

The Modification of Welfare Activities by Local Residents

—Focusing on the Long Term Care Insurance System—

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1 Introduction

This thesis aims to clarify the change of the content of community welfare activities conducted by local residents in Japan. Before the establishment of the Long-Term Care Insurance (LTCI; i.e. *Kaigo Hoken*) system in Japan, local residents frequently visited neighbors in need, offering personal care and household assistance for several hours, typically two or three times a week.

However, since the introduction of the LTCI system, professional caregivers have predominantly taken over the responsibility of caring for the elderly. As a result, local residents now engage in less demanding welfare activities within their communities. For example, they often organize and maintain community events focused on exercises for dementia prevention usually one or two times a month.

This study argues that the nature of welfare activities has changed, as revealed through an analysis of interview data and newspaper articles. This change has occurred because professional caregivers are now able to provide physical care and household assistance through the LTCI system. Consequently, local residents view physical care within households as the responsibility of professional caregivers, leading local residents, instead, to participate in various welfare activities outside the realm of physical care.

In Japan, generally speaking, elderly individuals can access professional care services under the LTCI system by paying insurance premiums. However, some elderly individuals cannot afford these premiums because of low incomes. Additionally, a certain number of people do not receive adequate professional care because of limitations imposed on the amount of care available. When elderly individuals wish to utilize the insurance system, their eligibility for physical care is assessed and determined based on individual health conditions within the confines of financial resources including

individual premiums and taxes(Tirado and Tamiya 2014). As a result, sufficient care is not always attainable through the LTCI system. In practice, many elderly individuals receive only minimal care due to the financial constraints, particularly in a super-aged society.

Thus, for some elderly individuals who seek to benefit from the LTCI system, there remains a need for physical care. This means local residents who are able to take part in community welfare activities have room to meet the elderly's needs. However, in fact, local residents are not likely to take physical care because there is the "implicit division" between the physical care that the LTCI system provides and the community welfare activities that local residents have created.

This paper begins by discussing previous studies related to community welfare and welfare activities carried out by residents (Chapter 2). After explaining the research methods (Chapter 3), it reveals the changes in welfare activities by residents triggered by the establishment of the LTCI system (Chapter 4). Finally, based on the findings presented in this paper, the current state of welfare in Japan is analyzed (Chapter 5)

2.Previous Research

Takagawa (2006) has pointed out the phenomenon of the "mainstreaming of community welfare" in the laws and policies related to social welfare, where there is an increasing expectation for residents to engage in welfare activities within their communities. In the research on sociology and social welfare studies, there has been a growing focus on how to "develop" residents as "welfare resources" (Katsube 2020; Imamura, Sonoda, and Kaneko 2010), indicating that there has been a situation where "expectations" are placed on welfare activities led by residents. In policies and research related to community welfare, there has been an expectation that welfare activities carried out by residents will play a pivotal role in the community.

On the other hand, it has made it clear that organizing welfare activities led by residents can be difficult. For instance, Mega (2010: 124) mentions that such organization was largely limited to urban areas and that the scope of welfare activities led by residents had a quantitative limitation at that time.

Moreover, Morikawa (2019) discusses the actual state of resident-led welfare

activities based on a national survey conducted by the Ministry of Health, Labour and Welfare on the “types of life support” in the Community-based Integrated Care System (conducted in the fiscal year 2017). According to Morikawa (2019:104), among the “diverse services” in life support services under the Community-based Integrated Care System, the proportion of “resident-led” services in home-visit or day-service types is less than 10 percent. Morikawa(2019) concludes that it is difficult to expect residents' welfare activities to be carried out in a continuous and organized manner.

Ishida (2015, 2018) investigated the actual situation of resident connections in the suburban area of Tama Ward, Tokyo. The results showed that in regions with a high proportion of long-term residents, connections among residents were relatively observable. However, in areas with ongoing development, such as progressive development districts or large-scale developments like new towns, building connections among residents proved to be challenging (Ishida 2015: 209-210). In this way, it has been indicated that welfare activities led by residents face limitations in meeting welfare needs in the community in terms of their quantitative volume.

However, in the context of growing expectations for community welfare, in order to understand the possibilities and limitations of resident-led welfare activities, it is essential to consider not only how their quantitative changes and constraints have evolved, but also how such activities and roles have been, or could be, carried out within the community. Therefore, it is crucial to explore the qualitative changes in the content of resident-led welfare activities. This aspect, however, has not received much attention. In this paper, the changes in the content of residents' activities will be clarified through interviews and newspaper articles.

