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The Political and Social Economy of Care: Japan Research Report 3

Aya K.Abe¹

Senior Researcher

National Institute of Population and Social Security Research

February 2009

¹ Contact Information: National Institute of Population and Social Security Research, 6th Floor, 2-2-3 Uchisaiwai-cho, Chiyoda-ku, Tokyo, Japan 100-0011, E-mail: ayaabe@ipss.go.jp

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Fax: (41 22) 9170650

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Introduction

Traditionally in Japan, the care needs of those who are elderly, sick or disabled as well as children have been met within the family. Being one of the welfare states with the highest proportion of elderly people (defined as those who are 65 years and older) the state also provided some care services, but its extent was limited and covered those with most severe care needs. However, a number of social forces have made it necessary to expand the public role in providing care. Such forces include changes in demography (ageing of the society), in family structure (the increasing proportion of one-person households and households that include only elderly persons), and in the labour force (increase in female labour force participation). For elderly care, it soon became quite apparent that the on-going welfare schemes for the elderly provided by the government were inadequate in both quantity and in quality. At the same time, the on-going practice was costly for the government, and could not be financially sustainable given the fiscal constraints faced by the government. Such social changes have culminated in the introduction of the Long-Term Care Insurance (LTCI) in 2001. The LTCI has incorporated the market mechanism into state provision of elderly care services and has made some impact in changing the “care diamond” of elderly care in Japan. However, it is this paper’s argument that the fundamental characteristics of the Japanese care diamond remain unchanged: the bulk of personal care demand is still met within the family, and overwhelmingly by a female member of the household.

It should be noted, in Japanese, there are two words for “care”. One is *Hoiku* (=Rearing), which only refers to child care. Of course, children of all ages need some degree of supervision by adults but *Hoiku* usually refers to caring for pre-school (under 6 years old) children who actually need someone to watch over them at all times. Children above 6 years old are usually considered to be able to be left alone for a few hours, at home after school or on weekends. Nearly 100% of children attend 9 years of compulsory education (from ages 6 to 15) and then 3 years of secondary (non-compulsory) education. Thus, in this paper, I will mainly discuss child care for children under 6 years of age.

The other term for care is *Kaigo* (=Assistance) which refers to caring for those with severe care needs, mostly elderly persons, but it may also include caring for disabled and sick persons (which may include children). *Kaigo* refers to a series of assistance activities such as helping to go to toilet, bathing, eating, turning over (for bed-ridden persons), doing some non-technical procedures for medical needs (such as phlegm removal) and/or simply watching over physically and/or mentally (e.g. dementia) frail persons. Since the introduction of LTCI, some daily needs for less severe frail persons who are living alone are also included (such as doing grocery shopping or cooking for those elderly who cannot do it on their own). Elderly care is getting to be a much bigger social issue than child care in Japan, because Japan’s population is ageing rapidly and elderly care can sometimes last 20 to 30 years. Thus, this paper will place its main focus on *Kaigo* (the report will use the term “elderly care” for “*Kaigo*”, but it also includes caring for disabled persons and children who are not elderly.)

The paper will describe the enormity of the elderly care (and some child care) problem in

Japan and examine the government's role in providing care, and to a limited degree, the market's role before and after the introduction of LTCI. The report expands on the idea of "care diamond" introduced by Razavi (2007) and applies the idea to Japan's elderly care and child care, and compares the "diamond" between the two. The outline of the report is as follows. In the first section, characteristics of Japanese social policy regime are described in order to give readers some insight into the principles governing the various social programmes and schemes. Then in the second section, a brief description of Japanese social policy regime, including information on the coverage and benefit incidence of the key programmes (public pension, public health insurance, public assistance, etc.) is given in order to provide some contextual background for the readers. The third section provides the overview of the elderly care problem in Japan. The latter half of this section will describe state policy vis-à-vis elderly care, with special emphasis on the description of the Long-Term Care Insurance. The fourth section will turn to prevalent child care arrangements in Japan, and the state's role therein. The last section will construct "care diamonds" for elderly and child care and compare the two.

1. Japanese Social Policy Regime

Japan, as a welfare state, has been analyzed by scholars, both Japanese and non-Japanese. One of the first analyses in English which clearly positioned the Japanese welfare state among the welfare states of other industrialized countries was Goodman and Peng's (1997). Goodman and Peng (1997) sum up the Japanese welfare state as follows:

- (a) A system of family welfare that appears to negate much of the need for state welfare;
- (b) a status-segregated and somewhat residual social insurance based system; and (c)
- corporate occupational plans for 'core' workers. (Goodman and Peng 1997, p.207)

They offer an alternative explanation of the Japan and other Asian countries' (notably Korea and Taiwan) so called "Asian model" of welfare state, different from traditional ethnocentric explanations. Their main claim is that the development of social welfare in these countries can best be described as "peripatetic adaptive learning and development strategies with the prime goal of nation-building (p.210)". For example, Japan imported the Bismarckian social insurance system, supplemented by theoretical ideas found in the English Poor Law of 1834, and at the same time, social work practices influenced strongly by the American model. From these examples, Goodman and Peng (1997) concludes that Japanese social welfare developed out of learning from multiple sources, instead of driven by theoretical ideas of its own, and that it is issue-driven.

