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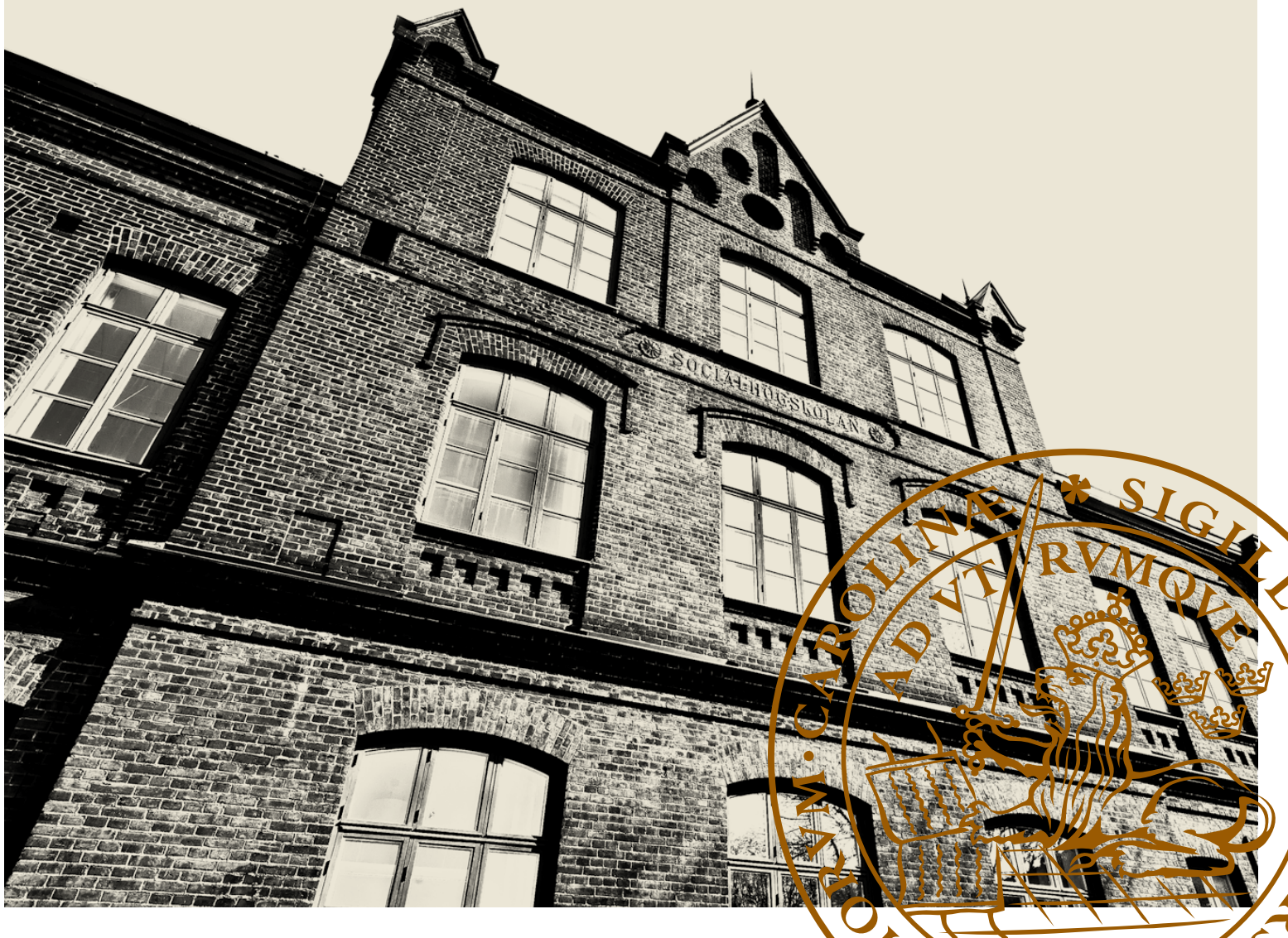
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What is good elderly care in Japan and Sweden?

A study of how managers of residential
care facilities describe care arrangements

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Introduction

This report is the result of a long collaboration between Håkan Jönson at Lund University and Haruko Watanabe at Hiroshima International University. Haruko Watanabe has visited Sweden since the 1990s, first as a Master's student and later as a researcher on elder care and a lecturer accompanying groups of social work students. Håkan Jönson has visited Japan several times since 2003 to lecture and conduct interviews on the topic of nursing home neglect.

Following a discussion of some striking aspects of residential care in the two countries (see below), we decided to apply for funding to conduct a comparative study on the topic of good care in residential facilities for the elderly, and we received small grants from the Crafoord Foundation and the School of Social Work at Lund University.

The report is a product of Lund University and Hiroshima International University in collaboration with the research program "Transformations of Care" (headed by Professor Marta Szebehely and supported by the Swedish Council for Working Life and Social Research) at Stockholm University.

Interviews were conducted jointly. Håkan Jönson and Haruko Watanabe contributed equally in the analysis of data. Håkan Jönson wrote the draft version of the report and revised the text according to comments and suggestions by Haruko Watanabe.

The purpose of the study

The study on which this report is based aimed to investigate how managers of residential care in Japan and Sweden perceive good care. The following questions will be discussed in the report:

- How do managers in the two countries define good and bad care, and what possibilities and difficulties do they perceive when attempting to provide good care?
- What differences regarding the needs of care users and the provision of care can be discerned in a comparison between the two countries?
- Do managers refer to specificities of Swedish and Japanese culture when commenting on care and accounting for different arrangements?

The design of the study was inspired by previous interviews and study visits that we have conducted in the two countries. During these encounters managers of residential care have emphasized for us that good care should respect the *individuality* and *autonomy* of the care user and respect his/her *privacy* (and these

concepts also appear as fundamental in the literature on care and nursing: Leino-Kilpi et al., 2003; Suhonen et al., 2011; Ågren Bolmsjö, Sandman & Andersson, 2006), but what they meant by some of these values seemed to differ, as did their ideas on possibilities to live up to them.

The study is based on sixteen interviews, eight in each country. This design enables the researcher to compare arrangements and to identify aspects that may be taken for granted if only one setting is studied (Blomberg, 2008). Unlike the design used in most comparative studies, the Japanese researcher conducted interviews in Sweden (using the Swedish researcher as an interpreter between Swedish and English) while the Swedish researcher conducted interviews in Japan (using the Japanese researcher as interpreter between Japanese and English). This design was a product of experience from previous interviews and study visits, where Japanese managers had asked the visiting Swedish researcher about the occurrence of shared rooms in Sweden and stated that older Japanese people had a different view of privacy and some were happy to share rooms. These types of comments on cultural difference led us to develop a design aimed at facilitating/eliciting comments on cultural specificities. Blomberg (2008) suggests that, although it may be difficult to make relevant interpretations in an unfamiliar setting, the outsider may detect phenomena that are taken for granted by a researcher who is familiar with a particular culture. In this study, we have taken this suggestion one step further, and confronted our informants with an interviewer who is a cultural outsider and therefore in need of explanations that would perhaps not be necessary to mention to a researcher who is native to the country. The outcome of this design will be discussed at the end of the report.

Theoretical framework and methodology

The present study is situated within a constructionist framework; it is primarily the construction of good care, individuality, autonomy, privacy and culture through *talk* that is investigated. Descriptions will be regarded as *representations* and analyzed from the perspective that such representations are themselves important aspects of reality (Potter, 1996; 1997). Although our general impression was that our interviewees spoke honestly about their facilities, our prime interest is not to investigate or claim that their descriptions are true representations of certain arrangements. The constructionist framework and our aim to elicit or facilitate talk on culture have methodological implications. Interview are not regarded as ways of communicating value-free facts, but as arenas for interaction (Holstein & Gubrium, 1997). In an approach that focuses on the transmission of “facts” the interviewer aims for neutrality, being as non-directive as possible. In the later approach it is acknowledged that *influence* is always present and the study must therefore be sensitive to context and interaction. Managers are likely to present somewhat different versions depending on whether they speak with a researcher, their staff, visiting family

members, a local politician and so on. This is not to suggest that they lie but that context and interaction are part of reality, in interviews and in other situations. The design of the study is therefore a way of being conscious about something that is already present and using it to further the understanding of how culture comes into play in different contexts.

In addition to our general focus on how managers describe the concepts above, two types of sensitivity have been applied: to the invocation of *rhetorical contexts* and to the use of *accounts*.

The concept of rhetorical contexts rests on the assumption that arguments do not stand by themselves, but appear in relation to ongoing “debates” (Billig, 1996). There are known standpoints, opinions and counter-opinions that interviewees may refer to. For instance, descriptions of autonomy in residential elderly care tend to refer to problems and ethical dilemmas involved in upholding autonomy, and interviewees may signal awareness of different rhetorical position in a debate on the issue. If autonomy is celebrated as an important value, interviewees are likely to emphasize this standpoint as a principle when commenting on cases where the norm is not possible to uphold in order to avoid being labeled as opponents of autonomy. An interviewee may for instance use a disclaimer (Hewitt, 2007) such as “I’m a strong proponent for autonomy of care users but ...” when describing a standpoint on a particular situation. Interviewees may also refer to rules or conflicts of interest that affect the facility, and comment on these matters as relevant or problematic. In the analysis of data we have tried to detect rhetorical contexts that managers invoke or indicate in order to understand the way they frame different topics in relation to existing values and norms.

Good care, autonomy, individuality and privacy are normative concepts. Care providers are supposed to provide good care rather than bad, and infringements of autonomy, individuality and privacy are likely to warrant explanations. The present study is sensitive to this need to explain how facilities live up to expectations and account for deviations from ideals and norms. *Accounts* are linguistic devices that people use when being questioned in relation to background expectations, i.e. norms, and it is usually meaningful to distinguish between justifications and excuses (Scott & Lyman, 1968). When using a justification a person assumes responsibility but denies that a specific act is wrong. When using an excuse a person admits that the act is wrong, but denies responsibility. The search for accounts enables researchers to understand the relative importance of normative concepts, including cases where ethical dilemmas occur. The aim to uphold the autonomy of the resident is an example of a norm or ideal that may appear to be in conflict with the aim to provide good care in cases where the resident acts in ways that jeopardize safety.

As mentioned previously, an aim of the study was to elicit and discern cultural references, and to some extent the design of the study promoted the occurrence of accounts. A cultural stranger has the capacity to introduce

unfamiliar background expectations, thus eliciting accounts about acts that otherwise appear self-explanatory. It is less likely that phrases like “Swedes usually prefer...” and “in Sweden, it is common to...” are used if the interviewer is Swedish, because the interviewer is to a greater extent supposed to know about preferences among Swedes.