3. Method

This paper examines the changes in the content of community welfare activities conducted by local residents using data from newspaper articles and interview surveys.

For the newspaper articles, a search was conducted using the search systems of the Mainichi Shimbun newspaper, Asahi Shimbun newspaper, and Yomiuri Shimbun newspaper from 1980 to 2019. Articles relevant to the search terms “Resident-participation Type In-home Service Organization(“zyuminsankagata-zaitakuhukusi-

service” in Japanese)” and “home welfare” were reviewed, and articles that discussed the actual state of welfare activities led by residents during that period were selected for analysis.

Additionally, between October 2022 and January 2024, interviews (semi-structured interviews) and participant observation were conducted with residents engaged in welfare activities and “volunteering” within the community in City A. The interview survey was conducted with 13 residents living in a city, and for this paper, the narrative of a resident, A, who actively discussed the relationship between the establishment of the LTCI system and their own activities, was selected for analysis.

4. The Modification of Welfare Activities by Local Residents

4-1 The Situation Before the Establishment of the Long-Term Care Insurance System

—The situation in the 1980s and 1990s—

This chapter discusses how welfare activities by residents have changed with the establishment of the Long-Term Care Insurance system. First, it clarifies the situation before the establishment of the system, based on newspaper articles and other sources (4-1). Then, using interview data and newspaper articles as a foundation, it examines how welfare activities by residents have changed due to the establishment of the Long-Term Care Insurance system (4-2).

As the aging population gradually progressed, the Tanaka Kakuei administration aimed to expand public welfare in 1973. However, the oil shock that occurred in the latter half of that year became the catalyst for a policy shift, leading to the declaration of the “re-evaluation of welfare” and a move toward the reduction of public welfare. In response to this trend, “White Paper on Health and Welfare” in 1978 outlined a shift toward the cutback of public welfare and proposed the concept of the “Japanese-style welfare society,” where family care was regarded as a “latent asset.”

However, in this context of welfare policy, where there was an over-reliance on the caregiving role of families, the limitations of family caregiving became a widely discussed social issue in the 1980s. This period saw the recognition of the aging trend

across the Japanese society, and the issue of “caregiving” became more pressing in people's daily lives. At that time, Japan's social welfare system primarily relied on institutional care facilities for welfare. However, with the progress of the aging society, the limitations of institutional care in care facilities became evident.

In response, there was growing attention to the development of “home-based welfare services,” such as the dispatch of home helpers through municipal programs. However, the eligibility criteria set by municipalities, which considered economic conditions and the caregiving capacity of the family, limited the scope of coverage and were insufficient to meet the full demand for care.

In this context, the increasing needs for “light household chores” and “basic caregiving tasks” that could not be addressed by family caregiving or the municipal-based home welfare services led to a rise in “resident-led welfare activities” to meet these needs. Japanese Council of Social Welfare (“*Syakyō*” in Japanese) have taken on the role of promoting the participation of residents capable of providing welfare in Resident-participation Type In-home Service Organization, to address needs not fully met by institutional care or municipal home welfare services under the existing system (Japan National Council of Social Welfare, 2015).

During the 1980s and 1990s, there was an increase in Resident-participation Type In-home Service Organization where residents provided “resident participation-based home welfare services” for low fees. These services, which included assistance with meals and housework such as cleaning and cooking, directly replaced care that was previously provided by families.

An newspaper article from the Asahi Shimbun newspaper on December 21, 1988, provides an example of resident participation-based home welfare services, describing a case in the Tama New Town area of Tokyo, where “former nurses” and “housewives” initiated such services.

□The Part of the Article from the Asahi Shimbun newspaper, December 21, 1988

The former nurses and housewives in the Tama New Town area have started a Resident-participation Type In-home Service Organization which has been well received. The “Tama Care Center” provides support for elderly members by housewives who are also members. Those receiving care pay 650 yen per hour, while the caregivers receive 550

yen per hour. The difference is used for the operation of the organization. (Omit some sentences)

The “Tama Care Center” was launched in October. The chairperson, Kazuko Sasaki (46), is a former nurse who worked in elderly hospitals. While at the hospital, she was in a position to recommend home care to the families of elderly patients. However, seeing the challenges of family caregiving, she decided to quit her nursing job and, last fall, created a paid caregiving organization called “Tama Home Care Center,” staffed by people with nursing qualifications.