Japanese scholars have also been active in explaining the so called "the East Asian model" of welfare state. Some insightful analyses have pointed out that: 1) the main force to propel the welfare system was the bureaucracy and it is a product of top-down decision-making, rather than a product of political forces such as labour movement, liberal or conservative

forces (Kamimura 1999, Tominaga 2001, Miyamoto 2003); 2) even though each scheme is “mimicked” from different welfare models in an ad-hoc way, the overlaying principle is prioritization of economic development (Miyamoto 2003).

From a gender perspective, Japan’s welfare state is easy to categorize. The feminist movement has never been strong in Japan, and Japanese welfare schemes reflect this. Ikami (2003) notes that by any of the feminist welfare state typologies such as those proposed by Lewis (1992) (“bread-winner model”), Sainsbury (1996) or Fraser (2000) (“caregiver parity model”), Japan can be categorized into strongly male-breadwinner, female-caregiver model. This model is reinforced not only by dominant ideologies, but also by women’s weak position in the labour market, as we will see in later sections of this paper.

However, it is apparent that the Japanese welfare state is in the midst of a crisis and it will need to introduce some changes to its current model of welfare. Even though it still retains the main features and schemes of the past 40 years, which have been in place since the beginning of the “welfare state” in Japan, many of its underlying assumptions are changing. The three “features” noted by Goodman and Peng (1997), namely, strong family welfare, residual social insurance based system, and corporate welfare for ‘core’ workers, are all under severe strain. As this paper will discuss in detail, the family provision of welfare is no longer a force to “negate the need for social welfare” because of changing family structures. The social insurance system is also on the verge of losing its universality; the coverage of occupation-based social insurance is shrinking, and the default rates of premiums for the National Pension and the National Health Insurance are increasing, so that we are beginning to see a fragment of the population that has completely dropped out of social insurance. The corporate welfare system has also been cut back drastically. The “core workers” have been reduced and were replaced by “non-core” temporary and part-time workers. Further, even for core workers, the corporate welfare provision, such as life-long employment, corporate housing, and generous retirement packages is no longer the norm.

The retrenchment of family and corporate welfare support means that there is an increased need for provision of public support and social services, especially by those who are on the lower end of the income strata. However, this need has not been met by expansion of public support thus far. The government has been unable to implement necessary reforms to fill in the gaps left by the retrenchment of family and corporate welfare for two reasons. The biggest reason is the budgetary constraints. The Japanese social expenditure has been increasing rapidly because of the ageing of the population. In 2002, Prime Minister Koizumi at the time enacted a policy to decrease the natural increase (i.e. increase caused only by demographic change) by 220 billion Yen from fiscal year 2003 to 2006, and then extended this policy in 2006 to cover fiscal years 2006 to 2011 (The so-called Koizumi Reform). This policy is still in place, and almost all aspects of social provision, both in-cash and in-kind benefits, have been cut back (for example, Old Age Pension, health services for elderly, Public Assistance, benefits for disabled persons, benefits for single mother households). The second reason is the institutional constraints. Japanese welfare is designed under the

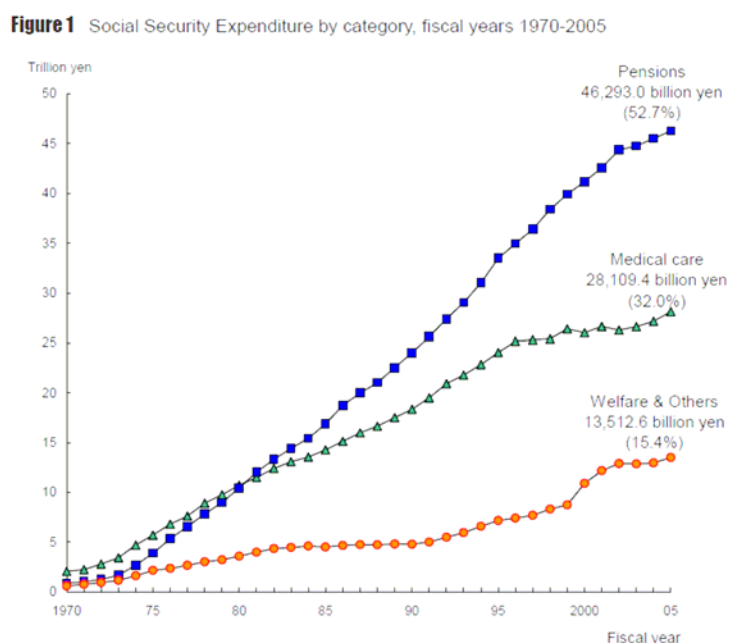
assumption of strong family and corporate welfare provision. Thus, it is extremely rigid and resists the forces to implement a major reform that expands the state's role in social welfare. For example, social insurance schemes have created a sense of “ownership” and “rights” in their subscribers and many of them are against the idea of providing benefits to those who have not contributed premiums, using “their” contributions.