Method

The study was based on 16 interviews, eight interviews with managers in Japan conducted in 2008 and eight interviews with Swedish managers in 2009. The Swedish interviews lasted between one and one and a half hours. The typical length of Japanese interviews was two hours, although one interview lasted four hours and had the form of a seminar/lecture held by the manager. At one Japanese facility, the interview was interrupted for lunch together with residents and a visit to a department store. All interviews were conducted at facilities and in all cases we were invited to take a walk around the facility. These walks provided us with additional information of value for the study.

Interviews had a semi-structured character; an interview guide was used but additional questions were asked and interviewees were allowed to elaborate on issues (Bryman, 2011). As mentioned previously, one researcher asked questions and the other acted as interpreter. Following a request by some Japanese managers, the interview guide was sent out to all interviewees in advance. Our impression was that most managers had read the guide in advance and made preparations. All Japanese managers but only one Swedish manager (representing a for-profit facility) provided us with pamphlets that the facility used to inform about itself. All interviews were recorded, using a digital memory. In addition notes were taken during interviews, mostly aiming to facilitate the compilation of facts (number of residents, number of rooms etc.) but impressions and some interpretations were also included to facilitate the coming analysis (Aspers, 1997).

A professional interpreter specialized in translations from Japanese and Swedish to English transcribed all interviews except one. In one of the Japanese interviews, the manager had invited two employees and held a seminar during four hours where he developed his views on care work. Since much of what he said had little relevance for our study it was judged to be cost-effective to take notes from the recording instead of transcribing the entire interview.

The transcribed text included the visiting researchers' questions and the answers provided by the interviewee, thus excluding translations during the interview. In order to increase the reliability of the data, both researchers listened to the recordings while reading the transcriptions and corrected parts where mistakes had occurred. This was particularly necessary in the case of the Japanese interviews, as the interpreter was not native to Japan and did not fully comprehend some concepts and issues used to describe care arrangements.

During the process of sorting data, it turned out the translator had misunderstood some sentences and summarized some sections rather than transcribing verbatim. These sections appeared in the Japanese interviews, and even though they were corrected by Haruko Watanabe, they still contained language that did not facilitate the use of qualitative analysis.

Ethical considerations

Respondents were informed about the purpose of the study and agreed to participate. Managers responded to questions from an official position. No sensitive personal data was collected and interviews did not touch upon topics regarded as ethically problematic to talk about.

Since knowledge about the specific facilities did not appear relevant, names of managers and facilities has been excluded in the report and managers will be referred to as JA, JB, JC, JD, JE, JF, JG, JH and SA, SB, SC, SD, SE, SF, SG, SH.

Coding data

Both authors read through all interviews and made notes on general impressions. Data were sorted according to all interviewees' answers to specific questions, and these compilations of answers were reviewed using an inductive approach. This part of the analysis was guided by questions like: how does each interviewee define the concept of X and Y? Is it possible to discern commonly used views and vocabularies? Are there differences depending on country? Results from this review were discussed and potentially interesting findings were identified for additional review. In order to test the reliability of patterns and differences discovered in this part of the analysis, all interviews were reviewed once more (using questions like: no Japanese managers mention X in relation to question A, but do they touch on X in any other part of the interview?).

Elderly care in Japan and Sweden

In this section we will provide some basic information on the systems of care in Japan and Sweden.

As in other Nordic countries, the care sector of Sweden is highly formalized. In comparison to other countries, the state, in the form of local municipalities, has a dominant role in the provision of care. The system of care is funded by taxes and provided on a universal basis. Although recent years have been characterized by an increased informalization and privatization, the public sector is the main financer, provider and employer (Lyon & Glucksman, 2008; Simonazzi, 2009). Following a legal reform in 1992, all forms of elder care except geriatric care are covered by the Social Services Act and a legal responsibility for local municipalities. Nursing homes, group homes for people with dementia and service houses are all referred to as special housing (SH) for the elderly (*särskilt boende*). Residents in special housing are formally regarded as living in their own apartment, even when they live in a room adjacent to a corridor in an institution-like setting. Facilities usually consist of several units with 8–12 residents in each unit where meals and common activities take place. Some facilities have units that specialize in care for people with dementia, but dementia may be prevalent at other units as well. With few exceptions residents have private rooms with en-suite bathroom and most often a kitchenette. Residents are supposed to bring their own private furniture to the facility. Swedish care facilities are providers, and do not make decisions on admittance. The process of becoming a resident starts with an application to a case manager who makes a decision based on needs and suggests a facility. During the last decades the threshold for entering residential care has been raised, and as a result residents in care facilities are very frail, and it has been suggested that dementia constitutes a normality in residential care for the elderly (Melin Emilsson, 2007).

While Sweden constitutes an example of a Social Democratic welfare state, according to the typology by Esping-Andersen (1996) the elder care of Japan is less easy to define, as the system is undergoing change. Abe Auestad and Saito (2010) suggest that on the one hand there is a similarity to the German conservative and corporatist model, since Japanese elder care relies on social insurance (the long-term insurance care system *Kaigo Hoken*) rather than taxes. The absence of universal ambitions of the Japanese system resembles the liberal Anglo-Saxon model, while the tradition of relying on the family as the primary care giver is a hallmark of the Asian model.

There are several types of care facilities in Japan. Apart from geriatric wards, there are health service facilities for the elderly (HSFE), special nursing home for the elderly (SNHE) and care houses. In theory, health service facilities are clinics with a higher level of medical competence that aim for rehabilitation, while nursing homes and care houses emphasize social needs. In reality people who are

refused admission health service facilities for medical reasons may be accepted into nursing homes (Horiguchi, Hara, Ikeda & Nobutomo, 2004). Care houses are mostly designed to help people with lesser needs, but there is variation.

While some facilities – and care houses in particular – have single rooms only, it is not uncommon for residents to share rooms for two or four people. Japanese care facilities are primarily run by NPOs, created for the specific purpose of providing care (Tamiya, Chen, & Sugisawa, 2009). The existence of such organizations – referred to as Social Welfare Juridical Persons – is regulated in the *Social Welfare Service Law*.

In Japan, the process of admission is linked to the LTC system that reimburses nursing homes. An independent committee from the municipality judges the care level of the older person according to the LTC levels. The older person makes an application to a specific facility, and signs a contract with that facility if admittance is agreed (in case of dementia the family signs the contract). There is usually a waiting list. The waiting lists at the facilities in our study ranged from 100–300 people, but an applicant would in reality not have to wait until that number of people have been offered a bed at the facility.

Presentation of facilities

The 16 facilities of the study are presented below. Seven of the Japanese facilities were special nursing homes for the elderly (SNHE) and one was a care house. Swedish facilities cared for similar residents to Japanese nursing homes, but are labeled special housing for the elderly. One short-stay unit was included in the Swedish sample.

It is difficult, for a number of reasons, to compare facilities based on numbers of residents and staff. Facilities cared for somewhat different needs. One Japanese facility (JA) catered to day-care guests in addition to residents, and another provided home care (JH). There were differences within the population of residents. For instance, manager SA estimated the number of residents with dementia at 32 out of 48, while manager SB estimated the number in his facility at 8 out of 77. The number of people with dementia may also be calculated differently; not all residents who suffer from dementia have the formal diagnosis.

In addition, Swedish care workers are often employed part-time, and only three Swedish managers recalculated the total number of staff into full-time equivalents. Given all this, the figures in the table are included to provide some general information about the size of facilities.

All Japanese facilities were operated by NPOs in the form of *social welfare organizations* (SWO), a situation that is typical for Japanese nursing homes. Swedish facilities were operated by local municipalities, except in one case where the facility was run by a large for-profit corporation.

Among the Swedish facilities, all but one had single rooms only. The short-stay facility SC had two double rooms and 18 single rooms. Among the Japanese

facilities, two had single rooms (JA and JD) and the rest had a mix of single rooms, rooms for two and four residents.

Table 1: Information about facilities

Respondent	JA	JB	JC	JD	JE	JF	JG	JH
Gender	F	M	F	F	F	M	M	M
Education	Nurse, CM	Nurse, CM	–	Teacher	–	–	–	Social worker
Work exp.	4 years	8 years	21 years	3 years	17 years	28 years	30 years	10 years
Facility type	SNHE ¹	SNHE	SNHE	SNHE	SNHE	SNHE	SNHE	Care house
Organization	SWO ²	SWO	SWO	SWO	SWO	SWO	SWO	SWO
Number of residents	50 + 10 short stay + 28 day service	50 + 10 short stay	60 + 4 short stay	50 + 10 short stay	84 + 50 short stay	100 + 10 short stay	50	20 + 10 short stay + 55 day service + 106 home care
Number of staff	53	31	40	89	65	68	25	83 ³
Respondent	SA	SB	SC	SD	SE	SF	SG	SH
Gender	F	M	F	F	F	M	F	M
Education	Nurse	Social worker	Nurse	Nurse	Nurse	Social worker	Nurse	Social worker
Work exp.	3	1	14	15	3	8	4	9
Facility type	SH (NH) ⁴	SH (NH)	SH (NH)	Short stay	SH (NH)	SH (NH)	SH (NH)	SH (NH)
Organization	Municipal	Municipal	Municipal	Municipal	Municipal	Municipal	Municipal	For-profit
Number of residents	48	77	46	22 + 2 emergency	39	36	38	42 + 1 short
Number of staff ⁵	60/50	75/55	50	31	42	31/18	39	40

Principles and goals

Managers were asked whether the work of the facility was guided by any principles or ideas, official as well as personal. Such principles were mentioned by all managers and several also showed pamphlets that the facility used to present its policy. The section below will only deal with principles that interviewees labeled as “official”.

¹ Special Nursing Home for the Elderly

² Special Welfare Organization

³ Only a number of the staff worked with the residents. The facility was part of a complex that provided home care and day services. Residents at the facility were helped by home care workers.

⁴ Special Housing (Nursing home like facility)

⁵ Total/full-time. Numbers are difficult to compare since some staff work part-time and that could imply half-time or almost full-time.

