context to my argument, and convey the way in which this system is actualizing the goals it originally sought. The insurer of the LTCI is a municipality of Japan, for example a city, village, or ward of Tokyo.[112] The decision to designate municipalities as insurers resembles the original intent of the LTCI, to be a welfare service. Specifically, previous welfare policies required municipalities to take responsibility, and thus the LTCI adapted this framework of a social welfare approach rather than that of a federal health care system.[113]

Recipients of the LTCI are separated into two categories: those who are aged 65 and over (Category 1), and those aged 45 to 64 who are also registered in other insurance schemes (Category 2). Over 32 million persons are qualified in Category 1, and nearly 43 million persons are in Category 2.[114] Everyone over the age of 65 is guaranteed services regardless of ability to pay.[115] The LTCI is a mandatory insurance system, and thus any resident of these given municipalities who qualifies is required to enroll in this insurance system. Assessment officers evaluate applicants through home visitations, assessing the applicant's mental and physical state. "In addition, the applicant's family doctor is required to submit a diagnostic appraisal and rate the applicant's need for supportive services."[116]

A "Board for Certifying the Need for Long-Term Care, (*kaigo nintei shinsakai*),"[117] is required for Category 2 participants, demonstrating that they need care due to one of 15 diseases

[112] Hiraoka, Koichi. "Long-Term Care Insurance in Japan.", 364.
[113] Ozawa, Martha N., and Shingo Nakayama. "Long-Term Care Insurance in Japan." 69.
[114] Health and Welfare Bureau for the Elderly. "Long-Term Care Insurance System of Japan."
[115] Matsumoto, Yoshiko. *Faces of Aging: The Lived Experiences of the Elderly in Japan*. Stanford University Press, 2011., 65.
[116] Hiraoka, Koichi. "Long-Term Care Insurance in Japan.", 365.
[117] Ozawa, Martha N., and Shingo Nakayama. "Long-Term Care Insurance in Japan.", 72, 73.

qualified as specifically related to aging. For example, these persons could suffer from "early-stage dementia, cerebrovascular disorder, amyotrophic lateral sclerosis, and Parkinson's disease."[118] Certification is attained through the assessment officer's answers from an 85-item questionnaire, and these results are used to assign applicants to an according care level.

There are three main categories of applicants: those who are "non-applicable," those who require support, and those who require long-term care.[119] Those qualified as non-applicable do not receive benefits. Applicants in need of support receive in-home services. For example, some in-home services are: "Home visits, day rehabilitation, allowance for home renovations such as handrails, etc."[120] Applicants who require long-term care are assigned to one of five levels of care varying in severity.[121] A yen-value is assigned to these various levels of care and, typically with the assistance of a care manager, a caregiving plan is arranged.[122]

The bureaucratic operation of determining who will receive benefits, and what specific kinds of benefits they need greatly signifies the increased efficiency and efficacy of the LTCI. This addresses the motivations of creating the LTCI, specifically to deter social hospitalization and reorganize the old Social Welfare Law for the Elderly.

LTCI Funding and Cost

The LTCI is funded through enrollee contributions and public funding. This cost is split in half between the insured and the government sector. Specifically, 17 percent of the expenses come from Category 1 participants and 33 percent from Category 2. Likewise, the central

[118] Hiraoka, Koichi. "Long-Term Care Insurance in Japan.", 364.
[119] Hiraoka, Koichi. "Long-Term Care Insurance in Japan.", 365.
[120] Health and Welfare Bureau for the Elderly. "Long-Term Care Insurance System of Japan."
[121] Hiraoka, Koichi. "Long-Term Care Insurance in Japan.", 365.
[122] Matsumoto, Yoshiko. *Faces of Aging*, 65.

government is responsible for 25 percent of expenses, the prefectures 12.5 percent, and municipalities 12.5 percent.[123]

The insured persons can be responsible for three possible payments: a premium, a copayment, and a deductible. A premium is defined as the amount paid periodically to the insurer by the insured for risk coverage.[124] Category 1 premiums are collected by municipalities and their premium is based on income brackets. This amount is typically taken out of social security benefits if the insured elder receives more than ¥180,000 per year.[125] The Category 2 premiums are collected for health care insurance by the insurers. In Category 2, insured persons pay their premium through payroll taxes or directly to their municipality if they do not have an employer.[126] The premium amount is therefore based on income, and these premiums are collected and placed into the Long-Term Care Insurance Trust Fund. From there, the LTCI Trust Fund distributes 33 percent to each municipality in accordance with the designated budget for Category 2 persons as aforementioned. Thus, there is a "built-in redistribute function by design," since municipalities with greater financial need will receive 33 percent, regardless of what their contribution was.[127]