2. Description of Social Security System in Japan

2.1 Overview

The fundamental design of Japanese social policy is universal social insurance schemes supplemented by fairly small social assistance and welfare programmes. The social insurances are, as pointed out by Goodman and Peng (1997), segregated by the status of the profession, yet it is widely held notion in Japan that they are universal because all citizens are covered by at least one of the social insurances. The four social insurance programmes are: Pension (retirement, disability and survivors), Health, Unemployment, and Long-term Care. The public pension and the public health insurance systems take up the bulk of the social security expenditure, which amount to nearly 24% of national income. The expenditure on public pension takes up nearly one-half of the entire social expenditure, and health insurance, a little more than one-third. (pensions 12.59%, health 7.65%, others including unemployment and long-term care insurance and other social services 3.68% as % of national income). Overall, the social security programs have grown to become an increasingly large share of national income (**Figure 2.1**) and are forecasted to grow even more due to population ageing. Thus, in 2001, the government announced that it will curve the natural growth of social security related expenditures and started to implement a series of measures to cut down the costs.

Figure 2.1 Social Security Expenditure by Category, 1970-2005

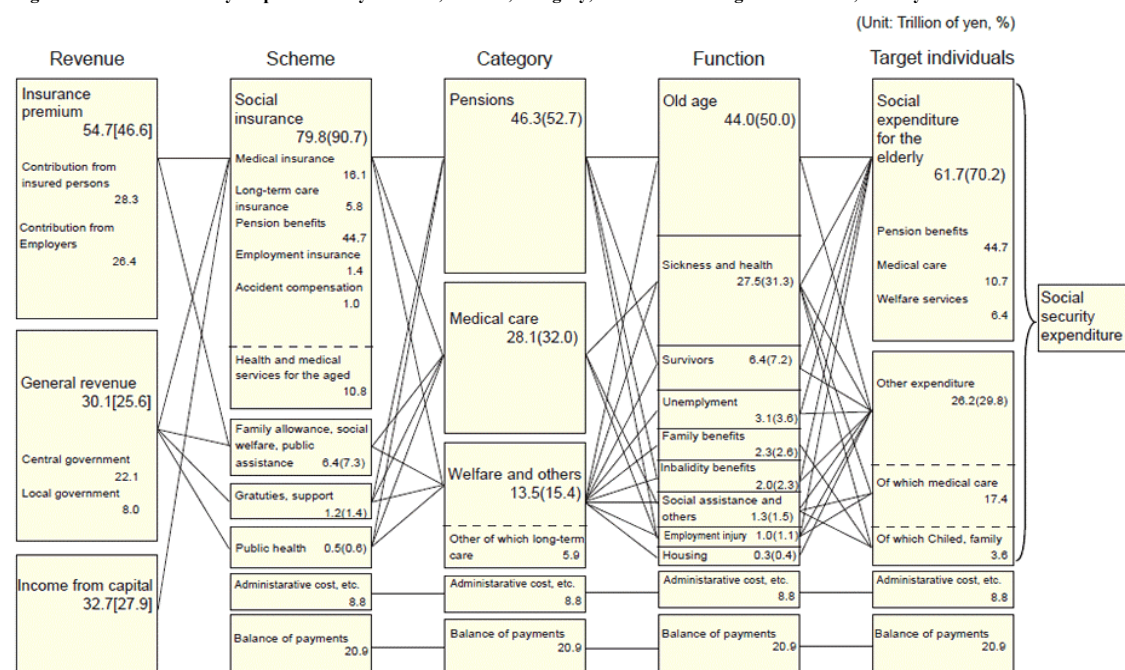


Source: NIPSSR, HP.

All of social insurance schemes, in principle, are financed by premiums collected from the subscribers and in the case of employees, employers as well, even though the outlay from the government general budget is significant in all social insurance schemes. Consequently, they require individuals to pay premiums for certain period of time in order to qualify for the benefit.

Figure 2.2 shows a breakdown of social security revenue and expenditure as defined by the International Labor Organization. Insurance premium accounts for nearly 60% of the total revenue and government contributions and others for the rest.

Figure2.2 Social Security Expenditure by revenue, scheme, category, function and target individuals, fiscal year



- Notes:
- 1 "Child, family" refers to medical insurance in the form of a lump sum maternity allowance and child-rearing allowance, employment insurance in the form of parental leave allowance, day-care facilities administration costs and single parent family and disabled child allowances.
 - 2 Fiscal year 2005 Social Security Revenue amounted to 117.5 trillion yen (excluding transfer from other systems). The figure in square brackets [] represents the ratio of the Social Security Revenue total.
 - 3 Fiscal year 2005 Social Security Expenditure amounted to 87.9 trillion yen. The figure in parentheses () represents the ratio of the Social Security Expenditure total.

Source: NIPSSR, HP.

Universal Coverage through Male Breadwinner Model

The year 1961 is a memorable year in the history of Japanese social security system because it is the year when the new schemes for public pension and health insurances began, in which the entire population, at least in principle, is covered. Prior to the new system, there were public pension and health insurance schemes (the Employee's Insurances), but it was not mandatory and they covered mainly full-time and formal employees of large corporations and the public sector. The new National Pension (*Kokumin Nenkin*) and

National Health Insurance (*Kokumin Kenko Hoken*) were intended to cover all those who are not covered by the Employee's Insurances, namely the self-employed, farmers, and elderly who have retired from work (in case of health insurance). In doing so, many women who did not have a formally employed partner also became subscribers to these schemes since women are less likely than men to be employed formally and full-time (in order to qualify to be covered by Employee's Insurances, one has to work minimum of 30 hours per week).