Several Swedish interviewees referred to values/ethics expressed by the Social Services Act (Socialtjänstlagen) and/or values/principles established by the municipality to which the facility belonged. Examples of goals established by local politicians were “quality and participation” and “contentedness and safety”. Such goals were then adapted into the practical work of the facility, as expressed by manager SC: “The politicians have their goals and we have to break them down to our own goals.” Some Swedish interviewees described additional principles as established in meetings between managers of the municipality, or that the successful work of their facility had been adopted as official policy on the municipal level. To summarize, there was a first similarity based on the values expressed in the Social Services Act, and a second similarity based on municipal belonging. One of the Swedish facilities was operated by a for-profit corporation. The manager of this facility referred to the goals of the corporation, but also emphasized the quality control of the municipality that used and paid for its services.

In contrast, the principles and ideas of Japanese facilities had a local and personal character. When asked about official principles, Japanese interviewees rarely made references to political goals or authorities outside the facility. To some extent, this difference can be explained by organization belonging. All Swedish facilities except one were run by municipalities while all Japanese facilities were established as local NPOs. In other sections of the interview Japanese managers did refer to political goals and principles, for instance the prohibition to use physical restraint and the aim to ensure privacy by providing care recipients with single rooms. Among the Japanese facilities, principles and visions had been established by a founder or leader of the organization, and interviewees presented them as belonging to a particular person: “These are Mr. Sato’s principles.” In several cases interviewees answered the question about principles in a story-like manner. Manager JD provides an example:

Actually, I have written the ideology to be realized here. I am a Christian and since I was in my twenties I wanted to create this kind of facility but for different reasons it did not come true at the time. I am now 62 years old. I made a donation to the organization for the construction of this facility. I will explain the ideology. It is about how to make people happy in their everyday lives and to live together. Such feelings come to everybody, I think. We talk about how to make them happy. Before providing care, we should think of their happiness.

Our interviews indicate that the Japanese system gives room for individual visionaries to realize “their” ideas in “their” facilities. At one of the Japanese facilities, the charismatic manager was clearly admired and some care workers had changed workplace to become part of his visionary project.

Manager JD may also be used to illustrate a top-down perspective that was present in several of the Japanese interviews. JD stated that she *told* her staff

about *her ideas*. She suggested that she needed to simplify the governing policy of the facility when talking to staff:

I have established a basic ideology. When I talk to the staff I say that they should do things slowly, gently and exactly/reliably. The old people stay here until they die and they should keep their dignity till the end. The ideology has quite difficult words and not all of the staff can understand them, so when I talk to them I say *slowly, gently* and *exactly/reliably*.

In contrast several Swedish managers described local principles as a result of a *process*, involving manager and staff (residents and relatives were not mentioned as part of this process, although that does not necessarily mean that they did not participate). Among the Swedish managers SD described this kind of process: “When we started in April last year, we gathered all staff and we had five or six rules that we discussed.” Several Swedish managers also used expressions such as: “we work in groups and try to discuss different issues about this” and “we work all the time with the principles on how to work.” The *process* was described as a goal in itself. This reflects a view according to which it is more important to have an ongoing discussion than to establish set principles. In Sweden this view has been expressed in the warning that ethical principles may prohibit critical reflection on ethical dilemmas (Svedberg, 2002). Among the Japanese interviewees, only manager JF mentioned a process involving the staff in the process of establishing goals:

These principles were written by the [founding] doctor eighteen years ago so they were very complicated. However, we have made a current version for our own use in 2006. All staff has participated in creating them by handing in their ideas and an executive has chosen them and presented them.

Yet another difference concerns the character of the official principles. Among Swedish facilities principles were to a greater extent specified as *methods* relating to ideas on good care and professional methods. For instance, in a document about how to work at one of the Swedish facilities, the ultimate goal to “keep the personality of the individual” was operationalized in the aim: “to base care on a life-story perspective” (SF). Some official principles of Japanese facilities had a quite different character. They were similar to mission statements among private companies: “We try to improve and develop the quality of care all the time.” One reason may be that these principles include the type of general goals that appear at the political level in Sweden. Another reason may be that some principles were advertisements; they appeared in brochures and on walls at the facility. Some Japanese managers commented on their vagueness and the lack of correspondence between principles and the care that was actually provided.

What is good elderly care?

Interviewees were asked to describe their view on good care. Following this question, they were asked about bad care and problems as well as possibilities involved in providing good care. Below, we will discuss answers to these questions together with answers provided to the question concerning views on *dignity* in residential care. The reason for this choice is that answers about good care and dignity were in most cases overlapping.

Descriptions of good care focused the needs of care users as well as the provision of care. Manager SC combined these two ways of defining good care when stating: “The people who live here have to feel that they are safe. The staff shows them respect and a sort of affection. Old people should be treated with love, humor and cordiality.” Maslow and the hierarchy of needs was mentioned by Japanese as well as Swedish managers, who suggested that good care means providing a safe and secure environment, but that it was also important make the everyday life meaningful for residents at the facility. Several interviewees stressed that it was “not enough” to only attend to basic needs, and manager SB even used the lack of fulfillment of higher needs to define bad care: “Bad care is when you provide food, medicine and shelter but you do not give a crap about the other things. Keeping people alive, but you don’t do anything for the social... that is bad care for me.” Some managers defined good care through contrasts between improper and proper acts: speaking above the head of the care user rather than to the care user, acting according to routines rather than individually, hurrying people instead of following their own pace, leaving people to die alone rather than in the company of others.

All managers suggested that good care was based on the view that the care user is an individual with a unique personality and a will that needs to be respected. This was also the most prominent way of describing dignity in residential care, expressed in phrases like: “to see every human being as unique”, “to respect the individual”, “the right to decide about your life”, “a hundred residents means a hundred different lives”. This aim to individualize care is central within the person-centered care paradigm, where it aims to replace a task-oriented paradigm (Edvardsson, Winblad & Sandman, 2008). Among some Swedish managers goals were specified as a need to keep the personality and to enable the resident to be the same person as before entering the facility. This was in turn connected to the use of a life history perspective and methods that some facilities used to map the habits and preferences of a care user. In the Japanese interviews, the importance of the life history was mentioned when respondents talked about getting information from relatives, but the issue was absent in comments on good care or dignity.

Potentials and problems

Managers described a number of different possibilities and obstacles relating to the provision of good care. As could be expected from the fact that we interviewed managers, some comments were framed in terms of supervision, leadership and coaching. Many examples were mentioned as illustrations, some concerning activities aimed at providing “golden moments”, such as outdoor activities, dancing nights and wine testing, and others referring to individuals being allowed to engage in preferred activities. In connection with this, managers mentioned frailty as a limiting factor. Many residents suffered from a lack of energy and got tired when participating in activities. In addition, some people suffering from dementia were aggressive and others could not make clear what activities they preferred.

When studying a Swedish official investigation on *good quality* in care work, Markström (2009) identified four different ways of defining quality: as a matter of having qualified staff (medically trained, specialized in dementia), as a matter of having suitable staff (engaged, mature), as a matter of having enough resources and as a matter of what the care user prefers. This division is useful since it makes clear that definitions may align as well as compete and collide. Someone may argue, for instance, that it is more important to have suitable staff than staff that is formally qualified, or that it is wrong to focus on qualifications/suitability when there is a lack of resources, or that the professional knowledge linked to formal competence threatens the self-determination of users.

All four definitions were mentioned in our interviews, sometimes in combination but also as a matter of stressing that one aspect was not enough. A lack of resources was commonly mentioned as a reason for care not being as good as it should be. Japanese managers mentioned the lack of single rooms, and three Swedish managers belonging to the same municipality commented on a recent demand to cut costs as a threat. Lack of staff and problems recruiting staff, given the low wages of care workers, were also mentioned among managers of both countries.

Below, we will discuss the issue of *attitudes* and the link between a lack of resources and the ability of the staff to provide good care. Several Japanese managers spoke about the concept of *kokoro*, which literally means “heart”. Manager JD suggested that education and training of the staff was important and continued:

To develop *kokoro* is the most important thing. If you do not have the right feeling, that you want to improve more, it is difficult to achieve (find) it. You always have to focus on what is the happiness for old people.

In a similar manner, manager SC stated that “you have to be a special person to take care of others.” Like several other Swedish managers, she continued by saying that she was proud of working at the facility: “I think I have very good

staff, they work with their heart.” She compared the situation with “the old days” when residents were medicated to stay calm.

When speaking about *kokoro*, JD added that precarious working conditions and outside obligations could threaten the balance that was needed for staff to engage emotionally in care users. In a similar manner, manager JF suggested that his staff could not do their best if their private lives did not work out due to a low salary. His ability to provide staff with a reasonable income was thus crucial for the quality of care.

Manager SF commented on the connection between salary and work status in a different way: “We try to have some professional pride. It’s a low-paid job but there have been improvements during the past few years. We cannot achieve this unless we work professionally.” Manager SC warned that people who came to work only because they were unemployed were a threat and stated that “You have to get the right people to your place and make them leave if they are not good enough.” It is difficult to know whether the answers above reflect a real difference in practice. Would manager JG really accept that staff suffering from problems outside the facility provided bad care? What the analysis indicates is the presence of a rhetorical position/viewpoint among Swedish managers, according to which the quality of care can never be excused with reference to outside problems of staff (Jönson, 2006).

The claim that good care depends on having the right attitudes was also developed in relation to the facility in general, for instance in claims that the facility must give priority to the needs of the care users rather than the staff. Some managers mentioned the status of older people and care users as crucial for the provision of good care. Manager SF stated that nowadays residents at her facility were referred to as “tenants” since this countered the diminution of the care user. When doing this, it is interesting to note that she elaborated on a risk of giving priority to the needs of the staff:

We call the residents “tenants”. We are the only place in this district doing that. They are not care users or patients. They are human beings that rent an apartment here. We should not belittle them. They have a name and they are tenants with a contract. This means that we are guests in their own homes. It is their homes and not our workplace. To a certain extent it is our workplace but primarily it is their homes. If they had not been here, we would not have been here either. We are here for their sake, which includes a lot. We knock at the door and then we go into the apartment. We are here for their sake and not the other way around.

The quotation above is not merely a claim that a certain vocabulary enhances the status of the resident in a care facility. It is useful in this case to consider the rhetorical approach developed by theorists like Billig (1996). An utterance never stands by itself, but connects to a context of previous and expected utterances. The obvious counterpart in the debate that SF engaged in is claims-makers who

argue that the situation of the staff is paramount for providing good care. This staff-centered perspective is prevalent in discussions on elderly care in Sweden, among trade unions and researchers on care, and it is sometimes expressed in phrases like: “The only way to improve the situation for older people receiving care is to improve the situation of care workers providing care” (Jönson, 2006).

