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Elderly Care in Sweden and Japan

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(Abstract) In Sweden, the public home help services (PHHSs) have been given to the elderly to live at their homes as long as they do not need a comprehensive supervision and care since 1960. The PHHSs in Sweden led to the change of care paradigm from institutional care to care at elderly's own home, resulting in that the responsibility of caring for the elderly is transferred from the family to the public domain to a great extent. However, the PHHSs in Japan were not well developed until the early 1990s. Many factors, such as collective familiar responsibility on elderly care and shared negative attitudes toward the public welfare services among other things, have contributed to the late development of public welfare services for the elderly in Japan. The practices of the elderly care in both countries are recently questioned in context of

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structural changes. The PHHSs are now getting harder and harder because of both shrinkage of the family size and increase of women's participation in the labor market in Japan and because of the shrinking economy together with the growing number of oldest old led in Sweden. Consequently, those structural changes forced politicians in both countries to deal with the elderly care problems.

[Key Words: Care Paradigm, Elderly Care, Structural Change, Welfare Service]

At the early 1990s Sweden was hit by the global economic recession. Followed by financial difficulties on both central and local government, politicians enforced the austerity policy on social benefits (Olsson, 1993). As a consequence, many Swedish people got worse in their living standard. The austerity measures especially affected the living conditions of many elderly persons; elderly persons who had received generous social home care services from municipalities during the 1980s became more and more subjected to the strict means-test, and even those elderly who live with spouses or who have children living near by often were excluded from getting home care services (Szebehely, 1998).

Thorslund (1990) argued that recently the imbalance between the care needs and care resources for elderly have considerably increased. Even if Sweden needed a increase of care resources to meet the needs of care what actually happened was that public resources and public commitments for elderly people were cut back consciously during the 1990s (Szebehely, 1998). And politicians began to emphasize that family members had to take on more responsibility for the elderly, which is contradictory to the perception of Swedish people: "it is only natural for Sweds to presume that society will provide care" (Johansson, 1991).

On the other hand, Japan did not experience the economic

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hardship until the early 1990s. But in recent years the growth of the economy has been transforming into a slow-growth, resulting in a series of social changes such as a structural reform (Ministry of Health and Welfare, 1998). One target of the reform is about elderly care. In Japan, elderly care has been characterized by the family ideology, in which well-being of the elderly is under the collective responsibility of family members. This established practice of elderly care still reflects the conception of Japanese: “it is natural to take care of aged parents” (Anbacken, 1997). But the ratio of Japanese elderly people is growing very fast being unable to cope with the capacity of catering for the elderly. And the trend and responsibility of family care is no longer taken for granted.

Even if Japan and Sweden face similar problems in balancing between care resources and needs of the frail elderly, their approaches are somewhat different. While Sweden is moving from universal to selective principles in home-based welfare services, Japan is focusing on home-based welfare services which even many social and private organizations participate in. The two countries have given priority to “home care” over “institutional care” in their policies for caring for the aged, although they have different political ideologies, individual values, and economic circumstances. The purpose of this paper is to provide an opportunity for comparing the two different public care systems to some extent and even for identifying the problems that the two countries face and try to solve them by themselves.

Method

Following the Frankfort-Nachmias and Nachmias' (1992) instruction of constructing units and categories related to the research purpose, a content analysis was used. Units composed of

words, terms, paragraphs and/or items from the collected data were recorded first. The recording unit is the smallest body of content in which a reference is a single occurrence of the content element. The recording units represent events, ideas or phenomena, and so on in this paper. After recording units, I compared any unit with other units which I labeled in different sources before I classified the units into similar categories. After that, the categories were coded into appropriate themes.

Data used in this paper are composed of secondary materials: articles from the two Swedish daily newspapers (*Dagens Nyheter* & *Svenska Dagbladet*), scientific journals, reports of public investigations, statistics, and other literatures. Compared to interview or questionnaire in which one can conclude one's research from the collected primary material, this paper based on secondary data has a weakness in this respect. But in the materials I used elderly care was treated out of different viewpoints, which in turn increased the possibility to analyze the phenomenon this paper deals with. In addition, a comparative study gives an opportunity to examine patterns of similarities and differences across units and come to terms with diversities (Ragin, 1994).