However, even back then, most women were and still are covered by the Employee's Insurances. This is because the Employee's Pension Insurance and Employee's Health Insurance not only cover the workers (typically men) but also his/her dependent spouse and in the case of the health insurance, other dependents (children as well as elderly parents who are financially dependent on the worker). Since the premium is a fixed rate of the salary, it is the same no matter how many dependents the worker has. Thus, it creates an incentive for women to become (or to remain) a housewife because if she decides to work, she will no longer be her husband's dependent (according to tax laws, a person cannot be another's dependent if he/she earns more than 1.3 million yen per year), and will have to pay premiums of her own. In this respect, the social insurance scheme strongly embodies and reinforced the "male breadwinner model". It is not only that the social security system in Japan reflects social reality (in a society where many families conformed to the male breadwinner model), but the social security system, in turn, IS a driving force perpetuating this type of family.

From a gender perspective, one advantage of the introduction of universal social insurances is that it became clear that a woman, even when she herself is not paying premiums and is covered by her husband's insurances, is entitled to her own pension rights. Persons who have been dependents of his/her spouse (called Category No.3) are entitled to the same amount of pension as those who are National Pension subscribers (called Category No.1). This is so even if she is widowed and divorced (in case she is divorced before the age 60, she would have to pay the premiums for the remaining years up to when she reaches 60).

Incorporating the Poor into the Social Insurance schemes

The premium for Employees' social insurance schemes are divided (almost) equally between the employer and the employee, and it is a fixed rate of the employee's salary. Since the premium is deducted out of the payroll, the payment is automatic. However, the collection of premiums for the National Pension and National Health Insurance was problematic from the beginning.

First, there were always real concerns that the poor are not able to pay the premiums because the premium structure is regressive. The premium for the National Pension is a fixed sum for all subscribers regardless of his/her income. The premium structure for the National Health Insurance is partly based on the subscriber's income, but mostly based on the number of dependents in the household. Thus, the premium rate (=premium amount/income) is much higher for poor households than for rich households. This

regressive premium structure was, on purpose, designed to be this way mainly because it is difficult for the state to know the exact amount of income for self-employed who are supposed to constitute the biggest pool of the National Pension and the National Health Insurance subscribers, and it was suspected non-negligible amount of income is not reported. However, this in turn meant that those whose income is really low may not be able to pay the premiums, even though it is likely that they would benefit in the long-run. Thus, a scheme was introduced that for qualifying recipients, the premium amount is reduced or exempt completely. Thus, the poor are also incorporated into the scheme, but their pension benefit amount is also reduced accordingly, and for those with long period of exemption, or those who do not have continuous record of paying premiums, the pension is not enough to bring them out of poverty when they become old. This is one of the main reasons that the poverty rate of female elderly is very high. The pension amount, when combined with husband's, is usually adequate, but when a woman loses her husband or has never married, the pension amount is most likely to keep them below the poverty line.

2.2 Effectiveness in Fighting Poverty and Inequality

Even though the amount of national pension was not enough to cover the entire living cost of the elderly, it was expected to reduce much of poverty which was mainly considered to be the elderly problem. In any case, the poverty and inequality did not surface on the political agenda during the entire 1970s to 1980s, helped by two-digit growth rates of the Japanese economy and rapidly rising living standards. It is during this period that the public shared the “100 million all middle-class” view of Japan (100 million was the population of Japan at the time) (Tominaga 1979). Consequently, the social programmes became more universal, so “the middle-classification” of the social system progressed (Hoshino 2000). The effectiveness of social policy in fighting poverty and inequality was never questioned, and poverty “forgotten” (Iwata 2007).

In the middle of 1990s, with the burst of the bubble economy, rising income inequality became a social issue. The Gini coefficient was said to be increasing rapidly during the 1990s and into the 2000s (**Figure 2.3**). The official statistics, one by the Ministry of Health, Labour and Welfare, shows that the Gini coefficient increased from 0.314 in 1980 to 0.3812 in 2001. This is quite a big increase, making Japan one of the most “unequal” countries next to the U.S. among the OECD countries. Poverty also became an issue, a little later in the 2000s. There is no official poverty line and thus no official poverty rate in Japan, but some estimates by scholars using the nationally sampled surveys are available (for example, Abe 2006, Komamura 2002). The **Table 2.1** is an estimate of the poverty rate for Japan from the 1990s to the early 2000s by Abe (2006) using 50% of median equivalized income as the poverty line. The poverty rate of elderly persons is higher than the rest of the population, but it has stabilized at around 20% in the 1990s. In contrast, the poverty rate has been increasing for children and working-age population.