In addition to a premium that keeps the insurance active, recipients of the LTCI are also required to pay a copayment for services. A copayment is defined as, "a relatively small fixed fee that a health insurer requires the patient to pay upon incurring a medical expense covered by the

[123] Hiraoka, Koichi. "Long-Term Care Insurance in Japan.", 364.
[124] "What Is Premium? Definition of Premium, Premium Meaning - The Economic Times." Accessed February 6, 2022. https://economictimes.indiatimes.com/definition/premium.
[125] Ozawa, Martha N., and Shingo Nakayama. "Long-Term Care Insurance in Japan."., 71.
[126] Ozawa, Martha N., and Shingo Nakayama. "Long-Term Care Insurance in Japan.", 72.
[127] Ozawa, Martha N., and Shingo Nakayama. "Long-Term Care Insurance in Japan.", 72.

health insurer."[128] The copayment is set at ten percent for most elders, and can be 20 percent for those that reach a certain income bracket.[129]

This is a recent development of the LTCI that has been an attempt to keep the system sustainable as the aging population continues to grow, which is also an important objective of Ibasho. That is, sustainability is perhaps the most important factor in any discussion of future eldercare methods, as population change is creating pressure on the caregiving gap that will only continue to grow. Thus, a sustainable system will not only alleviate issues of the present, but also continue to address issues throughout the unfolding of this demographic pattern of population aging.

The Community-Based Integrated Care System

The LTCI is currently undergoing the revision of the Community-based Integrated Care System (CbICS), which will further emphasize the role of the community in caregiving. This revision seeks to "comprehensively ensure the provision of health care, nursing care, prevention, housing, and livelihood support," so that "the elderly could live the rest of their lives in their own ways in environments familiar to them, even if they become heavily in need of long-term care."[130] This new legislation will go into effect in 2025, when the baby boomer generation will be aged 75 and older. The CbICS will coordinate the hospitals, welfare facilities, and home-visit

[128] "Definition of CO-PAYMENT." Accessed February 6, 2022. https://www.merriam-webster.com/dictionary/co-payment.
[129] Health and Welfare Bureau for the Elderly. "Long-Term Care Insurance System of Japan."
[130] Health and Welfare Bureau for the Elderly. "Long-Term Care Insurance System of Japan." November 2016. https://www.mhlw.go.jp/english/policy/care-welfare/care-welfare-elderly/dl/ltcisj_e.pdf.

services across the neighborhoods.[131] I will argue that this revision epitomizes the trait of elder independence, as it structurally prioritizes the voice and autonomy of the elders.

The revision is centered around five principal goals. The first objective sought to promote initiatives that strengthen insurer's ability to be *independently* supported, to encourage coordination between medical care and long-term care, and to promote initiatives that unify regions of society. In addition, this revision possessed monetary reworkings to keep the system sustainable. Specifically, there was an increase in the copayment rate from 20 percent to 30 percent for those whose incomes are in a high bracket, but to keep an upper limit at ¥44,000 per month. Additionally, the change introduced an income-based payment system that coincides with care levels for Category 2 patients.

This revision was born out of a rural town, Mitsugi. Since most of the rural populations in Japan are experiencing population aging at a more rapid pace than cities, these communities have essentially been the first-responders to the caregiving gap in Japan. Hatano et al. note, that this is usually vice versa, with cities setting the stage for healthcare policy, especially with regard to universal healthcare. However, the unique situation of Mitsugi demonstrates the power of one small town changing the scheme of eldercare in an entire country. Thus, it is evident that this commendable model of eldercare warrants the attention of other prefectures, cities, and even countries across the globe. Admittedly, there certainly exist limitations when it comes to applying this rural approach to other areas, and it will be necessary to alter and mold a long-term care insurance system to the environments where it is implemented.[132]

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[131] Hatano, Yu, Masatoshi Matsumoto, Mitsuaki Okita, Kazuo Inoue, Keisuke Takeuchi, Takako Tsutsui, Shuhei Nishimura, and Takuo Hayashi. "The Vanguard of Community-Based Integrated Care in Japan: The Effect of a Rural Town on National Policy." *International Journal of Integrated Care* 17, no. 2 (n.d.): 2. https://doi.org/10.5334/ijic.2451., 1.

[132] Hatano, et al. "The Vanguard of Community-Based Integrated Care in Japan: The Effect of a Rural Town on National Policy." 6.