Actors in the policy-making process in Japan and Sweden

Since the WWII the Japanese social policy has been made by chief groups of social elites such as politicians, corporate elites, and bureaucratic elites. An analysis of the development of Japanese social policy for the elderly shows an overall picture of how the elites have been working for developing their social policy (Usui & Palley, 1997). The elites were classified into 3 groups: (1) The Liberal Democratic Party (LDP) – the only political party that has

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controlled Japanese policies since the two conservative political blocs, Liberal Party and Democratic Party, merged in 1955, (2) Elites of large corporations – cooperate with LDP and exert powerful control through financial contribution, influence policy-making and also mediate and represent the policy advocate by business elites, (3) The government bureaucrats or civil servants selected from top universities – usually generate legislation through their bureaucracies.

The triumvirate of political power supports each other to dominate the Japanese politics and the policy-making process; the LDP needs bureaucratic expertise in formulating and implementing policies and also needs the contribution of business to finance expensive election campaigns and party management. Business, in turn, wants to maintain free market without much interference of government, while bureaucracy wants the LDP in power so that the policies initiated by bureaucrats will be ratified in the Diet (Verba, 1987). Although these groups of elites have cooperated considerably on many economic and political issues, the interaction among them has not always been apparent. The role and direct influence of economic elites in the decision-making is often reflected in the national budget for social programs, particularly in periods when the economy is not robust (Usui & Palley, 1997).

It was only Japanese bureaucratic agencies that initiated some social programs for elderly (Campbell, 1992); e.g., the draft of Welfare Law for the Aged in 1963, free medical examination for the elderly aged 65 and over in 1963, and the introduction of the discounts of train fares in 1964. In the early 1970s, the old-people problem was given real attention on the national agenda (Campbell, 1992). Social policy for the aged subsequently expanded in scope, coverage and benefits, including the introduction of a national program of free medical care for the aged in 1973. However, before

the social policy had reached full maturity Japanese politicians cut it back in the 1980s. In 1989 the triumvirates, however, made a ten year social welfare project again, known as the “Gold Plan”, a policy emphasizing community-based and in-home services to meet the growing need of elderly.

The early Swedish social policy could, on the other hand, be characterized by an ideology “people’s home” which the Social Democratic Party (SDP) leader Hansson brought up in a 1928 parliamentary speech. His speech “the good society was a society that functioned like a good home” has implied solidarity and equality and has been earmarked in developing the social security system under the initiative of the SDP (Heclo & Madsen, 1987).

Most Swedish policies, unlike Japanese policies, have been made by a coalition of socialist political blocs and powerful organized labor unions. The SDP took power about 50 years from 1932. Behind the success of the SDP, there were the Swedish labor movements that support the Socialist political blocs in the political arena. With a strong back-up for the SDP financially and politically, the main initiative for social policy and its change has come from the SDP. The success of the socialist-union alliance made it possible to achieve the Swedish system of welfare which grounds on the principle of democracy, equality, and solidarity.

What the concept of equality and solidarity implies is that “a person would not take more than his or her share, but neither would anyone stand outside the system of community provision” (Heclo & Madsen, 1987). This concept was given concrete form and carried into the practical policy-making by the alliance between a powerful trade union confederation LO and the SDP. Many Swedish welfare programs provide universal benefits under this principle, although some benefits are scaled to income.

There are another social actors, the Swedish Boards

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(*ambetsverk*), who play an important role in Swedish power structure. Even if it is not the same degree as Japanese bureaucracy in policy-making process, the boards also solidify the bureaucratic power in their way. The Swedish Boards are often headed by powerful Director Generals and are responsible for a well-defined field of operations. Administrators in the boards deal with questions of detailed policy implementation, while civil servants in the ministries have worked closely with politicians in the cabinet and in parliament regarding policy issues (Heclo & Madsen, 1987). Ministries of Sweden are entrusted with policy-making vis-a-vis Boards in charge of administration.

The official care policy for the elderly

The government led by a conservative-business alliance after the WWII has not followed the same path of Swedish government-led social welfare programs for the elderly. Instead, Japanese tried to find their own way. Anbacken (1997) shows how Japanese social ethics and political structures are shaped by "Confucianism". According to her, the Confucianism played a significant role especially in shaping the relations between parents and children among other things. One of the norms is the filial duty. According to this norm, the eldest son must support and take care of his old parents under the same roof. In return for his commitments, he inherits all properties from his parents. The filial piety is rooted deeply in the Japanese life and reinforced by political actors at the early period of social policy development for the elderly (Anbacken, 1997; Tsuji, 1997).