“Tama Home Care Center” handles medical caregiving tasks that require medical knowledge, such as suctioning for tracheostomy patients, applying oxygen masks, and providing rehabilitation guidance, charging 2000 yen per hour. However, the actual “orders” from the elderly are often requests like “Be a companion” or “Go shopping,” and from families, “Please stay with them,” which are more home care tasks that don’t require medical knowledge.

To address this, they considered how to offer these simpler caregiving services at a lower cost and decided to establish the new membership-based “Tama Care Center.” To become a member, both caregivers and care recipients must go through an interview at the “Tama Care Center” and pay an annual fee of 3000 yen. The caregiving services offered include cooking, laundry, cleaning, bathing assistance, helping with dressing, writing letters, reading aloud, and accompanying patients to the hospital. The “Tama Care Center” acts as an intermediary to connect caregivers and care recipients. Additionally, the “Tama Care Center” plans to hold workshops to teach caregiving tips for elderly care.

This article highlights that, at the “Tama Care Center,” not only “former nurses” but also “housewives” without nursing qualifications were providing “household assistance” and “minor caregiving” tasks, such as cooking, cleaning, bathing assistance, dressing, writing letters, reading, and hospital visits.

According to the survey by Japanese Council of Social Welfare in 1990, 97.5% of Resident-participation Type In-home Service Organization provided “household assistance services (Japan National Council of Social Welfare 1991: 27). Thus, in 1990, it was common for unqualified “housewives,” as seen in the newspaper article, to provide caregiving services that did not require medical knowledge, which were essentially the

same types of care that families had been performing in their daily lives, referred to as “minor caregiving.”

Additionally, residents who belonged to Resident-participation Type In-home Service Organization and provided welfare services tended to spend long hours at the homes of care recipients, as there were no time limitations based on care levels, unlike the services under the current LTCI system. For example, the following article from the Mainichi Shimbun newspaper provides another case study.

□The Part of the Article from the Mainichi Shimbun newspaper, September 15, 1992

“Is it tasty?” Gently asking while bringing food to her mouth with a spoon and chopsticks. This scene takes place in the home of Takehiko Kakimoto (54), a publisher, in Kitami, Setagaya, Tokyo. Shunko Izashi (56), a volunteer housewife living in the area, helps Kakimoto’s mother, Chiyoko (83), with her meals. Chiyoko chews slowly, and Izashi carefully matches her pace, taking one bite at a time. On days when Chiyoko is not feeling well, a single meal can take nearly an hour to finish. “I may not get a verbal response, but when I give her favorite foods like pudding or yokan, I can see her chewing speed increase, and I know she’s enjoying it,” says Izashi. Ten years ago, to bring Chiyoko from her hometown of Kochi City, Kakimoto bought this two-story house. The room facing south right at the entrance is Chiyoko’s six-tatami mat room, where an electric bed is placed in the center. Chiyoko has been bedridden for six years. For the past five years, Izashi has been assisting Kakimoto’s wife, Kimiko (50), with caregiving three times a week, from 10 AM to 5 PM, helping with Chiyoko's meals, changing her diapers, and turning her to prevent bedsores.

This article illustrates that, before the establishment of the LTCI system, residents visited care recipients' homes to provide minor caregiving and housework assistance, spending long hours with the care recipients. Although caregiving and support were the primary focus, the relationship between caregivers and care recipients also involved close communication, as seen in the example of volunteer in the article. Even if the person in need of support is bedridden and unable to speak, by offering them “pudding” or “mizu

yokan” during meals, the volunteer was able to establish intimate communication with the person. Additionally, when the person in need of support was able to speak, they would have casual conversations with the volunteer, and in some cases, cook and share meals together.

Thus, before the establishment of the LTCI system, resident-led welfare activities, including minor caregiving and housework support, were crucial in providing long-term, personalized care, fostering strong bonds between caregivers and care recipients.

4-2 The Situation After the Introduction of the Long-Term Care Insurance System

—the situation since 2000—

With the enactment of the Long-Term Care Insurance Act in 2000, the situation until the 1990s began to change. Through the establishment of the Long-Term Care Insurance System, people aged 65 and older became the primary insured individuals, enabling them to access care services. Once individuals began paying long-term care insurance premiums as insured members, it became common for them to receive services under the insurance system if they needed care, rather than choosing services outside of the system, such as the services of Resident-participation Type In-home Service Organization.