It is evident that the CbICS is a necessary response to population aging, as the feasibility of institutional long-term care for every aged person is becoming less likely as the elderly population continues to grow and simultaneously get older. Changing population demographics necessitate a vast amount of resources and access to care, and so this revision resolves this by facilitating elders to live in their own homes and communities. The CbICS promotes a social approach in caring for elders, first looking to families, then the community, and then the institutions. The prioritization of home-based care allows a proper care method to be provided to elders, and is less costly to both elders and the government. One key facet of this idea is that home-based care does not necessarily have to be definitively provided by the elder's family, but rather the CbICS designates the entire community responsible. In fact, in their publication the MHLW states:

> "Insurers should analyze issues that communities face and play an active role in supporting the elderly to lead independent lives. This will help promote the Community-based Integrated Care System and maintain the sustainability of the system in this aging society."

Through looking to the community for care, there is more individualized care, too. Matsumoto et al. describe, "Residents are more than recipients of care; they are a fundamental element of the system. They can identify elderly neighbors who need medical or long-term care services, support them and introduce them to the system."[133] This new revision represents a new approach to eldercare, in which communities can care for elders as a neighbor, a friend, a family member, or even a stranger. This is an apt approach to the future of eldercare, as the majority of elders in Japan do not require intensive care. However, even elders that do suffer from severe

[133] Hatano, et al. "The Vanguard of Community-Based Integrated Care in Japan: The Effect of a Rural Town on National Policy.", 7.

conditions and disabilities can receive care in their own home through home visits from medical professionals.[134]

Lessons Learned: Elder Independence

A repeated theme throughout the entirety of detailing the LTCI and its recent revision is the importance of maintaining elder independence. As emphasized through the CbICS, the independence of elders opens the door for the community to support these elders in their homes. The CbICS utilizes four key components to provide socially integrated care: self-help, mutual aid, social solidarity care, and government care.[135] The former two components, self-help and mutual aid, are essential in promoting elder independence. In theory, this reduces the economic burden on elders, the community, and the government and thus less cost arises from billed medical long-term care.

Generally speaking, a national long-term care insurance system as a whole is the foundation upon which elder independence rests. In fact, the MHLW describes the three basic concepts of the LTCI are to provide a social insurance system, allow for user autonomy, and to support the independence of the elders themselves.[136] Furthermore, it is worth noting that such a comprehensive system contributes to the economic freedom of elders, helping elders maintain reciprocity as they age, which is vital as detailed in Chapter Three. Specifically, relatively low premiums and copayments allow elders to remain financially free, as they are not met with great burden from institutional caregiving cost. The amalgamation of reciprocity, integration, and independence represents an interconnected web of cause and effect relationships. Nevertheless,

[134] Hatano, et al. "The Vanguard of Community-Based Integrated Care in Japan: The Effect of a Rural Town on National Policy.", 2.
[135] Sudo et al., "Japan's Healthcare Policy,", 5.
[136] Health and Welfare Bureau for the Elderly. "Long-Term Care Insurance System of Japan."

these three traits are what I argue create the best care environments for elders as they age, regardless of whether this is in an institution or the home.

Socialization of Care

The LTCI exemplifies the socialization of care at a governmental, policy-driven level. The original proposed system, as well as revision that has come along the way, both point to a new future of eldercare where elders are able to obtain care through their communities. The MHLW even states that the LTCI was introduced as "a mechanism to enable society to provide long-term care to the elderly."[137] An expansive social welfare state such as Japan is uniquely interwoven within society. For example, the CbICS looks to families first, then communities, and finally the institution for care. The social safety net that this revision implemented is constructed through the fabric of society, not in addition to it. This, I argue, is the key to the socialization of care at a governmental level.

[137] Health and Welfare Bureau for the Elderly. "Long-Term Care Insurance System of Japan."

Chapter Five: Conclusion

Current and projected population demographics reveal the need to adapt and create ethical and sustainable eldercare structures. It is well established that redistributing caregiving responsibility to the community is a recourse for the caregiving gap in Japan, and the rest of the world as these demographic patterns unfold. This thesis has utilized the examples of both grass roots and public institutions of eldercare in Japan to postulate what values must be implemented in caring for our elders, particularly reciprocity, integration, and independence. In noting the compelling traits of each eldercare institution, it is evident that the solution to eldercare requires both a grass-roots effort and a governmental effort. Ibasho fosters care for elders through communities, facilitating opportunities to create social and economic capital. On the other hand, the LTCI generates a policy driven method to keep elders independent in their homes and financially free. Thus, a two-pronged approach to caregiving creates an ethical care environment not only at the community level, but also on a national level. I argue the presented values have and will continue to provide the best quality of care for the increasing number of elders worldwide.