Because politicians consider families as a primary welfare provider and public sectors as a secondary welfare system for the elderly (Kinoshita & Kiefer, 1992). However, in the 1970s when the

ratio of elderly people increased and the social expenditure for the elderly rose rapidly Japanese politicians had to change their strategy. The Japanese-style welfare society, advocated by conservative elites in the late 1970s, was considered as the only solution to the problem of aging society without putting much pressure on financial burden, and at the same time preserve the traditional family value which was weakened by postwar reforms in the civil code, the increase in nuclear families, and the high frequency of wives in the paid work outside the home (Campbell, 1992).

What is the Japanese-style welfare society and what are the unique points that make politicians to endorse eagerly in their policy-making for the elderly? First, it is about a conscious policy supporting the maintenance of the family, full employment, and tight fiscal control (Usui & Pally, 1997). Second, it symbolizes “society with vitality” which reflects the viewpoint of politicians on the welfare for elderly people (Campbell, 1992). The Japanese politicians believe that traditional virtues of family, community, and work ethic will bring true welfare with less government intervention, and thus avoid the dependency and cold bureaucratism of the Western welfare state. The Japanese-style welfare society became an ideology of the official care policy during the 1980s.

In Sweden, it had also been quite usual customs that the family members took care of the frail elderly at the turn of the century. Such a way of caring for the elderly was grounded on the law and tradition. Elderly people who could not be taken care of by their adult children became, however, a municipal concern (Edebalk, 1991). During the first half of 1900s the Swedish public elderly care was generally dominated by an ideology of “old-people’s home” which was characterized by the poor relief. When the Swedish parliament approved political outline for elderly care in

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1947, the ideology became the first official care policy (Szebehely, 1995). The basic idea of creating old-people's home was mainly to provide for the poor and old people with humane refuge from harsh surroundings (Edebalk, 1991). However, this official care policy was an object for critics in 1950s and an alternative care policy was advocated "care in home instead of nursing home" which resulted in a new official outline for elderly care in 1957 and remains until today. This new alternative home care *hemma-boendeideologi* did breakthrough on the plan of elderly care (Edebalk, 1990).

Home help services as care ideology was considerably expanded in forms of cleaning, cooking, visiting and some home medical care. Today, the majority of elderly people live at their ordinary homes and manage their daily lives either for themselves or more or less comprehensive support of relatives and/or public commitments in forms of home help services and home medical care. Only 8% of the elderly population live and get help in so called "special housing" which include nursing home, group dwelling, old-people's home and service house.

Health care system

Institutional care for the elderly

The majority of the elderly in Japan and Sweden live at their homes (e.g, about 94% of Japanese elderly in 1993 & about 92% of Swedish in 1991). The remaining percentage of elderly population (6 & 8%, respectively) lived at different kinds of public institutions, in which elderly people who needed more or less help received it. However, there have been very different levels of care institutions. The main institutions of the present forms in Japan are as follow:

1) *Special nursing home for the aged (tokubetsu yogo rojin home)* are institutions for the elderly whose physical and mental condition require constant supervision and care. But these homes do not generally function like a hospital because advanced medical treatments are not provided. Elderly people who have difficulties to be cared for at homes are eligible in the first place. A room is commonly shared by four persons. In 1994, over 200,000 persons lived at these facilities (Anbacken, 1997).

2) *Nursing home for the aged (yogo rojin home)* are another Japanese social welfare facilities for the elderly, “the old age homes”. But they have the most negative images among other facilities. One reason is that only elderly people who lack of economic resources and receive social allowance are eligible in general (Yamanoi, 1993). The residents of these homes do not need care services for their daily lives, and thus no one who needs of nursing care is admitted. According to the 1991 survey, the majority of residents answered that the main reason they moved was the conflicts in families, and another ones were economic or physical conditions. In 1993, 67,703 elderly persons sheltered at these nursing homes (Anbacken, 1997), however, the number of places are decreasing to keep pace with the improved economic situation of elderly and construction of new alternative care system for the elderly.