Making residents happy or providing self-help?

In four Japanese interviews, good care was described in terms of making old people happy and content. Manager JA answered the question about good care like this: “What is good care? If you measure it, the scale is people’s satisfaction.” The mention of happiness was less accentuated when Swedish managers spoke about good care. Manager SB spoke about good care as a situation where “they can feel OK when getting help”, but this goal was based on the idea that a person receiving care is at a disadvantage and that good care *reduces* the feeling of disadvantage. The aim to make old people content did appear in some Swedish interviews, in the section dealing with principles/goals (“The goal is to increase the feeling of contentedness and safety of the resident”) and when managers commented on user surveys.

Given the way Swedish managers developed their thoughts on care, it is possible that “happiness” was not included in definitions of good care since the concept fits less well within a professional discourse on care work. This interpretation is supported by the fact that Swedish managers emphasized *activity* as a foundation for good care in Sweden. Although Japanese managers mentioned activities that care users participated in, none of them suggested that activity was a goal or guiding principle for providing good care. Among Swedish managers, activity was an explicit ideal and in several cases described as the very foundation of good care. For instance, manager SF suggested that: “Our goal is ‘help to be able to help yourself’. They need to make an effort. Otherwise they will just sit passively. If they can make their sandwich, they should do so.”

Manager SG used very similar reasoning and added that it was a matter of keeping the healthy part and to focus on social rather than medical aspects. Expressions like *help to self-help* and to *focus on the healthy parts* were frequently used by the Swedish managers but did not occur in any of the Japanese interviews. Statement suggested that if the resident is happy being passive, the facility may try to activate the resident. Swedish managers warned about a risk of “taking over” by helping directly instead of prompting care users to manage tasks themselves. The present focus on activity was juxtaposed with a medicalized way of thinking: “Back in time, they had more medication, psychopharmacological drugs and sedatives to make them calm. Today we have more competence to take care of people” (SC). Manager SA told us that her facility was involved in an outdoor project, where residents spent time outside during the winter, making

snowmen and throwing snowballs. Previously, it was feared that residents would get cold, but today this was judged as “overprotecting”.

The point here is not to determine to what extent residents at facility SA really participated in snowball fights, but to comment on the strong emphasis on activity. In fact, manager SG suggested that the work “should aim for *rehabilitation*”. It is also of interest that the aim to keep the healthy part was not only mentioned as a motive for a self-help approach, but also in relation to the aim to base care on the history of residents: “The care is based on something called a life-story, in order to be able to *keep the healthy parts of each individual*”. This link made activation part of a person-centered paradigm: to prompt activation was to uphold the person from before.

The direction toward activity in Swedish elderly care rests on the activity paradigm predominant in gerontology and on theories about learned helplessness and hospitalization (Törnström, 2002). It has also been described as paramount for a holistic approach, where care is provided in relation to the *person* rather than a specific task or the illness (Edvardsson, Winblad & Sandman, 2008). In relation to the goal of making residents happy and content, it is of interest that activities judged to be beneficial in rehabilitation are not always appreciated by the care user. The user may be content with a passive life, but from the professional perspective this poses a challenge: how to *motivate* the resident to become active. In a study by Damberg (2010) care workers and managers described how some care users were not happy to learn that they were expected to do as much as they could to help themselves even if they had been granted help by the municipality. Care workers prompted users to participate in tasks such as cleaning, and this was a source of some conflict. Interviewees in Damberg’s study referred to this as a social approach that was preferred to a medical approach.

Autonomy and self-determination

Autonomy (self-determination) is a *value* and an important concept within medical practice, where it is part of an ethical dilemma: to balance between autonomy and beneficence (Edwards, 1996). There are strong links between autonomy and ideals of privacy and individual freedom of choice, and it is usually suggested that autonomy is particularly strong as an ideal in the central and northern parts of Europe, in comparison to countries where family members have a strong impact on elderly care (Scott et al., 2003).

Autonomy has been theorized and investigated in nursing research on residential care (Collopy, 1988; Mattiasson et al., 1997). In theory autonomy applies to decision as well as action, and Collopy (1988) has developed a framework where autonomy refers to six different polarities: decisional vs. executional, direct vs. delegated, competent vs. incapacitated, authentic vs. inauthentic, immediate vs. long-range and negative vs. positive. Since the purpose of our study was to map out the general understanding of autonomy among managers, we will only comment on the precise meaning of these polarities to the extent that we use the concepts.

The message of the managers of our study was that autonomy is threatened in residential elderly care. All respondents answered the question of how to describe autonomy in relation to residential care by pointing at difficulties and dilemmas linked to the aim of keeping the self-determination of the user. Autonomy was presented as an ideal that was difficult to realize. The prime reason was that some residents suffered from dementia. Within the framework of Collopy (1988), dementia may result in incapacitated autonomy, but the scenarios described to illustrate the problem are also cases of immediate vs. long-range autonomy in the sense that some actions of the resident may jeopardize future possibilities to live as independently as possible.

Several managers commented on life-threatening situations when backing their claims about a need to abandon the ideal of autonomy: “Some would like to go home in the middle of the night at -10°C . We cannot allow that as they would probably die” (SB). Some managers stressed the issue as a dilemma, while others described ways and methods used to solve or decrease the problem. These methods invoked the type of authenticity that Collopy (1988) refers to in terms of the importance of identifying arrangements and acts that seem to be in line with the true self of the resident. For instance, manager SH introduced the problem of keeping autonomy for people with dementia and then added: “If you have dementia, you should be respected as the person you have been before. We get a lot of information from relatives about this” (SH).

Upholding autonomy

When commenting on care users without dementia, several Swedish managers stressed that the right to decide – even to decide poorly – was very strong. Manager SA described upset calls that she received from people outside the facility, about one of the residents who was suffering from Parkinson's disease. He frequently fell and needed assistance when walking around in the city, but as he was capable of making decisions, she did not try to stop him from going out. "I have even been threatened with being reported and I think that it would be a good idea to test this case. He prefers his freedom to his safety."

Manager SB told us that some staff at his facility had difficulties accepting the lifestyle of a couple living there. The couple belonged to a Christian sect where the status of the woman was very low, and this clashed with norms about gender equality in Swedish society in general. However, he argued, their lifestyle was their way of enacting autonomy. In connection to this, manager SB commented on the dilemmatic character of autonomy:

We have overweight people who love to eat and we can see that it is going to be their death. Should we allow them to eat themselves to death or should we stop them? It is very... There are a lot of dilemmas. Every day there is something like that.

Interviewer: But you have a priority... First, alive and healthy...?

SB: No. Self-determination is my priority number one. If they decide to eat a lot of chocolate when they have diabetes, I make sure that I have a talk with them saying that there is a big risk here. We want to stop you. If you want to do this... Every room here is their own apartment so they can buy whatever they want. It is up to them. We try not to interfere if it is not due to a mental disease or something or dementia. It is a very hard balancing act.

The interviewer's question about priorities may be regarded as a way of eliciting accountability, by evoking a norm about health and safety. This refers back to Maslow and the suggestions that the responsibility of the facility was to attend first to basic needs. Should not safety come before autonomy? In his response, the manager *justified* the practice of not forcing people to live a healthy life by referring to the norm about autonomy, and in particular the fact that residents were living in their own apartments (be it rooms at a facility). Proper information is usually regarded as a precondition for exerting autonomy (Scott et al., 2003), and the comment by SB on risks and exceptions to the rule underscored the suggestion that he was talking about an *informed* decision by a competent resident. Comments on the dilemma – the balancing act – underlined the concerns that were devoted to the issue: it was not a simple matter of avoiding responsibility with reference to the right to decide.

The basic outline of arguments on autonomy provided by Swedish managers reads like this:

Norm: Residents should keep their autonomy.

Problem 1: Some residents make “bad” decisions and this poses a challenge since we are responsible for their care.

Solution 1: We try to inform or persuade them to do what is best, but still give priority to autonomy.

Problem 2: People suffering from dementia cannot make rational decisions and this poses a challenge/dilemma.

Solution 2A: So they cannot keep their autonomy.

Solution 2B: We reduce the problem by asking relatives and by getting to know the inherent will of the care user.

Threatened autonomy

A review of the Japanese interviews provides a somewhat different picture. Japanese managers appeared to perceive the general concept of autonomy in the same way as their Swedish peers, but their view on possibilities of keeping autonomy was less optimistic. Partly this may be a result of a different evaluation of the difficulties involved in becoming dependent and moving to residential care. Manager JE stated that the move to a care facility was in itself accompanied by a loss of autonomy, even if residents still could express their will:

It is difficult for residents to have a life of their own and independence at a facility as they cannot do things themselves. Those who can have autonomy and self-determination cannot enter a facility. People who need help twenty-four hours a day cannot reach autonomy and self-determination. They may say “I don’t want to have a bath”, “I don’t want to eat” or “I don’t want to get up”. It is difficult to provide self-determination in a four-bed room.

As is clear from the quotation above, the problem of upholding autonomy was partly related to the lack of privacy in four-bed rooms, but also to being dependent of others as such and not being able to exert executional autonomy (Collopy, 1988). Swedish managers commented on this difficulty, but seemed to argue that autonomy was still possible to keep in cases where the resident did not suffer from dementia, although problems occurred.

It is not possible to judge whether the pessimism among some Japanese managers reflected a less favorable situation or a more honest way of describing residential care. From an approach that focuses on descriptions and accountability, it is possible to suggest that, to some extent, optimism indicates that autonomy was a stronger norm among Swedish respondents.

Descriptions of autonomy among residents by Japanese managers differed from the ideal-type argument provided by Swedish managers. Several Japanese managers used a regretful mode when simply stating that there were not enough resources to provide autonomy. Manager JB claimed that the great care need of residents at his facility, combined with a shortage of staff, made it difficult for care users to assert determine about their life:

About Self-determination, the members of the staff decide the rhythm of the everyday life for old people e.g. when having a meal and how often to have a bath. Decisions are made according to the long-term care insurance. Old people live in such a situation. It is important to be able to choose another day for having a bath but at present they have almost no opportunity to do that. We think about the importance of self-determination but at present there is almost none.