In many cases, Resident-participation Type In-home Service Organization transitioned into NPOs and began providing care services under the Long-Term Care Insurance System. To illustrate the outcomes of these changes, let’s look at an example of an NPO’s activities, formerly “Resident-participation Type In-home Service Organization”, as introduced in an article from the Asahi Shimbun newspaper on May 4, 2015.

□The Part of the Article from the Asahi Shimbun newspaper, May 4, 2015

The NPO “Tasukeai Hirata” started as a volunteer organization. The turning point came when Miwako Kumagai moved to Hirata City (now Izumo City) in Shimane Prefecture due to her husband’s job transfer. At the time, she was struggling with caregiving for her father-in-law and raising three children, but she was helped by those around her. This experience led to the philosophy: “Neighbors are more helpful than distant relatives,” and “We help each other in times of need.”

The services provided include cleaning, laundry, shopping, cooking,

companionship, simple carpentry work, and as much as possible. Although the organization is a service provider under the Long-Term Care Insurance System, it covers aspects that cannot be covered by the insurance system through the “Tasukeai” project. Both staff members and volunteers, as well as users, are members of the organization. The weekday daytime home care service has a user fee of 880 yen per hour, with 150 yen going to the office and 730 yen going to the volunteers. Based on her own experience, Miwako Kumagai decided to charge a fee to make it easier for people to ask for help. She strives to provide services from the user's perspective.

- Kumagai Miwako

Born in 1938. In 1992, she started a Resident-participation Type In-home Service Organization for household chores and childcare assistance, and with the launch of the Long-Term Care Insurance System, the organization transitioned into an NPO providing services under the system.

According to the article, we can see that Kumagai started a Resident-participation Type In-home Service Organization in 1992 and later transitioned the organization into an NPO under the LTCI system after its implementation.

Regarding the shift in community activities, local residents who can take part in welfare activities in the community stated that “after the establishment of the LTCI system, we are careful not to overlap with home helpers providing services under the insurance system when visiting elderly people.” Therefore, the form of activity where residents would stay at the homes of individuals in need of long-term support and build close relationships with them gradually ceased to exist with the establishment of the long-term care insurance system (Uenoya, Takemura, and Iwama, 2014: 48).

Therefore, behind the change in the nature of these community activities, there is an implicit awareness among residents engaged in welfare activities that, in relation to the LTCI system, 'the support covered by the system should be left to the system.' This study argues that, due to this awareness, the nature of the community's activities and role awareness has become “more modest.”

Similar shifts can be observed in day services as well. For example, in an interview with A (71years old, female), her history of welfare activities highlights the implicit

division of activities between day services and A's own activities, revealing a change in the type and nature of her volunteer work from the 1990s to the present (At the time of the interview conducted in 2022).

Interviewer: In your volunteer group, you used to cook meals and clean for elderly people, correct?

A: Yes, that's right. I did such activities like cooking and cleaning for elderly people's homes. It would usually be for about two hours.

Interviewer: So, were these activities for elderly people?

A: Yes, back then, before the Long-Term Care Insurance system was established.

Interviewer: Ah, I see. So, this was in the 1990s?

A: "Yes, I did these activities because the Long-Term Care Insurance system hadn't been introduced yet. It was similar to what 'handyman' services are today."

According to A, in the 1990s, she provided household services such as cooking and cleaning for elderly people's homes, which are now typically handled under the LTCI System. A notes that she did these activities because "there was no Long-Term Care Insurance system at that time."

Interviewer: You used to do volunteer work before the Long-Term Care Insurance was introduced. (Omit some sentences) Now, you're continuing your activities as a member of your local community.

A: Yes, (Omit some parts) now, I provide listening services.

Interviewer: Listening services?

A: Yes, I visit people using day services in a facility and just listen to them, including those with dementia. They often want to talk, including complaining about the facility. We just listen; we can't resolve things.

Interviewer: So, it's just listening to them.

A: Yes, just listening. Some of them say they feel better after talking, and smile.

From this conversation, we can see that A's current activity is focused on "volunteer listening services," which is a different role from the direct caregiving activities like

cooking or cleaning that she was engaged in during the 1990s. She emphasizes that her role is not to provide direct care but to offer emotional support through listening. In contrast to her earlier role, A now sees her role as a listener for the elderly rather than taking on household tasks or nursery care.