3) *Homes with moderate fee (keihi rojin homes)* are divided into 2 types of *keihi* homes, A and B. The residents at *keihi* A only pay for the actual living cost, while the managements fees are paid by authorities. The residents at *keihi* B, however, pay all the costs and no meals are served. These types of homes function neither nursing homes nor old age homes. They actually function more like residential flats (Hashimoto, 1995). In 1993, there were 17,112 elderly persons at homes with moderate fee.

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4) *Geriatric Hospital* are places where the elderly stay long. In 1992, there were 151,905 in-patients at 1,197 geriatric hospitals, representing 11.7% of all hospitals (OECD, 1996). Some elderly choose geriatric hospitals because of not only medical treatments but also the long waiting queue for the social welfare facilities. Before elderly persons can move into those public welfare facilities they usually wait for one or two years. Those geriatric hospitals and hospitals function, however, like medical institutions which mean that the in-patients have to check out when treatments are finished. But many of them still stay at hospitals even after finishing medical treatments, which give a reason to the imbalance of distribution of the care resources.

5) *Homes with full cost (Yuryo rojin homes)* are not belonging to the category of social welfare public facilities. First of all, the target group of elderly are those who can afford to buy very expensive services provided. Neither residents nor the private organization receive any subsidies from the public sectors. 25,463 elderly lived at 246 places in 1993. Although there are a variety of institutions that are not described here, the afore-mentioned institutions are typical in Japan. Of 5.7% of the institutionalized elderly in 1991, we can find 72% of elderly at acute hospitals including geriatric hospitals, 25% at social welfare facilities, and the remaining 3% at private retirement homes (Anbacken, 1997).

In Sweden, there are generally five welfare facilities/institutions for the elderly: old age homes, service houses, group dwellings, nursing homes and long-term care places. In 1991, about 8% (124,551 persons) of 1.5 millions of elderly lived in social welfare facilities of municipality and medical institutions of county (Socialstyrelsen, 1993).

1) *Old age homes (Alderdoms hem)* are the oldest type of institutions. They existed in the 1920s and aimed at the elderly

who need constant supervision and comprehensive care. The homes are now even called “service house with full board and lodging”, which means that residents automatically get services and care they need. The present form of old age homes can be characterized by small rooms (about 10–15m²). But unlike Japanese institutions, residents in *Aldershem* usually have their own rooms with a bathroom and share other spaces together. In 1991, 34,224 elderly lived at old age homes which made up to 28% of all institutionalized elderly persons.

2) *Service houses (Servicehus)* are usually blocks of flats containing 20–100 housing units and designed for the elderly and handicapped persons. The residents live in fully equipped flats and have a rental contract. Unlike old age homes, residents at service houses can choose different kinds of services, and charges for the services are income related. Even municipal home help services and nursing care are available to the residents after a certain criteria. There were 48,677 elderly who lived at service houses which corresponded to 39% of the institutionalized elderly persons in 1991.

3) *Group dwellings (Gruppboende)* are new kinds of senior housing that are provided by municipalities and designed for a small group of 6 to 8 persons who need constant supervision and help because of their dementia. Each resident has his/her own room and shares other spaces. Care personal staffs are available for 24 hours. When the first group dwelling was instituted in 1987, this form of housing has been considered as an alternative to the traditional Swedish public institutions. The number of units of group dwellings was constantly increasing between 1987 and 1991. In 1991, 197 of 284 municipalities instituted this form of senior housing and the total number of residents were 4,769 persons which were about 4% of the total institutionalized elderly persons. Today, this form of senior housing is not increasing in numbers

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due mainly to the expensive running cost for the municipality.

4) *Nursing homes (Sjukhem)* are places where residents usually have comprehensive and long periods of care. There are two types of nursing homes; local and central. Since 1992, the municipality has taken over social services and health care and financial responsibility from the county councils. The number of elderly who lived in nursing homes were 18,888 persons in 1991, which made up to 15% of the institutionalized elderly. Now, some nursing homes are specializing in hospice care, while others in respite care, dementia care and short term rehabilitation.

5) *Long-term care (Langtidsvard)* is a place like nursing homes where the elderly stay relatively long. Geriatric hospitals are typical examples of long-term care. Several residents usually share a room and more comprehensive medical care than any other public institution is given. 14% (18,002 persons) of all institutionalized elderly in 1991 lived in long term care places. The table 1 shows the comparison of the percentage of elderly people in Sweden and Japan who were institutionalized at welfare facilities and long-term care.