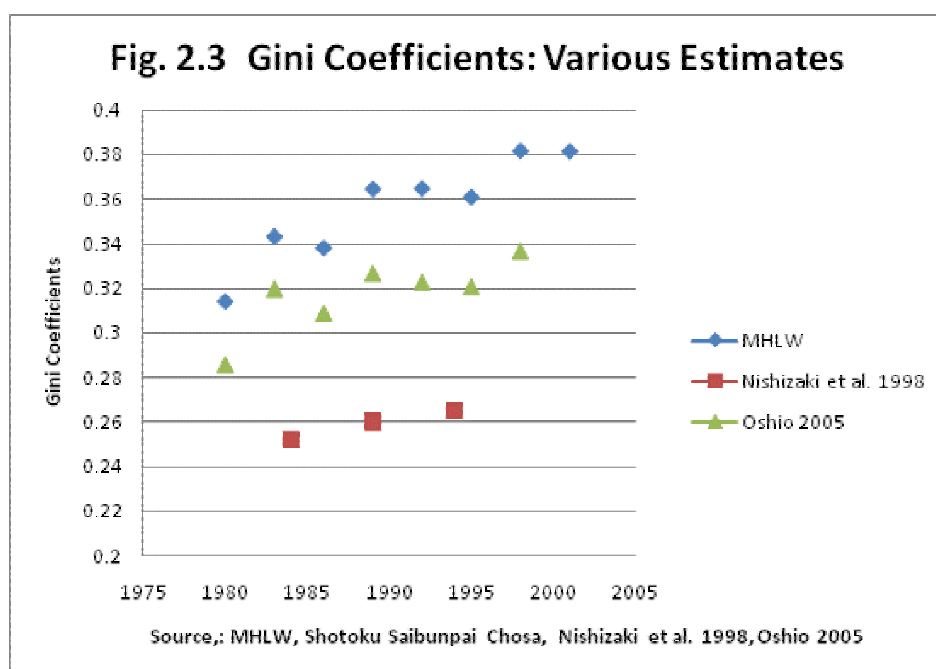


Table 2.1 Poverty Rate by Age Group: 1984–2002

	1984	1987	1990	1993	1996	1999	2002
Population Share (%)							
Elderly (+60)	13.1	14.3	16.5	19.0	20.6	21.9	24.3
Working age (20–59)	55.1	54.2	54.7	56.2	55.2	54.0	51.9
Children (<20)	30.7	29.2	26.3	24.2	22.9	21.6	20.0
Poverty Rate (%)							
All	10.05	10.67	13.18	13.09	13.45	14.85	14.80
Elderly (+60)	9.10	16.69	20.15	20.35	19.64	20.70	20.05
Working age (20–59)	10.27	9.10	10.96	10.33	10.95	12.12	11.87
Children (<20)	10.09	10.19	12.77	13.17	13.53	15.11	15.02

Source: Abe (2006)

However, social security systems and tax systems in Japan are not as effective as in other countries in reducing inequality and especially, poverty. This is because the Japanese social security system is based mostly on social insurance programmes. More than 70% of social security expenditure, as seen in Figure 2.2, goes to the elderly population. Thus most of the fiscal transfer is inter-generational, i.e. it occurs from the working-age population to the elderly population, and not from the rich to the poor. Also, benefits through social insurance schemes are not necessary progressive. The benefits are given on the basis of prior contributions (in terms of premiums) and not on the basis of “need”. Thus, poor individuals who have not contributed much do not receive as much benefits as rich individuals (e.g. pension benefits; health service benefit is supposedly the same). Such “need” base benefits are given in the form of limited means-tested benefits such as the Public Assistance and the Child Rearing Allowance, but their benefit level is set very low.

In order to demonstrate the Japanese social security system’s ineffectiveness of reducing poverty, let us turn to three figures showing pre-transfer and post-transfer poverty rates of some OECD countries (Table 2.2). Pre-transfer poverty rate refers to market-income

poverty rate, before tax and social security premiums are levied and before benefits such as pensions, child allowance, etc. are given. Post-transfer poverty rate refers to disposable income poverty rate, after tax and premiums are paid and benefits received. **Table 2.2** shows that while Japanese social policy's effectiveness in reducing poverty of the elderly is fairly good (from 61.9% to 22.0%), that for working age is dismal (from 16.4% to 12.3%), and for children, it actually increases poverty rate (from 12.8% to 13.7%).

Table 2.2 Poverty Rates of OECD Countries: Before and After Tax and Transfers, by

YEAR		CHILDREN(0-17)		Working Age (18-65)		Elderly (65+)	
		bef	aft	bef	aft	bef	aft
Australia	2005	27.3%	11.8%	21.4%	10.1%	72.5%	26.9%
Austria	2005	13.7%	6.2%	17.6%	6.6%	60.8%	7.5%
Belgium	2000	21.5%	9.4%	26.5%	9.6%	90.5%	15.4%
Canada	2005	23.7%	15.1%	17.9%	12.2%	51.1%	5.9%
Czech Republic	2000	21.4%	7.2%	19.5%	3.8%	84.3%	2.1%
Denmark	2005	13.1%	2.7%	17.3%	5.1%	68.2%	10.0%
Finland	2005	15.8%	4.2%	15.5%	7.1%	28.4%	12.7%
France	2005	22.6%	8.0%	12.7%	6.6%	8.7%	3.8%
Germany	2005	27.0%	16.3%	22.0%	10.2%	83.6%	8.5%
Israel	2005	15.8%	8.3%	13.0%	7.0%	71.9%	5.0%
Ireland	2000	24.9%	15.7%	18.8%	11.9%	68.4%	35.5%
Italy	2005	24.4%	15.5%	23.2%	10.0%	80.8%	12.8%
Japan	2005	12.8%	13.7%	16.4%	12.3%	61.9%	22.0%
Korea	2005	12.2%	10.2%	13.9%	11.7%	55.1%	45.1%
Luxembourg	2005	22.6%	12.4%	20.6%	7.7%	82.7%	3.1%
Netherlands	2005	20.0%	11.5%	18.3%	7.4%	66.4%	2.1%
New Zealand	2005	27.4%	15.0%	18.1%	10.9%	73.7%	1.5%
Norway	2005	13.7%	4.6%	16.9%	7.1%	75.4%	9.1%
Poland	2005	28.8%	21.5%	32.1%	14.4%	81.6%	4.8%
Portugal	2005	16.4%	15.6%	15.7%	9.6%	72.6%	29.2%
Slovak Rep.	2005	16.9%	10.9%	21.0%	7.6%	85.7%	5.9%
Sweden	2005	15.0%	4.0%	16.6%	5.6%	80.3%	6.2%
Switzerland	2005	12.8%	9.4%	10.6%	6.6%	61.1%	17.6%
United Kingdom	2005	25.1%	10.1%	17.5%	7.1%	66.9%	10.3%
United States	2005	27.4%	20.6%	19.5%	14.5%	59.4%	23.6%