This change indicates that with the establishment of the Long-Term Care Insurance System, there has been a shift in the role of local volunteers. While A once took on direct caregiving tasks, today, she recognizes that care services should be provided by professional services under the insurance system. Her current role is limited to offering emotional support by listening, which illustrates the shift in both her personal role and broader community expectations in caregiving. In summary, as the Long-Term Care Insurance System has become more ingrained in local communities, an informal division of activities has emerged between professional care services and community volunteer activities.

5. Conclusion and Discussion

In the 1980s and 1990s, welfare activities carried out by local residents were quantitatively limited compared to today (Mega 2010). However, the relationship between the individuals in need of support and the residents providing support was extremely close. Residents built close relationships with individuals in need of support by spending long hours together at their homes, not only providing care but also becoming their conversation partners.

However, with the establishment of the Long-Term Care Insurance System in 2000, the scope of residents' welfare activities began to shift. Specialized professionals such as home helpers, who are qualified under the new system, took over the responsibility for home-based caregiving. This development significantly alleviated the demand for household chores and caregiving services, which had previously been addressed by local residents.

As a result, residents began visiting individuals facing some challenges in their daily lives, having brief conversations at the entrance of their house, or engaging in activities like exercising or sewing at the community center. On the other hand, residents gradually stopped taking on roles such as providing 'housework' or 'care,' including

activities like eating and talking with the individuals in need of support, and it can be said that they no longer considered these activities as part of their role.

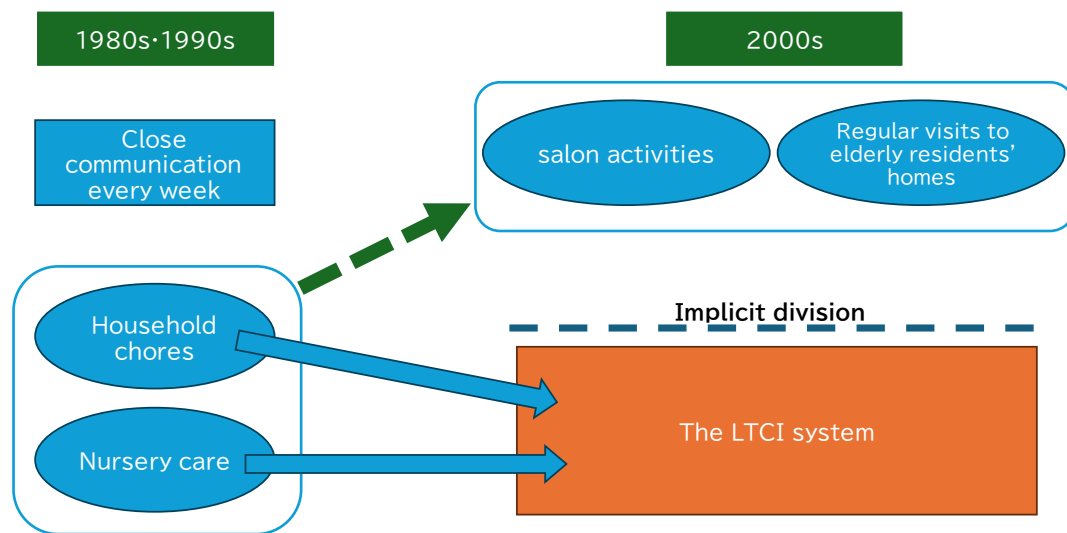


Figure 1: The Modification of Welfare Activities by Local Residents

This modification of roles was not merely a result of the fact that caregiving and household chores were sufficiently addressed by the Long-Term Care Insurance System. It is crucial to note that the insurance system, although widely implemented in eldercare, does not meet all care needs. In Japan, generally speaking, elderly individuals can access professional care services under the LTCI system by paying insurance premiums. However, some elderly individuals cannot afford these premiums because of low incomes. Additionally, a certain number of people do not receive adequate professional care because of limitations imposed on the amount of care available. When elderly individuals wish to utilize the insurance system, their eligibility for physical care is assessed and determined based on individual health conditions within the confines of financial resources based on individual premiums and taxes (Satomi, Niki, and Ito 1996). That is why sufficient care is not always attainable through the LTCI system. In practice, many

elderly individuals receive only minimal care due to the financial constraints, particularly in a super-aged society.

Therefore, in recent years, issues such as the care of individuals with mild dementia, which may not be addressed by the Long-Term Care Insurance system, have arisen. As a solution to this, there remains room for residents to take on caregiving and housework as part of welfare activities outside the system. Consequently, in social policy, expectations are growing that residents involved in welfare activities will “overcome” issues that cannot be resolved by the long-term care insurance system.