The cultural and economic aspects are the main factors behind the low percentage of Japanese elderly in social welfare facilities compared to Swedish. But it does not mean that Sweden approves the institutionalization of elderly culturally. It should understand that Swedish elderly prefer to live independently from their adult children even after they become frail. And the Swedish municipalities provide them with a variety of senior housings and services, which the elderly can choose.

The formal home care services

In most advanced countries, the home help system was instituted for the purpose of making it possible for the frail elderly

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<Table 1> The percentage of elderly aged 65 and over at social welfare institutions in 1991 Sweden and in 1990 Japan (%)

Countries	Sweden	Japan
total %age of residents at social welfare facilities	8.0	1.7*
Old age home	28.0	21.5
Service house	39.0	0
Group dwelling	4.0	0
Nursing home	15.0	41.0
Long-term care clinic	14.0	37.5
Total	100	100

(Source: *Social service and care in Sweden*, Socialstyrelsen, 1993)

* It did not include the elderly who lived in other institutions (4%) such as general hospitals, health facilities and private retirement homes (Yamanoi, 1993).

to remain at their ordinary homes. Even in Japan the starting point of public home help is not so different from that of Sweden, but the developing process of the system is very different. While the Japanese public home help services (PHHSs) were started with 250 home helpers by the Ministry of Health and Welfare in 1962 (Usui & Palley, 1997), the Swedish PHHSs were becoming as an important form of elderly care both in terms of quality and quantity in the 1960s.

In Sweden, however, it was not the public agency that initiated the home help services. It was the Red Cross in Uppsala that engaged in giving help assistance to elderly people in cleaning, cooking, visiting and some health care. Their commitments were so

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highly appreciated by elderly people that the municipalities took over activities of home help services gradually from the Red Cross. In 1957 when the home help services became the political ideology of elderly care in Sweden the majority of home help services have been organized and mainly run by municipalities (Edebalk, 1990). As consequences of political consensus about investing on the home care, quality of home help services have constantly been developed and improved.

Especially, when the Swedish politicians decided to give the subsidy to municipalities that provide home help services in 1964, the public home help services were more and more easily available for the elderly which resulted in expansion in the 1960s and 1970s (Szebehely, 1995, 1998). However, the number of recipients of PHHSs constantly decreased; the recipients number was 329,000 persons in 1975, 313,000 in 1985, and 245,000 in 1995 (Szebehely, 1998).

While Swedish elderly prefer home help services to institutions care Japanese elderly and their families are not enthusiastic to receive any help from the public sectors. The general negative attitudes against the public welfare and Japanese hesitation to let outsiders enter into their homes were the main reasons why the Japanese home help system had not noticeably developed under the 1970s and 1980s (Yamanoi, 1993). Other contributory causes are economic factors which make Japanese politicians hesitate to invest in PHHSs (Anbacken, 1997). Although Japanese policy-makers emphasize “welfare at home” as political priority, it does not mean that the public sectors should provide the PHHSs. The political slogan and priority is simply directed to the families whose obligation is to give proper care and attention to frail elderly at homes. Due to these factors, very few concrete measures were made to develop and expand the home help services until recently.

The early 1990s was, however, the turning point for the history of Japanese PHHSs for the elderly. With the government's Gold Plan (1990-1999), Japanese politicians and bureaucrats began to build the infrastructure of home help systems. According to the Gold Plan, the municipalities shall have 100,000 home helpers by 1999 and in New Gold Plan, the target of number of home helpers even further increased to 170,000. When 47% of the goal of Gold Plan was achieved on the number of home helper in 1995, there were about 79,700 home helpers available to elderly people in Japan (Usui & Palley, 1997). Yamanoi (1993) showed a comparison of the number of home helper. According to him, there were 17 home helpers per 100,000 population in Japan and 884 in Sweden in 1991. In 1993, 2% of Japanese elderly aged 65 and over received the PHHSs, while it was 17% in Sweden 1990-1991 (Korpi, 1995; OECD, 1996). Because of the slow development of home help system in Japan, the ratio of elderly who receive the PHHSs and the number of home helpers look more like extremely opposite poles compared with those of Sweden.