Source: OECD (2008) *Growing Unequal?*

Why is the Japanese social security system left to be as ineffective as it is? In the past few years, there has been much media coverage of income inequality and poverty. However, the awareness of inequality and poverty as social issues has not spurred political commitment to mitigate them. There are several reasons for this. First, Japan's fiscal position has been one of the worst among the OECD countries, and it is nearly impossible to allocate additional funds to inequality or poverty reduction programmes. Just by the naturally occurring population ageing, the social outlays continue to rise, and the government has made it its top commitment to curve the natural increase (due to population ageing) of the outlay. The Prime Minister Koizumi, at the time, has repeatedly stressed the need to "reform with no sacred ground", meaning that every aspect of social security should be reformed to cut the future burden. Such sentiment has led to the 2002 Koizumi Reform which was mentioned earlier. Second, there has been an academic controversy on the cause of the rise in inequality. Some researchers claimed that the rise in inequality is a natural consequence of population ageing and therefore is not a real "inequality". Many politicians and bureaucrats jumped onto this debate, making it difficult to achieve a consensus that anything should be done about it.

Third and probably the biggest reason is that Japanese society, the politicians and the public alike, believed very strongly that Japan is an egalitarian society. It came as a big surprise to many people when organizations such as OECD pointed out that Japan's poverty rate is not that low. It is because of this lack of awareness which is the main cause that there has not been much social discussion in reforming the social protection system.

2.3 Key Components of Social Policy

Japan's social security system is composed of many programmes and schemes. Some are in-kind and some are in-cash benefits. In-kind benefits such as health care, day care centres for elderly or for children, social services for disabled and unemployed, so forth are also provided by mostly private institutions, both for profit and non-profit. A significant portion of the payment is borne by the government, while beneficiaries are expected to pay part of the costs. Some of the programmes are listed in **Table 2.3** below which should give readers an insight into the extent of coverage. It is impossible to describe all of the programmes and schemes, thus a brief description of some of the programmes more closely related to the issue of care are listed in this section.

Table 2.3 The Social Security System in Japan

To Whom	Cash Transfers (in-cash benefits)		Social Services (in-kind benefits)	
	What is provided	Scheme	What is provided	Scheme
The Sick			Health services (70% coverage)	Public Health Insurance (Employee's Health Insurance and National Health Insurance)
The Elderly	Old-age and survivor's pension	Public Pension (Employee's Pension and National Pension)	Institutional and at-home care for the frail elderly (70-100% coverage)	Long-term Care Insurance & Services for the Elderly
The Disabled	Disability pension	Public Pension (Employee's Pension and National Pension)	Institutional and at-home care services for the disabled (70-100% coverage)	Long-term Care Insurance & Services for the Disabled
The Poor	Livelihood support	Public Assistance	Health and care services	Public Assistance
The Unemployed	Unemployment benefits	Employment Insurance	Employment services	Employment Insurance
The Children	Child allowance	Child Allowance	Day care centers for pre-school children	Day Care Centers (Hokuen)

1) Social Services (esp. health)

● Health Services

Japan's medical services are financed through a public mandatory health insurance system, which is composed of two types of schemes: occupation-based (*Employees' Health Insurance*) and region-based (*National Health Insurance*). The occupation-based public health insurances cover employees and their dependents and both employers and employees contribute a fixed percentage of the employee's salary. Housewives, children and elderly parents (and even sisters and brothers) who are economically dependent (i.e. "dependents") receive the same medical coverage.

Those who are not covered by the occupation-based health insurance are required to participate in a region-based health insurance, called the *National Health Insurance*, for which the municipalities act as independent insurers. Mostly self-employed, farmers, workers of smaller firms and their family join the *National Health Insurance*, thus its participants more or less overlap with those of the *National Pension*. A portion of the premium for the *National Health Insurance* is according to income, but it is mostly determined by the number of subscribers in the family.

As in the case of public pension schemes, housewives, dependent children and other family members of those who subscribe to the *Employees' Health Insurance* are automatically covered by the insurance with no extra premium. They receive the same services at the same costs (deductible and co-payments). The dependents of those who are subscribers to the *National Health Insurance* are also covered effectively, since the subscription is by "household", not by "individuals" (i.e. either the entire household is covered or none). However, the premium increases with the number of dependents in the household. Except for the premium structure, the *National Health Insurance* and the *Employees Health Insurance* extend the same health coverage, at the same costs. Thus, as long as they are covered by either of the two public health insurance schemes, there is no bias, by gender or by profession, in receiving the health services.