Nevertheless, after the creation of the care insurance system, residents who engage in welfare activities have increasingly viewed caregiving and household chores as the domain of services provided under the LTCI system,” leading to a reduction in their involvement in such tasks. Thus, there is an implicit division of activities between the care insurance system and the welfare activities of local residents. Activities such as “shopping” for individuals receiving care, which were once part of community-driven caregiving before the system’s establishment, have also gradually been left to the LTCI system. Residents have come to see heavy caregiving tasks—like household chores and caregiving—as the role of “systematic and specialized services.”

What does this implicit division of activities mean for recipients of welfare? As pointed out by Yamane (2023) and Saito (2011), welfare professionals under the care insurance system are often too focused on providing care based on the designated care level, leaving them unable to provide assistance with the broader daily living needs of individuals. On the other hand, local residents engaged in welfare activities also perceive such daily living support as the responsibility of the care insurance system, so they rarely provide such support themselves.

Moreover, in rural areas, where the number of residents engaging in welfare activities is declining, maintaining community-based welfare activities has become increasingly difficult (Takano 2015). Therefore, the needs for support such as changing light bulbs or having meals together remain unmet by both the LTCI system and local residents, and these issues remain unresolved.

The existence of these unmet needs tends to be obscured by growing expectations of residents’ involvement in welfare activities. However, welfare needs that cannot be addressed by the LTCI system can, in many cases, be resolved through the expansion of

public policies. For example, under the current long-term care insurance system, the need for support is assessed on an individual basis, but in reality, there are cases where other family members also require welfare services. Therefore, if there were a public system that allowed home help at the household level, rather than the individual level, it could provide more comprehensive support. Additionally, the current Long-Term Care Insurance System only allows for support based on a predetermined time unit. However, if a system without the time limitations could be established, it would allow for more flexible responses to the needs of each person requiring assistance. Such reforms to the system would make it easier to address the daily living challenges of individuals in need, and it is believed that they would also reduce the excessive expectations placed on residents' welfare activities in welfare policies. Through the development of such public systems, residents engaged in welfare activities would find it easier to carry out these activities in a way that suits their individual living circumstances.

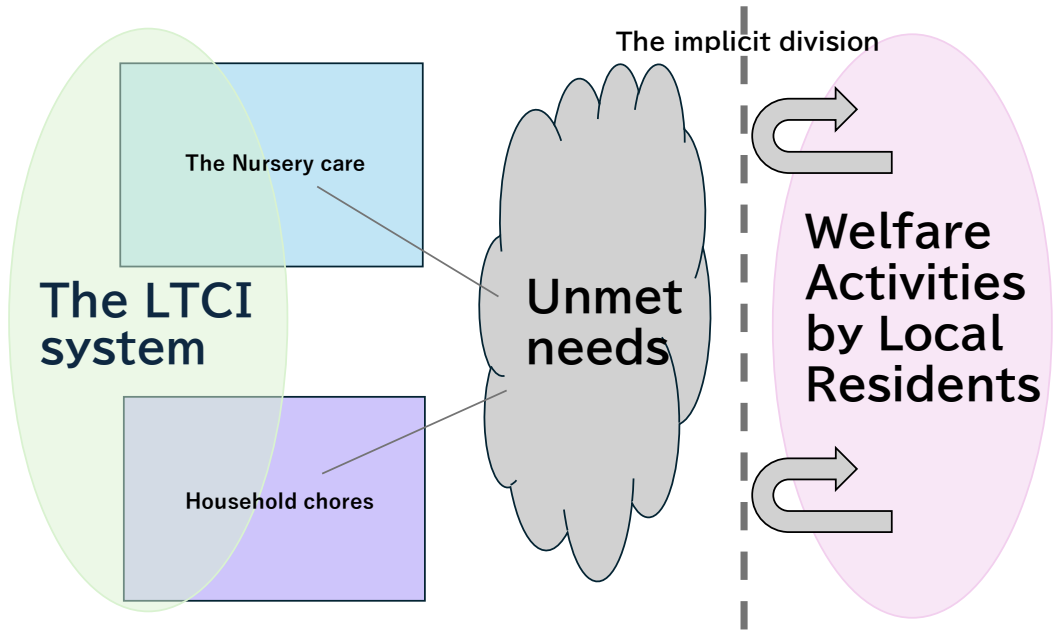


Figure 2: Needs that cannot be met by either the long-term care insurance system or welfare activities by residents.

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