The ratio of expenditure for health care and social services

This is one of emerging political issues that most politicians feel uncomfortable to allocate care resources appropriately between care sectors. In both countries, health care within the medical sectors has been dominating form of elderly care and consuming most of the resources. A report from the Ministry of Health and Social Affairs in Sweden (1989) separately showed the cost of health care for the elderly aged 65 and over and the cost for elderly and handicapped persons in forms of home help services, transportation services, and so on. The former (health care) marked 48.3 billion and the latter (social services care) made up to 25.8

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billion Swedish crowns. These figures corresponded to 3.9% and 2.1%, respectively, of Swedish Gross Domestic Product (GDP) in 1989. The total expenditure of health care and social services for the elderly aged 65 and over increased to 9% of GDP in Sweden in 1992 (Thorslund & Parker, 1995). As for the Japanese figures for the costs of health care and social care for the elderly in 1989, we can also find that the care resources are not appropriately distributed between the two care sectors. According to Yamanoi (1993), almost 93% of care resources was allocated in health care and 7% in social care in Japan. The expenditure of health care and social care made up to 1.33% and 0.13% of Japanese GDP in 1989.

This overemphasis on health and medical care has triggered to the general debate among politicians and social researchers in both countries. Many suggestions had been made, but they were mainly focused on sharing the burden of expenditures. For instance, co-payment of patients, allowing the private organization to engage in elderly care, emphasizing the responsibility of family, encouraging voluntary organizations, and so on. These efforts have not yet produced satisfactory results in reducing imbalance of health and social care especially in Sweden (Nygren, 1994).

<Table 2> The expenditure on health/medical care and social services for the elderly aged 65 and over (%age of GDP, Sweden & Japan 1989)

Countries	Health Care Expenditure (%)	Social Services Expenditure (%)	Total GDP (%)
Sweden	3.9	2.1	6.0
Japan	1.33	0.13	1.46

The strategies for the care of the elderly

The growing population of oldest old has led to the increase of the need and demand for medical care and social services in Sweden and Japan. However, because of the restricted care resources the distribution of care services among elderly people have not been met satisfactorily. Some elderly persons received more public assistance than other elderly who in turn rely on family members and relatives or voluntary organizations for their daily lives. As a consequence, some fundamental questions have been raised: the question of equality which, for example, is one of the cornerstones of the Swedish welfare system and the burden of family members. A variety of strategies have been employed to solve the growing disparity of care needs and care resources and/or at least lighten the burden of family care providers.

In Sweden, three approaches are applied in dealing with the problem of elderly care. The first approach is “technical”. It is to improve the fit between services and the actual needs. It includes questions such as what kind of service should be provided and how the best mix of services can be achieved. The second approach is “targeting”. It concerns how to distribute and make decision/priority between clients when resources are limited. To whom should what level of services be provided is the main concern in this approach. The third approach is related to the organization and cooperation of services between different care sectors. It involves a clear line of responsibility of who should deliver and organize services and care resources. The three approaches have been applying in Swedish elderly care since over the last few decades (Daatland, 1997).

On the other hand, Japan has mainly focused on the

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individual/family strategies on caring for the elderly. “Living Near by” is one of them, and represents a new way of life which recently emerges as an alternative to the traditional form of cohabitation. Kweon (1997) argues that this type of living arrangement is a way of solving the conflict in values between the traditional family-based care and the new ideal of nuclear family unit. This individual approach to elderly care, however, is not grounded on the one-sided decision in the family. It is rather based on the negotiation and compromise of the whole family members and on many factors such as financial, health, working conditions, and so on.

This separate living arrangement has some advantages for caregiving families, particularly for the middle-aged women who usually take a major responsibility of caring for frail elderly parents/parents-in-law (Anbacken, 1997). By living nearby and giving assistance on a daily basis the caregiving families find a much room for freedom both emotionally and physically. For the elderly’s separate living arrangement also means certain degree of independence from the children’s family in daily life. A survey on this new trend of lifestyle shows that a majority of children living apart from their parents live within an hour’s distance (MHW, 1998).

The other strategy, so-called the “Gold Plan”, is a set of conscious and concrete political measures to prepare for the coming needs of elderly. Its general objective is to establish a long-term care service system to allow elderly people to be independent as much as possible and continue to live at their accustomed homes and communities (Anbacken, 1997). According to the plan, about 3% of elderly people received long-term care services by 1999 in a specialized institutions rather than a hospital, and between 3 and 4% of elderly was assisted by home help assistants (OECD, 1996).