Manager JE stated that the most common will among residents was to return home, and since this was not possible they had no real self-determination. "They may not have any home any more or they have no family who can take care of them," she explained and added that when the staff explained about the situation the resident usually accepted that it was impossible to go back home. From the way she described this solution, it is possible to conclude that she was talking about people without as well as with dementia. When similar descriptions appeared in Swedish interviews, their aim was to illustrate the lack of insight among people with dementia, for instance by describing that they wanted to go home to their parents who had been dead for decades. It should be noted that Swedish managers did comment on the involuntary character of staying at residential care, although not when answering the question about autonomy. When describing community at the facility manager SF introduced a basic problem: "None of our tenants has made the decision to come here. Another person with knowledge about them decided this. Nobody is here voluntarily and this is a big trauma and we have to take care of this."

Manager JG claimed that in reality the power to decide always rested with the staff. He added, regretfully: "The staff should not do this but as there is not enough time, for different reasons, they have to plan in advance." From previous studies it is clear that a similar situation may occur at residential facilities in Sweden, but the determination of autonomy is open to interpretation. Nursing home staff may have a more positive view on the possibility of providing autonomy, as compared to that of residents (Scott et al., 2003). Staff may even reframe requests by care users in order to fit into the routines of the facility, thereby avoiding claims that autonomy is lost (Harnett, 2010). This situation touches on the problematic relation between decisional and executional autonomy (Collopy, 1988). In our interviews Swedish managers did describe problems of fulfilling requests of care users due to lack of staff as well as the

tendency to work according to routines, but these problems did not result in the conclusion that autonomy was lost.

There was also one case where the lack of autonomy was said to be inherent to a particular group of users – a cohort of care users born before World War II. Manager JA claimed that the majority of residents at her facility were actually incapable of asserting autonomy since they were products of an older patriarchal culture: “They don’t decide anything themselves. That’s why we need to take care of them in the way to draw out their feelings and thoughts.” According to JA, the staff at her facility had to find out what residents wanted and then present different possibilities:

We say: I think you should go as I know that you like that old song or singing. The members of the staff have to find out things they do not know. Things that old people seem to like.

She concluded that self-determination is difficult and that in Japan “it is different from America”. The question, again, is whether the statement on autonomy by JA reflected a real difference in the provision of care or a different understanding of the concept. When conducting interviews with care workers and managers in a Swedish municipality, Damberg (2010) encountered similar statements about care users who were born in the 1920s. Care users of the present were described as passive, undemanding and lacking the ability to take initiatives, in contrast to a cohort of self-conscious baby boomers expected to change the face of elderly care in the future. Care providers in Damberg’s study did not suggest that care users *lacked* autonomy, but that they had a reduced capacity to make relevant choices. This justified paternalistic attempts to promote activity and participation.

Relatives as substitute decision makers

The interview guide contained a question about the role of family members. Managers also commented on the role of relatives in relation to other questions. They mentioned that some relatives were absent and abandoned the care user, that some relatives were present at the facility, that relatives had different opinions among themselves, and that some relatives complained about care arrangements.

While Swedish managers talked about the importance of using relatives as resources for people with dementia, they also expressed doubts about letting family members decide about everyday matters:

It is a problem when they have children who say “mother should have this and that”. It not very common but it happens. I do not think that the children should decide for their old mother or father. When they were young and lived with their parents they were in one way but their parents

have changed as they have got old. We also focus on the relatives. “What did your father like for breakfast?” The daughter can answer “He has always liked eggs” and the 95-year-old father may say “I do not like eggs any more. I ate that in 1962.” We have to listen to the old people and to their self-determination and not to the daughters and sons. /SC.

Several Japanese managers described relatives as substitute decisions makers. In one case the manager described this as a way of *solving* the problem of autonomy among people with dementia: “She cannot express her own will so she gets autonomy and self-determination through her family”. This claim is in line with the idea that autonomy may be delegated (Collopy, 1988) and that the family acts on an implicit assignment of the care user. This kind of arrangement was criticized by other managers as resulting in a reduction of autonomy among care users with dementia:

Generally, there are almost no people able to have autonomy and self-determination at present in this facility. There are people with little self-determination but it can be misleading. Perhaps they can decide small matters. We want to respect it on such occasions. It is different from case to case. Now autonomy and self-determination is done by a contract. That makes us tend to respect the decisions of relatives and we follow them instead of the old person. I don’t know if it is good or bad. Before, we asked the old people who we could communicate with, those who had a low level of dementia. /JC

The contract referred to by manager JC is linked to the Japanese long-term care insurance system Kaigo Hoken and is actually a document aimed at strengthening the position of care users and their family members. A user not suffering from dementia makes a contract with the facility, but if the resident suffers from dementia there are cases where relatives sign the contract. Manager JC argued that for people with mild dementia, this resulted in a situation where decision making was moved to relatives. It is also relevant to recall a conclusion by Potter (1997), on the expression “I don’t know”. Potter suggests that the expression does not always denote a lack of knowledge and shows how people use it to avoid being held accountable for a particular action. In relation to manager JC, we read the statement “I don’t know” as a sign of criticism within a culture where it is not considered proper to be openly critical toward official policy.

Restraint

The lack of autonomy in its most extreme form is manifested in the use of physical restraint: belts, trays, bed fences and different kinds of clothes aimed at restricting movement. In Sweden it is formally illegal to use involuntary restraint unless it is done temporarily when the life of the care user is at risk (Klemme

Nielsen, 2012). Still, restrictions constitute an ongoing practice judged as necessary for preventing the harm of some people with dementia. The issue is regarded as difficult to regulate, and law-makers have not found a solution that makes the present practice legal. There is a prohibition against using physical restraint in Japan, and decisions to use such measures have to be submitted to a committee.

All Swedish managers stated that they did use restraint from time to time but that it was uncommon and always on doctors' orders. Phrases like "last resort", "after having taken all other measures" and "only when it is absolutely needed" were used to mark the exceptional character of restraint. Figures mentioned was "two or three cases for the entire place" (SG), "only one from time to time" and "nobody right now". Manager SD first stated that "it is neither common nor uncommon" but added "This year I think I have seen it once or twice" (the interview was conducted in March). A similar picture emerged in the Japanese interviews, but the character of restraint differed to some extent, and some managers downplayed the use of restraint more than their Swedish peers. In one case, a manager (JD) stated that restraint was not used at all and that this was a matter of keeping the dignity of residents. Bed fences had been replaced by low beds and tatami floors. Apart from bed fences and belts, Japanese managers mentioned the use of gloves and clothes that could be locked to prevent care users from scratching infected sores, removing tubes of diapers during the night (thus getting cold). One manager mentioned that some care users used a type of low wheelchair where the legs were higher than the bottom, but he was not sure if these chairs should be classified as restraint or not. Japanese law states that restraint must be decided by a special committee and two managers referred to such committees, while two others said that it was a decided by the manager after consulting relatives.

As mentioned previously, Japanese managers did not phrase any direct criticism against arrangements prescribed by the government, and this may be the reason why two of them first answered that they did not use restraint but then admitted that sometimes they actually did. Asked about the occurrence of restraints manager JE answered: "Basically we do not use it", but later added that "at present there is only one person in the short stay unit who uses the belt for the wheel chair." Manager JB claimed that restraints were not used, and in cases where a resident was at risk of falling during night, the facility used special mattresses and frequent checkups. Later he added: "I do not want restraint to be used. Sometimes relatives asks us to use it. There are three people using a bed fence." He also said that when drips were used, some people with dementia had to be restrained.

Japanese and Swedish managers described arrangements that partly replaced restraints, for instance alarms that warned that a person was going out of bed. This mention may also be regarded as a way of underlining the exceptional character of restraints, and it possible to interpret stories about previous massive

use and present careful use in a similar manner. Managers also mentioned residents falling down and incurring injuries as a result of not being restrained and described conflicts in relation to relatives who demanded that care users should be restrained.

Autonomy and participation

The analysis in this chapter suggests that autonomy could be regarded as a cherished value that was particularly present when Swedish managers described residential care. The ideal of autonomy was also described as being under threat in residential care but protected through different arrangements. For instance, when asked about activities and community at the facility, six Swedish managers invoked the issue of self-determination by suggesting that: “Nobody is forced to take part”, “They decide themselves whether to join or not”, “You decide yourself how much you want to take part in common activities”, “This is a bit connected to autonomy and self-determination”, “It is an individual choice”, “They can choose if they want to join or not”. That it was voluntary to participate in activities was something that could be concluded from some interviews with Japanese managers as well, but none of the managers commented on this in connection with the question of community. It is of interest that the right to decide was mentioned when managers described activities that residents could participate in. In terms of accounts it is possible to interpret the mention as a way of justifying the occurrence of lonely and isolated residents. Managers mentioned that it was a problem that some residents did not come out to join common activities, but explained that they lived in their own apartments and had the right to choose not to participate. Some managers touched on the perceived difference between Sweden and other countries regarding matters of community, and it is possible that the presence of a Japanese researcher evoked accountability about a lack of community – allowing people to stay passive and isolated could for instance be regarded as a case of neglect:

Manager SB: I see an old Swedish person just sitting on the sofa, thinking and nobody is around. He watches TV for three hours after dinner.

Interviewer: So what do you think about him?

Manager SB: That is what we are trying to avoid.

People were encouraged to participate, and with reference to the frail condition of residents, manager SB mentioned the creation of a meaningful life together with others as “the biggest task” of the facility. The lack of participation was also excused with reference to the involuntary character of staying in residential care and to the frailty of residents. Manager SG explained that some relatives were eager for more activities but that “people who are a hundred years old are tired and you have to understand that.”

In addition, it is possible to regard the mention of activities as voluntary as a way of preventing being held accountable for breaching the norm of autonomy by forcing residents to participate. This interpretation is supported by the way autonomy was constructed by Swedish managers: as a core value under threat.

As regards the Swedish interviews, it would have been very interesting to ask managers if they felt that the endeavor to keep residents active could collide with the value of autonomy, but since the result had not emerged so clearly for us at time of interviewing, this question was not asked.

Individuality and privacy

Individuality and privacy are closely related to autonomy and sometimes investigated together as ethical issues in elderly care (Leino-Kilpi et al., 2003; Suhonen et al., 2011; Ågren Bolmsjö, Sandman & Andersson, 2006). Treating care users as individuals is presented as a major challenge in residential care, where routines tend to govern the everyday life at facilities. In nursing and caring science a person-centered care paradigm has been developed in opposition to a medical model that focuses on disease rather than the particular situation of the individual resident (Edvardsson, Winblad & Sandman, 2008).

In our interviews, managers suggested that good care takes the unique personality of every resident as a point of departure. Managers were asked specifically about the concept of individuality in relation to residential care. Despite using different wording, most mentioned that all humans are different and care arrangements must acknowledge this. When commenting on individuality, managers mentioned the existence of individual care plans, compiled in cooperation with the care user and relatives.