Ibasho provides a model of the ideal grass-roots, non-profit method to care for elders communally. This organization's principles have guided elders and their communities to found informal caregiving institutions such as cafés and community resource centers that generate reciprocity and integrate elders into their communities. Despite Ibasho not being a formal institution of care, I selected this organization for analysis because of this very fact. That is, the culmination of demographic data presented in this thesis highlights the challenges that traditional caregiving institutions are currently facing and will continue to face. It is time to reconsider what

eldercare looks like, and to design institutions that are adaptable to individual community needs while prioritizing the reciprocity and integration of elders in all settings.

Even though the Ibasho organization began in Japan, it has since become international, which reveals the organization's ability to implement core, universal values of eldercare while still considering the individual needs of each community. Moreover, Ibasho has facilitated projects in LDC nations such as Bhutan, which addresses the current rate of population aging that the world is experiencing as noted in Chapter Two. A deeper look in Chapter Three illustrates Ibasho's approach is a model for global application, with the case studies of the Ibasho Cafe in Japan and the community resource center in the Ivory Coast.

In Chapter Four, the LTCI and its subsequent revision, the CbICS, exemplifies a governmental model of response to the eldercare crisis, and furthermore a mechanism to maintain elder independence. Once again, though Japan's LTCI is not a caregiving institution itself, it provides key lessons on conducting caregiving mechanisms in a given state. With attention to the CbICS, this revision further stresses the need to redirect care away from formal, traditional caregiving institutions and advance efforts for community-based care, which is achieved by keeping elders independent in their own homes for longer. Though the lessons learned from Japan's LTCI are not necessarily globally applicable in the current moment, I stress that population aging will create a dire need for similar insurance systems to be implemented in many areas of the world.

Implications for an Aging World

For example, the percentage of the population aged 65 and over sits at 16 percent in 2019, however, by 2050 this number is projected to jump to 21.4 percent.[138] These statistics demand attention, as it is evident that other countries are following very similar demographic patterns to that of Japan. Rather than formulating a comparative analysis, I allude to Medicare in the United States in order to exemplify how the aforementioned characteristics of Japan's LTCI can be integrated in different settings.

The United States Medicare system was created in 1965 under Title XVII of the Social Security Act to provide health insurance for persons aged 65 or older, those under the age of 65 who qualify due to disability, and to any aged person suffering from end-stage renal disease. The system pays for both inpatient hospital insurance (Medicare Part A) and outpatient medical insurance (Medicare Part B), and these two aspects are the most traditional pair. A long history of revisions has produced other sectors such as Medicare Part C and Medicare Part D for prescription drugs. Medicare is a federally administered program, yet on the other hand Japan's LTCI is delivered by municipalities, which allows for more adaptability and better redistribution.

In the United States, Medicare is often criticized for lacking a social safety net and dramatic increases in cost.[139] This is essentially the same issue Japan was facing prior to the implementation of the LTCI. Specifically, insurance was only available to low-income elders, making it especially challenging for elders in a middle or upper-income group to pay for care costs out of pocket. Consequently, new models are rising to popularity, adopting the community care framework of the LTCI. For example, the Community Aging in Place - Advancing Better

[138] "2020 Profile of Older Americans." *Administration for Community Living*, 2021, 21.
[139] McClellan, Mark. "Medicare Reform: Fundamental Problems, Incremental Steps." *Journal of Economic Perspectives* 14, no. 2 (May 1, 2000): 21–44. https://doi.org/10.1257/jep.14.2.21.

Living for Elders (CAPABLE) program essentially creates a care team, very similar to that of the LTCI, to help administer care to elderly patients. This team consists of a nurse, an occupational therapist, and a skilled home repairs professional who all work in conjunction to improve "safety, motivation, and function; reduce depression, and increase independence."[140] This similarity with the LTCI is part of a larger pattern, as the issues the United States is beginning to face are problems that Japan has already begun to consider and adapt to through revisions such as the CbICS, particularly due to a pre-existing strong welfare state as well as being at the forefront of the demographic transition.

Additionally, the insured persons in the United States face very similar challenges to those of Japan that the LTCI sought to eliminate. Specifically, middle income individuals in Japan faced great financial difficulties when attempting to pay for long-term care, as the subsidies typically only applied to low-income individuals under the previous Social Welfare Law for the Elderly. The current LTCI provides universal coverage to all, with a ten percent copay for nearly everyone. Recent revisions have increased the copayment to 30 percent for high income groups in order to keep the system sustainable, but this still remains at a very small percentage of insured persons. If the United States were to adopt a similar universal coverage, many of the current challenges of the long-term care establishment would be alleviated. Thus, by looking at Japan's LTCI as a model, many lessons, such as elder independence, can be learned, tailored, and implemented in countries and their communities across the world. This thesis has sought to advocate for the socialization of care when looking towards the future of eldercare, and to implement the identified crucial lessons of elder reciprocity, integration, and independence in eldercare institutions as the world continues to age.

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