However, there is a bias in terms of economic strata, and in effect, against women since women are economically disadvantaged compared to men. First of all, there are increasingly more *National Health Insurance* subscribers who fail to pay the premium. In 2008, the figure went up to 19% of all *National Health Insurance* subscribers (MHLW 2008). If they fail to pay premiums consecutively for some years, their health insurance card will be taken away.

Perhaps the most relevant part of the public health insurance to the problem of care is its treatment of elderly persons and their care needs. The retired persons are expected to subscribe to the *National Health Insurance* of his residing community. However, this has put a serious financial pressure on the *National Health Insurance* since it has over-represented share of elderly among its subscribers and medical costs for the elderly are much higher than that of working age person. Thus, a financing mechanism was put in place to transfer some of the funds from occupation-based Health Insurance to *National Health Insurance*. Even then, it was apparent that the rising cost of medical services for the elderly is going to bankrupt the *National Health Insurance*. One of the big components of the rising cost was the long-term care. To rectify this problem, the Government has introduced a mandatory *Long-Term Care Insurance* in April 2000, a description of which will follow in later sections.

● Education and Care Services for Children

Here, I will explain Japanese education system briefly. Since child-care system (up to age 5 or 6 – until entry into elementary school) will be discussed in later sections of this paper, here I cover the education system for children above 6 years old.

Japanese education system consists of 9 years of compulsory education (6 years in elementary school and 3 years in middle school) and higher education (3 years of high school and 4 years of university or 2 years of junior university, and for some graduate schools) which is not compulsory (See **Figure 2.4** below).

Figure 2.4 Japanese Education System

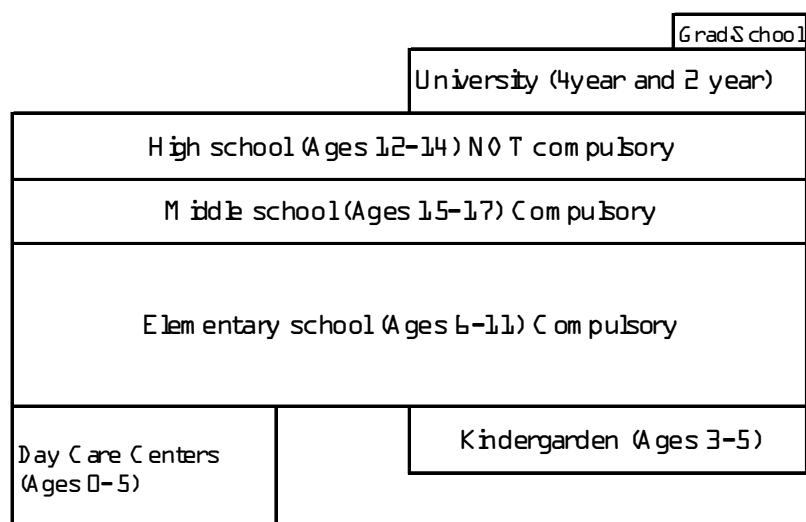


Table 2.4 Number and Share of Public Schools by Number of Children Enrolled

	All schools	Public	Private	Share of Public
Elementary School	7,187,417	7,067,863	119,554	98%
Middle School	3,601,527	3,320,772	280,755	92%
High School	3,494,513	2,447,387	1,047,126	70%
University	2,504,885	567,763	1,937,122	23%

Source: Statistics Dept., HP

For compulsory education, parents are required to enrol their children in schools, and municipalities are required to admit all children of the required age (including legally residing foreigners) in their public elementary and middle schools. Public compulsory education (including text books) is free of cost in principle, but there are some costs such as school lunch fees and extra-curricular activities (school outing, etc.) for which municipalities provide grants for children of poor households. Besides the public schools, there are also numerous private schools for which there are considerable costs. All children between ages 6 to 15 go to either a public school (i.e. schools financed and run by municipal governments) or a private school (i.e. schools run by private entities, and financed by tuition). At the elementary school level, the share of public schools by number of children enrolled is 98%, and it drops to 92% for the middle school level (**Table 2.4, 2006 Figure**). Children of wealthier families tend to go to private schools more often than children of poor families (no statistics available).

Even though the compulsory and free education is up to middle school, most children choose to go to high school. Currently, nearly 95% of all students enroll in high school

upon middle school graduation. There are both public (operated by municipality, prefecture and state) and private high schools (financed completely privately). Currently, about 70% of all high schools are public (**Table 2.4**). The tuition fees tend to be lower for public schools than private schools, but the financial burden on households is heavy even for public high schools, as there are few scholarships and student loans provided by the government. Some high schools are more occupation oriented (technical and engineering schools, etc.), while others are prep schools for university education.

About 50% of high school graduates attend higher education, either 2 years or 4 years of university. Japan is one of the most educated countries in the world. The share of university graduates among the 25-34 year olds is the second highest (50%) next to Canada (51%) (OECD 2004). However, there is a considerable difference in university attendance according to the income status of households. There are also publicly run universities and privately run universities. The share of the public universities is about 23% (**Table 2.4**). As in the high school, even for public universities, the tuition is quite expensive, and most of the cost is borne by the parents, not by state or any public source.