As in the case of good care, a couple of Swedish managers discussed individuality in terms of a life history perspective:

You should think about how the individual was before. That is why we have the life-story. Thanks to this we know a lot about the person. However, you are not the same person as when you were young but certain features are still there. /SG

This view is common in studies aiming to measure individuality (Suhonen, 2011), for instance as a matter of staff having knowledge about the previous life of the resident, and has been central to the person-centered care paradigm (McCormack, 2003).

Similar to autonomy, individuality was described as threatened in residential care where the daily life was run according to routines. Possibilities and problems of achieving individuality were also commented on in relation to such routines. Ideally there should be no routines at all, manager SA suggested, adding that this was still not possible.

Both Japanese and Swedish managers referred to sleeping habits and meals as cases where individuality was allowed, and several mentioned meals as a case where the wishes of the resident may be at odds with his or her needs, as judged by the staff. It was good if residents enjoyed the company of others, but they were allowed to eat in their rooms or make their own food. The arrangement of meals may also be used to illustrate the clash between routines and individuality. Manager JA stated that it was possible to have breakfast during a period of two hours “but we must think of their health so they can’t have breakfast and lunch

at the same time”. In this case the reference to the health of care users was used to justify the breach of a norm: to respect the individual preference of residents. Identical descriptions about flexible arrangements within limits were described by Swedish managers.

Managers mentioned interests and “oddities” that were supported and accepted as expressions of individuality, for instance folding napkins or collecting toilet paper in a drawer. There was a limit, however, where the habits of the individual collided with the safety and well-being of other residents. One Japanese manager described a situation where a man who liked drinking beer sometimes became too cheerful and bothered other residents. Manager SF said that some care users suffering from dementia had to eat in their private room, since they were aggressive against other residents. In line with previous descriptions of problems, the frailty of care users (and in particular the occurrence of dementia) and facility-related problems were mentioned as threats to individuality. It was difficult to provide resources/staff to accompany residents in preferred activities, and sometimes staff neglected requests in order to make their own situation easier.

Two Japanese managers questioned the possibility of achieving individuality at their facilities. Manager JB argued that although some requests could be satisfied, the lack of resources made it difficult to provide individual care:

If we can provide them with individuality and dignity according to their wishes, it is good but there is not enough time. We make a service plan before they come here to meet the wishes of the old person and his/her family. However, it is insufficient, so we cannot call it individuality. /JB

Manager JF argued that as individuality was strongly related to privacy, it was not possible to keep it at her facility. The Japanese government had stated that privacy could only be kept in single rooms, and since residents at her facility lived “in a group”, her conclusion was that individuality was impossible to achieve. The facility had nine double rooms and 23 four-bed rooms. The reference to the Japanese government indicates a situation where demands for individuality and privacy (which we will deal with in a section below) in residential care are perceived as coming from above. The situation described by manager JE was present in several Japanese interviews: the government provided a definition and demanded a certain standard, but many facilities could not live up to this standard and it was sometimes unclear if managers agreed on the definition of the government and if they agreed that a certain condition constituted a problem.

In residential care, individuality is usually presented in opposition to a situation where all residents are treated in the same way, and it has been suggested that a failure to uphold the unique personality of residents constitutes nursing home abuse (Harnett & Jönson, 2010). Care facilities/units are relatively small and closed settings that may create their own normality. Manager SB

suggested that demands among residents to treat everybody the same constituted a problem:

You cannot treat everybody the same. That would be catastrophic. You have to adapt to the person's identity, individuality. If you work where there are twelve different people you have to treat all of them differently to make the whole work. I think it is important that my staff can do that. We do not treat everybody the same as we allow them to have individualities. It can also be a problem if you treat one person in one way and the others go "She gets treated that way. I want to do that to." Sometimes it is like a big *kindergarten*. They get angry at each other because she had three carrots and I only got two. There is a lot of stuff like that.

The problem mentioned by manager SB is that residents tend to measure justice and injustice in relation to the situation of others at the same facility/unit. Providing care that is sensitive to the particular needs of a person may be regarded as a case of favoritism. It is of interest that few managers commented on this risk in relation to the question of individualized care. Justice did not appear as an opposite or something to be balanced against individuality. In our interviews, individuality appeared in opposition to treating everybody the same by following routines rather than treating everybody the same as a matter of justice. If asked, managers would probably have agreed with the democratic principle of treating everybody the same, but this matter did not appear to be connected with the way good care was discussed. Several managers did mention the need to treat people in the same way when responding to a question about the relevance of age, generation, ethnicity and gender. When using the theoretical framework developed by Billig (1996) such statements do not appear as self-contradictions but as cases where the rhetorical context has changed into a debate about discrimination. Manager SF stated that "to me there are three sexes, namely men, women and human beings". The finding merits further attention in studies that specifically investigate how individuality is related to justice within residential care.

Securing privacy

Interviewees were asked about the concept of privacy. All managers but one linked the issue of privacy to having a single room. In Sweden, the rule is that residents of care facilities have single rooms and a status as tenants, and some managers used the expression "apartment" instead of "room". Two of the Swedish managers stated that they now referred to their residents as tenants (*hyresgäster*) instead of care recipients (*omsorgstagare*) or users (*brukare*) as part of an attempt to establish a clear departure from older ways of thinking within elderly care. In our data, the only Swedish facility with double rooms provided short-term care (less than 4 weeks) and served as a transit from hospital care and

other care. This facility had twenty single rooms and two double rooms. Two of the Japanese facilities had single rooms only and the rest had single rooms mixed with double rooms and rooms for four people.

When asked about the concept of privacy, managers talked about the importance of treating “private parts” of the body carefully and avoiding exposure to others, for instance by providing intimate hygiene behind a closed door or behind a curtain if the resident lived in a shared room. A Japanese manager who commented on the fact that almost all residents at her facility wanted to keep their doors open during daytime, added that staff should shut the door when providing care or when the person was sleeping. Her argument for this indicates a division in need for privacy in relation to insiders and outsiders: “People who come here unexpectedly can see them sleep” (JC). For some residents it was also a matter of privacy to have intimate hygiene attended to by a person of the same sex. In Japanese facilities it is not uncommon that residents sit beside each other when washing/showering before taking a bath, and this was mentioned as a situation where privacy was threatened. As mentioned by several interviewees, privacy in this sense was closely related to the aim of keeping the dignity of residents.

Several managers discussed privacy in terms of residents being able to keep secrets and do things without being noticed. Being exposed when having sex with a visiting partner was mentioned as a situation that caused embarrassment. In relation to the issue of secrets, one of the Japanese managers said that gossip among residents coming from the same neighborhood threatened privacy among people living at the facility (JB). Manager SD said that the right to privacy among residents could collide with the aim of the facility to base care on a life-story perspective. Some people had trouble in the past that they or their relatives did not want to tell about, although knowledge of it would have made it easier to provide good care. She argued that “if they do not want to tell me about their private matters, I cannot ask them to do it”, but stated that the issue was a dilemma in the case of ongoing social problems.

One of the Swedish managers argued that although the boundaries of privacy became weaker at a facility, it was still important to try to mimic a social order that was natural to other settings. This meant that staff should knock on the door and wait for permission to enter, unless the resident did not want to have it otherwise. The furniture was the private property of the resident, so the staff should not poke around in drawers. Even outside the room, some privacy could be mimicked:

When the old people here have visitors and the relatives and they want to have a cup of coffee in the common space, it is a private conversation. You do not go there and talk on your own initiative but you have to wait to be invited to a conversation. It can be difficult for the staff when a person has lived here for many years and they have got to know the relatives.

Interviewees expressed awareness that privacy is under threat when people become frail, dependent and move into a care facility. Several managers commented on privacy as being possible or impossible to uphold at their own facility. Typically, these comments referred to the issue of single rooms. Manager JD stated: “Basically, we can achieve privacy as everybody has an individual room.” Some Swedish managers simply stated that “everybody has his/her own apartment” when answering the question about privacy. Supporting this basic link between single rooms and privacy, three Japanese managers suggested that residents who had to share rooms could not uphold privacy. For instance, JG stated: “When having four people in one room, there is no feeling of privacy”. In contrast manager JF argued that old people at a facility have a different way of viewing privacy (as compared to younger people) and for this reason, his facility could uphold privacy in shared rooms by taking certain measures:

Generally, we can provide dignity by using the curtains in the rooms. Of course, it is a bad thing to show their bodies among other people. I think we can provide privacy even though we do not have private rooms.

A fourth view was developed by two Swedish managers who claimed that privacy could not be upheld even though residents had their own apartments. Managers SB and SD argued that the fact that staff had to come into rooms days and nights to check on medicine and care-related issues, left residents with very little privacy. When asked if he did not think that privacy was upheld by having an apartment manager, SB elaborated on the possibilities and limitations of residential care:

Yes, they have [their own apartment], with their own furniture but it is not like living in your own apartment in the city. People go into your room to serve you food and they are very sick and need a lot of help. They are also very tired and do not have much of a private life. They have their life here with the employees and maybe one or two neighbors. Every resident has a contact person from the staff that they can share some extra privacy with. If there is something special they want to know, some problems they do not want everybody to know. They have a special person they can turn to and this person also has two hours a week with special time just for this resident. We try to make some effort but I think it is difficult to make this a private place because it is not.

The comments by manager SB reflect a critical view according to which a residential facility can never claim to be the same as a regular home. This is similar to the standpoint on autonomy by manager JE, who suggested that it is not possible to claim that people keep their self-determination when moving into residential care. Comments on the special character of facilities also appeared in other interviews with Swedish as well as Japanese managers; for instance manager SF stated that: “Privacy is reduced when you move in here.”

From a review of data it is possible to discern four standpoints on the connection between single rooms and the possibility of upholding privacy at a specific facility:

- 1) Our residents can keep privacy since they have their own room.
- 2) Our residents cannot keep privacy since they do not have their own room
- 3) Our residents can keep privacy even if they do not have their own room.
- 4) Our resident cannot keep privacy even though they have their own room.

The four categories should be regarded as ideal types that we use to clarify different views and arguments on privacy. Some managers held more than one view, by claiming that privacy was possible since residents had their own rooms and that privacy was reduced at the facility. As is evident from the above, privacy is a concept that may have different meanings, and during our interviews managers were not asked to use a general definition but had to elaborate on their own. Most managers would probably agree that privacy is impossible to uphold in residential care if they used the standard of manager SB, although it is interesting to note the suggestion by JF (and others, as will be evident below) that older Japanese residents have different standards when it comes to privacy.