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There are some further political considerations in coping with elderly care and its finance. One consideration is to introduce the public long-term care insurance. The number of elderly persons who needed long-term care was almost 2 millions in 1993, and the number will be about 5.2 millions in 2025 (Usui & Palley, 1997). In this critical circumstance and prognosis, the idea of introducing the public long-term care insurance system gets the political consensus. The other political consideration is to utilize the labor of middle aged women and housewives into the public service sectors as Sweden did in the 1950s and 1960s. Those women with the knowledge and experience of caring for the very frail parents at home are qualified caregivers at the public sectors. The main advantage of the qualified women is that they are so cheap to be social security manpower (Getreuer-Kargl, 1995). The Ministry of Healthy and Welfare openly emphasizes the need for making plan to mobilize housewives as supporters of social services.

Discussion

The Swedish welfare system has been characterized by the idea of *solidaristic* equality that everybody should participate in the common enterprise of distribution of welfare and that no one should stand outside the community welfare. This principle has been generally accepted by Swedish people. Under this principle, many social reforms and programs for the elderly have been carried out during the past several decades. Consequently, the establishment of social welfare system has entailed that the responsibility of one's well-being transfers from individual/family to the public domain to a great extent in a sense that the public sectors have been in charge of offering various services to all citizens in society.

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For the elderly, social home based services, health care services, night patrol, transport services and special housing for elderly people was given. Nobody does not consider those public services as a charity, but as a civil right. And no one would expect to stand outside the system of security. This principle of *solidaristic* equality has become a shared understanding among Swedish people, and are also often emphasized by political actors and their policy for the elderly. But recently there are some signs of changing people's perception today on the basic principle of *solidaristic* equality of the Swedish welfare system. An example is that some people begin to insure their pensions in the private sectors. Another example is that the share of private sectors in care work increased markedly during the 1990s. Even if the Swedish people generally understand that care services will be financed by general tax revenue and that the public sector should manage the distribution of care services, the private organizations more and more permeate in the public domain of care.

The private organizations are even expected to more involved in the future care services. Still much of the debate among politicians and researchers circles around how to balance the care resources within the system, without being given attention to the principle of *solidaristic* equality. Are those shared understandings of Swedish people changing toward the residual model of welfare in which individual or family responsibility of one's well-being rather than the collective responsibility of society functions as a shared understanding? At least, for Swedish politicians it looks like they are approaching a model of elderly care which seems to be in accordance with residual model or a model of pluralism, even if their rhetoric still sounds solidarity and equality.

Japanese society has long been influenced by the concept of *ie* (家), a stem family, home or house. This concept of *ie* has its root

in the Confucian ethics regulating the relationship between parents and children. Even after the reform of the 1948 Civil Law in which the responsibility of care for the aged leaves up to children in a sense that supporting for the aged becomes a matter of children's mutual consultation and decision, many elderly people are still taken care of by the oldest son and his family. The other children are, however, expected to more or less fulfill their filial duties according to their position in the family (Anbacken, 1997). This tradition supports that the principle of solidarity within the *ie* system is still accepted by most Japanese. The cultural heritage of such kind of collective behavior is often reinforced by the fact that those children who fail to fulfill filial duty are exposed to informal social sanctions in a sense that their character will be called in question from the surroundings (Hashimoto, 1996).

However, the perception of elderly care which commonly shared by most Japanese "it is nature to take care of aged parents by family" (Anbacken, 1997) is now changing to some extent because of a series of structural changes in economics, demographics and family structures. However, we have to notice that women stayed at home and took care of the household at the expense of their economic independence and work career, thus keeping the traditional value of caring for the aged alive within the *ie* system, especially in the absence of the cooperation of men in general and insufficient public social supports and commitments in particular. The public debates of today among Japanese politicians are, however, almost about balancing the care resources between health care and social services, and about decentralization of care services without giving much attention to women's situation. Japanese politicians even seem to take a further step to a pluralistic model of welfare compared to their Swedish counterparts.

The concept of Japanese-style welfare society was first coined

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by conservative LDP politicians in the late 1970s in an effort to control the growing public expenditures on social security programs. Since then, the concept has been positively endorsed and strengthened in subsequent years and even come to symbolize the Japanese unique way to handle the aging population. In this model of welfare society, public care sectors as well as private sectors such as the family, voluntary organization and business are expected to share their responsibility of well-being of elderly people. Thus, the Japanese style “welfare society” is rather a mixture of public and private sectors of care.