Accounting for rooms

Some interviewees commented on privacy and rooms before being asked specifically about these topics. In particular this was done by Japanese managers. From the way privacy was commented on, it seems clear that the presence of a Swedish interviewer evoked accountability (Scott & Lyman, 1968). Several Japanese managers mentioned that the Japanese government had stated that privacy could only be achieved when residents had a single room (and new facilities would not get funding for building rooms for several persons). This and the fact that the interviewer came from a country reputed for providing private rooms in residential care, may have increased a feeling of accountability among managers of facilities with shared rooms. As mentioned before, to create this kind of accountability was a thought-out strategy of the project, based on previous experience that Japanese managers justified shared rooms with reference to Japanese culture. In the section below, we will use the theoretical tool of accounts to discuss how managers commented on the issue of shared rooms.

It is possible to regard the comments by SD as an *excuse* in the sense that she admitted that shared rooms were bad, but made it clear that she was not responsible for the fact that they occurred in her facility:

When we built the ward, it was difficult to get single rooms because there was a wall and we could not move it. The architect said that we needed a double room. We agreed because sometimes it is OK for two people to live in a room. However, I prefer single rooms because you are very ill when you are here.

In this account there is a hint of justification, as SD stated that sometimes it is OK that two people live in a room. But by using the word “agree” and adding a sentence about contrary preferences, she confirmed the suggestion that good care is provided in single rooms. Excuses were also provided by Japanese managers who stated that their facilities had been built according to older rules and that it would be extremely costly to rebuild them into single rooms.

It is also possible to regard the argument of JF – who referred to the use of curtains – as a *justification* in the sense that he claimed that privacy could be upheld in shared rooms at his facility. This justification relates to background expectations about a need/right for privacy. In addition to this, shared rooms were justified in two different ways: through a denial of privacy damage (privacy need) and with reference to positive aspects that implicitly were judged as more important than problems with privacy. The following exchange between interviewer and manager JB is an example of denial that lack of privacy causes any damage:

Interviewer: How is it possible to keep privacy when two or four people live in the same room?

JB: Between care recipients? Privacy? I have never thought about it... Simply speaking, there is none, I think. What is it for people in general and for people with dementia? Is it same? The members of the staff try to keep the privacy of the old people by using just a curtain. What is privacy for the care recipients? It is difficult... You can say that you cannot keep it...

Interviewer: Do they care about it?

JB: No.

To express surprise in the way that manager JB does may be a way of indicating that an issue is not a relevant problem for the category being discussed. In the interview manager JB did not elaborate clearly on the reason for lack of privacy not being a problem, but from what he said it seems reasonable that his thoughts on the matter were similar to those expressed by manager JC: “I think that our residents don’t have a sensitive feeling for combining people as compared to our generation.” A similar reference to older care residents as special was provided by manager JG: “It is a difference of culture. We only use a curtain.”

Several managers stated that there was a lack of privacy in shared rooms, but argued that there were other gains and that it was wrong to have only single

rooms. For instance, JG stated that individual rooms did provide privacy (which did not exist in shared rooms) but added:

However, if there are problems, for instance an accident, help will come late. Another aspect is that they can make friends in a shared room, even though they are not married. This makes the care level go down and I am grateful for that. That is the feeling I have about a common life. If men and women live together there could be problems so it is best to separate them. I went to a nursing home in the U.S. There were thirty big rooms with one person in each in one building. They did not talk to each other and there was only one member of the staff. This was uncanny.

That some residents feel lonely and get isolated in private rooms was mentioned by Japanese as well as Swedish managers. These claims were backed by stories about events and individuals. Manager JE suggested that people suffering from severe dementia and bed-ridden people get peaceful when they see other persons sleeping and added that some years back, her facility had large rooms with either regular beds or tatami mattresses: “The people staying in the *tatami* room put their mattresses together in the very center of the room to sleep as they felt lonely. Even one of the night staff went there with her mattress.” She concluded that: “It is not right to introduce private rooms for everybody in the nursing home.” Swedish manager SC told about a female resident who was very unhappy when moving into a single rooms; it had taken her several years to get used to the new situation. However, Swedish managers related this phenomenon to the older order, where residents had been accustomed to living together. When commenting on the move to a new building with single rooms manager SA told us that “the old people did not like the fact that no sounds were heard when they had closed the door.” She then described how residents who moved into the new facility usually paid it a visit in advance and suggested: “I don’t think that anybody would like to have the old system back.”

Some comments among Japanese managers may be regarded as indirect justifications for having shared rooms in the sense that the need for privacy was questioned. Manager JC suggested that the issue of privacy was the most difficult matter at a facility, but that “perhaps it was a bit better” with single rooms. Her facility had single and double rooms. She then told us that residents at her facility could have the door to the corridor closed if they wanted, but almost nobody asked for that. The underlying suggestion was that when people had the opportunity to decide between privacy and community, they chose the latter. Manager JF at a facility with no single rooms stated that she knew what privacy was for healthy people, but in relation to people at her facility, she did not know. To this she added that “the government has told us that you cannot keep privacy in a room for more than one person”. As mentioned previously, expressions like “I don’t know” are sometimes used to communicate particular impressions

(Potter, 1997). In this case, it is possible to interpret the suggested lack of knowledge as a way of questioning the official view of the government.

Finally, it could be mentioned that several managers elaborated on principles for matching people together in rooms. Although favorable arrangements were mentioned in ways that resembled justifications, all managers who elaborated on matching mentioned problems with people who did not get along.

Speaking about culture

One aim of our study was to investigate the use of cultural references in talk about elderly care. There are numerous definitions on culture. *The Blackwell Dictionary of Sociology* (Johnson, 2000) describes culture as “the customs, arts, social institutions, and achievements of a particular nation, people, or other social group” and “the attitudes and behavior characteristic of a particular social group.” In this report we primarily use culture to signify nation-specific aspects, usually expressed in statements like “in our culture”, “in Sweden we usually...”, “it is different in Japan”, but depending on context also in less explicit terms like “here” and “for us”.

As described at the beginning of this report, this aim was a result of previous experience that Japanese managers sometimes justified arrangements with reference to culture when talking to a Swedish interviewer. In the present study we searched for cultural references in the dataset and also used a design that was likely to facilitate/ elicit comments on cultural specificities. The Japanese researcher conducted interviews in Sweden (using the Swedish researcher as interpreter between Swedish and Japanese) while the Swedish researcher conducted interviews in Japan (using the Japanese researcher as interpreter between Japanese and English).

Qualitative analysis interprets meaning, and meaning is strongly connected to culture in the sense that meaning is context dependent (Bryman, 2011). One problem associated with analyzing culture is that interpretations on the one hand risk imposing meaning based on cultural stereotypes and on the other may fail to acknowledge some cultural influences. This problem is partly solved in an analysis that focuses on how culture is brought into action, but there are some limitations to that approach. An example from our study concerns the absence of direct criticism of official policy among Japanese managers that in no explicit way invokes culture. Interviewees did not state: “In Japan it is not proper to criticize the government so I will just say that I don’t know the answer to this question”. Is it correct to interpret a statement from a manager that he or she does not know what is right or wrong in relation to a policy as potential criticism, with reference to a *Japanese way* of not criticizing directly? If not, it would be relevant to label Japanese managers as “ignorant” or “uncritical” in comparison to their Swedish peers, but that would perhaps be to impose a Swedish (cultural) framework when interpreting Japanese interviews. When using a constructionist approach, it is relevant to interpret this as a display of something, but what? Is the manager displaying “being ignorant” or “being uncritical”? Our point here is that although researchers must avoid cultural stereotypes, they should be aware that presumptions relating to culture are to some extent always part of the analysis.

Cultural references

Explicit references to culture appeared in Japanese as well as Swedish interviews. Country-specific arrangements or standards were mentioned in sentences like “it is a right here in Sweden”, “everybody is supposed to live well in Sweden” or “we do that now in Sweden” (treat people as individuals). Some Swedish managers mentioned loneliness and a lack of involvement from relatives as problems that occurred in Sweden, but less so in countries of southern Europe. Manager SF declared that “to take care of children and old people is not given priority in the Western countries, we have to learn from the Eastern countries.” To this he added that the best staff was immigrant women “as they have a completely different kind of respect and feeling, a fingertip-feeling compared to the Swedish feeling.”

Japanese interviewees mentioned and explained concepts, customs and arrangements typical for Japan. The reference to the concept of *kokoro* (heart) is an example; it was a concept that could not be easily interpreted into a single English world. Manager JA explained that *kokoro* had been a part of Japanese culture for a long time: “Even *The Tale of Genji*, which was written a thousand years ago, talks about the concept of *kokoro*.” Swedish managers commented on similar problems when talking about the importance of *bemötande* (a way of treating another person in direct interaction, relating to politeness) but in comparison to *kokoro* this term was situated in Swedish language rather than Swedish culture.

Some comments on culture referred to change. For instance JA said that younger people were not religious but old people held traditional beliefs, for instance by having a particular reverence for the nature of food (saying *itadakimasu* before eating). Self-deprecating comments similar to those of Swedish managers who talked about loneliness in Sweden were also heard. Manager JB informed about a historical development stretching from the Edo period until the present and suggested that “The present situation is that Japan has developed into a country with an increased standard of living, but culturally it is still like a child that has not grown up.”

Christianity was mentioned in both countries, in Sweden as a cultural background or history of society and in Japan as the personal belief of the manager and a motive for providing care for the elderly.

It is important to reflect on the occurrence of cultural references in relation to the provocation of introducing a cultural stranger as an interviewer. For instance, some Swedish managers referred to the autonomy of the care user when justifying decisions not to intervene in hazardous situations. They did not explicitly situate the arrangement in local or national culture, although it was clear that there were implicit references to national laws and guidelines. Had the interviewer actively questioned the priority of the managers from a Japanese perspective or displayed difficulties in understanding the arrangement, it is likely that mention of Swedish values and laws would have occurred. When

conducting our interviews, we decided not to take the provocation beyond the appearance of a cultural stranger asking about arrangements. When regarding interviews as forums for interaction it should be acknowledged that this marks a position on a scale of potential provocations and that our results are highly dependent on the appearance and activity of the interviewer. The point here is that appearance and provocation are always present during interviews and, as suggested by Holstein & Gubrium (1997), it is not possible to create a situation where context and interaction do not come into play.

Culture or age and generation?

As has been discussed in the section on privacy, some Japanese managers suggested that older people in Japan did not need single rooms/apartments, partly because they appreciated the community in shared rooms and partly because they did not suffer from a lack of privacy. Similar references appeared in comments on autonomy and individuality, and when managers were asked about age, gender and ethnicity (not discussed in this report). It is interesting to note that age and generational belonging was in several cases mentioned in these comments; some managers distinguished between “us”, younger Japanese, and “them”, older people born before the war. For instance, manager JC suggested: “I think that our residents don’t have a sensitive feeling for combining people as compared to our generation.”

When commenting on age, gender and ethnicity some Swedish managers actually made similar references to differences between generations. In the future, care users would demand service of better quality and/or act like customers. For instance, manager SB suggested that “We will have a generation problem as well, maybe in ten or fifteen years, they will have higher demands on us”, while manager SD declared that the older generation of people were thankful while people born in the 1940’s know what they want. She predicted that the facility would have to change to meet these demands. This way of distinguishing between older people of today and future care users is prevalent when Swedish managers and staff talk about their work in elderly care (Damberg, 2010). Like the baby boomer generation, Swedes belonging to the 1940’s generation (*fyrtilisterna*) are described as active, conscious and demanding. Jönson (2012) argues that this division between “us” and “them” is used to justify care that challenges the golden rule: to treat others as you would like to be treated yourself. The construction of generational difference answers the question: how can you provide care that you would not accept yourself? Care workers may, as in the case of Damberg’s study, may claim that older people of today are *different* from how they themselves will be when they grow old.

The point here is that references to older Japanese people as different are easily misinterpreted as proof of cultural difference, when they also indicate

beliefs about generational difference. And this way of presenting generations as different also appeared among Swedish managers.

The “teach and learn” context

From an international perspective, Sweden is a country where the standard of elderly care is regarded as high, and many Japanese researchers, students and practitioners actually travel to Sweden, Denmark and Norway to study and learn. From the way our interviewees presented their facilities regarding staffing and the standard of living (single rooms or shared rooms) it is obvious that Swedish elderly care in general – but not in all cases – has a higher standard than its Japanese counterpart. Given the initiatives of the Japanese government, it is also possible to speculate that the professional discourse developed by Swedish managers will in time be disseminated within Japanese residential care.

In this last section of our report, we will question an obvious conclusion: that the more problematic descriptions provided by several Japanese managers reflect problems in Japanese elderly care. Our suggestion is that some findings need to be related to the specific context that was evoked during interviews.

Manager JB described the situations at his facility in unfavorable terms. Unfortunately, he explained, a lack of resources prevented residents from keeping their autonomy and individuality. Does this merely reflect the fact that his facility was of the older kind and the level of staffing was comparatively low? Is it perhaps significant that JB, and several other managers, communicated that they wanted to learn from Sweden? Questions like “what do you think?” and “how do you arrange this in Sweden?” appeared frequently before, after and during interviews. This was in fact a reason why the Japanese interviews were so long. Japanese managers asked about arrangements in Sweden and not wanting to appear as impolite, the Swedish researcher provided some information on matters such as single rooms, the status of residents as tenants, residents’ rights and so on. During the interviews in Japan the Swedish researcher regarded this as an annoying breach of the “interview contract” (the interviewer asks the questions and the respondent answers), but from knowing Japanese and having information about the expectations expressed by Japanese managers when setting up the interviews, the Japanese researcher concluded that managers regarded the interview as a situation where they could get the opinion of the Swedish professor about care arrangements at their facilities. The interview with manager JH is perhaps the best example. The interview lasted for four hours and was held in the presence of two employees. Manager JH had prepared a presentation and tried to engage the interviewer in a seminar about his visions of residential care. He was also very keen on getting verifications and input from the visiting interviewer. The situation described at the beginning of this section – Japanese elderly care learning from the Swedish example – became a context in which it was not a problem to admit to problems like those described by manager JB.

The same “teach and learn” context was evoked in interviews with Swedish managers. Apart from the occasional comment on eastern culture (“you have an Eastern philosophy that we do not have, I miss that”), none of the Swedish managers said that the interview was an opportunity to learn from the Japanese professor. Managers did express a polite interest about care arrangements in Japan. But the suggestion that Swedish elderly care needed to become better and that Japan was an example never came up. On the contrary, several managers said that they had shown their facility to groups of visitors from Japan and others commented on knowledge about Japanese researchers, students and practitioners coming to “learn” about/from Swedish elderly care. Our suggestion is that our interviews with Swedish managers to some extent became part of this history of knowledge about care arrangements being transmitted from Sweden to Japan. Within this context it was perceived as relevant to communicate the ideals rather than commenting on problems and failures.

This finding suggests that eliciting talk about culture is not merely a matter of introducing a cultural stranger as interviewer. Cultural references are situated within a complex network of specificities that – as in this case – may involve presumptions that the elderly care of one country is an example for another.

Main findings of the study

The aim of the study was to investigate how managers of care facilities in Japan and Sweden describe good elderly care. Questions were asked about the goals and principles of the facility, the meaning of good care and a number of values that have been associated with the quality of elderly care: dignity, autonomy, individuality and privacy.

In this section we will summarize the main findings of the study. It is important to acknowledge that any such attempt risks exaggerating differences between countries while minimizing differences of opinions expressed by managers within the countries.

Good elderly care in Japan and Sweden

The format and character of goals and principles differed. All Japanese facilities had pamphlets listing goals and principles. Only one Swedish facility – belonging to a for-profit organization – presented us with a pamphlet. When commenting on goals and principles, Swedish managers referred to the Social Services Act (Socialtjänstlagen) and goals that were provided by the local municipality. Goals and principles of Japanese facilities were to a large extent described as a result of initiatives from a particular individual: a founder or manager who attempted to realize his or her goals. This allowed for a type of visionary entrepreneurship that we did not find when interviewing Swedish managers. In some Japanese facilities, however, the current manager seemed to struggle with the visions of the founder, who may have been a father or a father-in-law. Four of the Japanese managers worked in facilities that had been founded by an older relative.

All managers suggested that good care was based on the view that the care user is an *individual* with a unique personality and a will that needs to be respected. This was also the most prominent way of describing dignity in residential care. Although descriptions of good care were similar among all interviewees, several Japanese managers expressed doubts about the possibilities of providing such care at their facilities. They mentioned problems of providing residents with privacy and individualized care. Several Japanese managers referred to a division between older and modern facilities. Modern facilities could usually provide good care, while the older facilities often failed to do so. Japanese managers were surprisingly frank about perceived problems at their facilities.

A major difference concerned the presence of a professional care discourse among Swedish managers, according to which good care has the character of help to self-help and activity. In addition, Swedish managers used professional tools developed within a person-centered care paradigm that aims at keeping the persona intact (compare with McCormack, 2003). Some Japanese managers

theorized on care and had developed models for providing good care, but these models were to a lesser extent part of a common discourse on care. For instance, one manager referred to the writings of Florence Nightingale, another to Christian ethics and several to the visions and ideas of the person that had founded the facility. It is likely that the lack of a professional care discourse among Japanese managers reflects the facts that five of eight managers had no education relating to elderly care (social work or nursing). Care work in Sweden has become professionalized during the last few decades; managers and staff are to various degrees familiar with theories on ageing and the organization of care (Johansson, 2002). The finding about professionalism does not necessarily prove that Swedish care arrangements are better than Japanese. As shown by Szebehely (1995), professional ambitions among care workers in elderly care may in fact reduce care users' abilities to influence care arrangements.

Swedish managers described arrangements as integrated between different levels while Japanese managers to a greater extent used a top-down perspective when talking about aspects of care. In the case of principles and goals, Japanese managers typically described goals that they had to explain to staff, while Swedish managers talked about such goals in terms of an ongoing process involving the staff. Swedish managers described concepts such as autonomy, individuality and privacy integrated in a political and professional discourse. In contrast, several Japanese managers described a situation where the government was imposing values from above, but some facilities did not have the staff or the premises to realize standards that were officially demanded.

Cultural arrangements

One of the aims of the study was to investigate the occurrence of cultural specificities, i.e. comments on Japanese or Swedish customs and in particular arrangements that were justified with reference to culture. To facilitate and even elicit such comments, Swedish interviews were conducted by the Japanese researcher while interviews in Japan were conducted by the Swedish researcher. A number of cultural references did appear. Country-specific arrangements or standards were mentioned in sentences like "everybody is supposed to live well in Sweden". Managers explained the cultural meaning of some concepts (i.e. *bemötande*, *kokoro*) that would probably have been used but not explained when talking to a native interviewer.

Some arrangements were justified with reference to culture, most notably the fact that residents shared rooms at some Japanese facilities. An important finding of the study was that such justifications in some cases referred to a combination of culture and age or generation. It was not just "Japanese people", but "Japanese people born before the war". When reviewing data for references to age and generation it turned out that similar suggestions that older people of a particular generation were different also appeared in the Swedish interviews. Managers

suggested that a coming generation of self-conscious baby boomers (*fyrriotalisterna*) would not accept care arrangements provided today. The presumption that managers would justify arrangements with reference to culture thus had to be revised into a warning that a sole focus on culture may conceal the importance of age and generation.

As mentioned above, several Japanese managers described a situation where they could not provide good care for their residents. While it is likely that comments relating to failures at Japanese care facilities and success at Swedish facilities in several cases reflect different standards and possibilities to provide good care, a review of data indicates the possibility of alternative interpretations. The Swedish interviewer was clearly not just perceived as any cultural stranger at Japanese care facilities, but also as an expert coming from a welfare state that is known for providing elderly care of high quality. Our suggestion is that pessimism and optimism expressed among interviewees in Japan and Sweden partly reflects an established “teach and learn” relation between the two countries. Before and during the interviews Japanese managers expressed an interest in the opinion of the interviewer and seemed to be open about problems in the hope of getting input from the Swedish expert. It has not been uncommon that Japanese researchers, managers, workers or students of elderly care go to Sweden to study elderly care. Several of our interviewees in both countries referred to such arrangements, and some Swedish managers mentioned that they had themselves shown their facility to visitors from Japan. The mention of such visits before or at the beginning of the interview indicates that, to some extent, the Japanese researcher was regarded as a study visitor, and perhaps a person who should be told about residential elderly care in Sweden as it is supposed to work. The general implication of this finding is that the idea to introduce a “cultural stranger” was somewhat naïve. We were not strangers in each other’s countries. When visiting we were clearly surrounded by expectations relating to an established pattern in the relation between our two welfare states.

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