However, the Japanese way to solve problems of elderly care through this model of welfare society is not superficially very different from the liberal welfare state model of Esping-Andersen (1990), in which the state plays minimal role, while the private sectors are encouraged and supported through various state subsidies. In the Japanese context, the concept seems to work in somewhat different ways: the state plays a minimal role in distributing welfare services for the elderly, while the informal sectors take a major part of welfare services without receiving much state supports. Thus, the care for the elderly in Japan is still a matter of individual or family, which also supported by the perception of Japanese politicians: the Japanese leaders believe that welfare—particularly of the old should not be the prime responsibility of the government (Verba, 1987).

As for the definition of welfare state, there is no a single united definition among social researchers. Some researchers include the involvement of the market and volunteers as components of welfare state, while others exclude those private domains of welfare and focus only on the state’s involvement in social security and social services for all citizens in a relatively narrow definition (Cochrane & Clarke, 1994; Esping-Andersen,

1990). This narrow definition of welfare state is especially useful in a Swedish case, because in Sweden the public sectors; state, municipality and county councils, take on a large part of welfare services and care for the elderly instead of fostering the private sphere; the family, the market and the voluntary organization.

Thus, the Swedish welfare system has not been a mixture of public and private sectors of care in a general meaning as welfare society of Japanese does, although private sectors in caregiving has always been present even in a small scale. Behind the dominance of public sectors in welfare services and care we found a series of factors; the principle of *solidaristic* equality which permeated the mind of ordinary Swedish people including politicians; the negative attitude toward charity and personal care from the family members; the economic growth in 1960s and 1970s which led to a great expand of public sectors and so on.

The system of Swedish welfare state is now undergoing a period of transition associated with shrinking economy and a series of social changes. Its general principle of universalism and *solidaristic* equality on the social welfare becomes an object of reevaluation. For the elderly, it means that welfare services and care that once were generally regarded as a civil right can not be taken for granted any longer by elderly people in a context of daily life.

Swedish politician's strategies to deal with problems of elderly care through both focusing on the very needy and encouraging the private sectors. It seems like that Sweden moves toward a model of Japanese style welfare society or at least approaches a pluralistic model of welfare. But this way of distributing welfare services, as we have seen, creates some controversies among social researchers and caring families and relatives. Especially when social supports for caregiving families are decreasing, those

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strategies mean more transferring of responsibility to women who already play a multiple role.

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스웨덴과 일본의 노인복지체제 비교

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스웨덴의 노인복지정책 기본입장을 건강상의 포괄적인 치료나 수발을 요하지 않는 이상 노인들을 시설에 입소시키지 않는다. 특히 1960년대 이후 노인보호정책이 시설보호에서 재가보호로 바뀌면서 공공 재가서비스 기능이 확장되었는데, 이는 가족의 노인부양책임성을 공공분야로 이전시키는 결과를 초래하였다. 반면 일본에서는 재가서비스 발달이 1990년대 초에야 이루어지기 시작했다. 그렇지만 스웨덴과 일본 모두 최근 노인보호 실천의 입장에서 변화를 보이기 시작했는데, 여기에는 몇 가지 의문점이 제기되고 있다. 두 나라 모두 정치적인 사상, 개인적인 가치, 서로 다른 경제상황에도 불구하고 노인보호를 위한 정책에서 시설보호보다는 재가보호를 더 중요시하고 있다. 일본에서는 노부모를 부양하는 가족의 규모가 줄어들고 있으면서 여성의 사회진출이 현저하게 늘어나고 있으며, 스웨덴에서는 초고령자 노인의 증가와 경제의 약화로 인한 노인을 위한 질적 서비스 제공 유지에 어려움을 겪고 있다. 결과적으로, 이러한 구조적인 변화들은 두 나라의 정치인들로 하여금 노인문제에 대처하기 위한 다양한 제안을 강구하도록 압박하고 있지만, 그들의 제안들이나 접근방식들은 다소의 제한적이다. 본 논문의 목적은 두 나라의 공공 보호체제를 비교할 수 있는 기회를 제공하는 데 있으며, 또한 두 나라가 직면하고 있는 문제들을 확인하고 그들의 해결책을 고찰하는 데 있다.

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