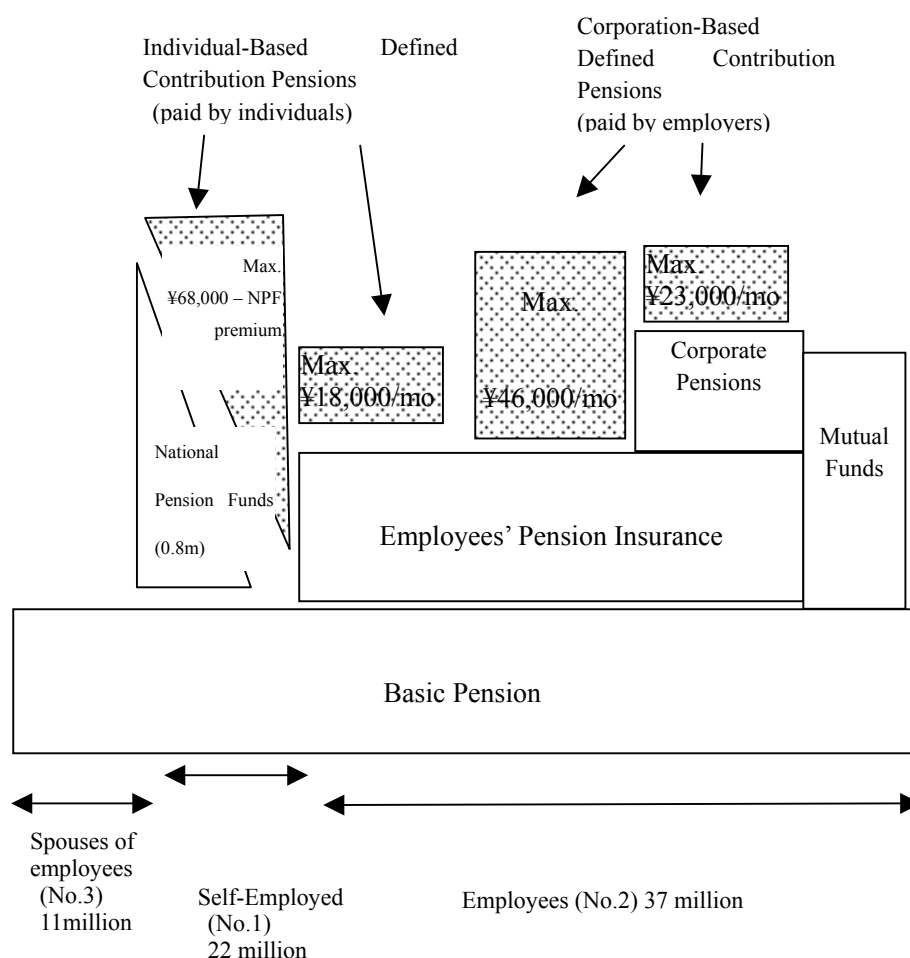
2) Cash Transfers (esp. pensions, unemployment, child allowances)

● Pensions

The Japanese pension system is multi-tiered, consisting of public and private pension schemes (**Fig.2.5**). The first tier is the Basic Pension (*Kiso Nenkin*), which provides the flat rate basic pension of with universal coverage. As a non-income-related pension, it aims to provide a basic income guarantee for the old age, and participation is mandatory for all residents. The second tier, the Employees' Pension Insurance (*Kose Nenkin Hoken*) covers most employees and is income-related in both its premium and benefit structure. Its provision is mandatory to all firms over a certain size, and the premium is shared between employers and employees. The first and the second tier pensions are both operated by the government and thus are public. The third tier is an optional scheme. It is provided either by private firms (employers) for their employees, or by collective national pension funds for the self-employed for which the government is the insurer.

The schemes in the first and the second tiers for employees are jointly operated and a single contribution rate covers contributions for both schemes. Thus, in many cases, the term "Employees' Pension Insurance" refers to both of them jointly. The Employees' Pension Insurance covers both employees (called Category No.2) and their spouses (Called Category No.3) (See **Fig 2.5**).

Fig. 2.5 Pension System in Japan



Shaded boxes indicate optional Defined-Contribution pensions. The amount inside is the maximum premium.

Note: Numbers in () are number of subscribers. No.1, 2, & 3 denote categories of subscribers: No.1 is for self-employed, farmers, students, etc., No.2 is for employees, and No.3 is for spouses of No.2.
(All numbers are as of March 2005)
Source: Kose Hakusho, MHW, 2006

Similarly, the Basic Pension for the self-employed, farmers and other non-employed (Called Category No.1) is called the National Pension (*Kokumin Nenkin*), which are operated, by municipalities (and thus called regional-based pension). The civil servants have a separate scheme of their own called Mutual Aid Pensions, which covers both the Basic Pension portion and the income-related portion. Thus, the entire adult population, in principle, is insured either by the Employees' Pension Insurance, the National Pension or the Mutual Aid Pensions. Currently, only about 1 to 2 % of the eligible persons fail to participate in the Basic Pension, and 96% of all persons aged 60 and over receive the Basic Pension, thus its scheme has achieved near perfect universality.

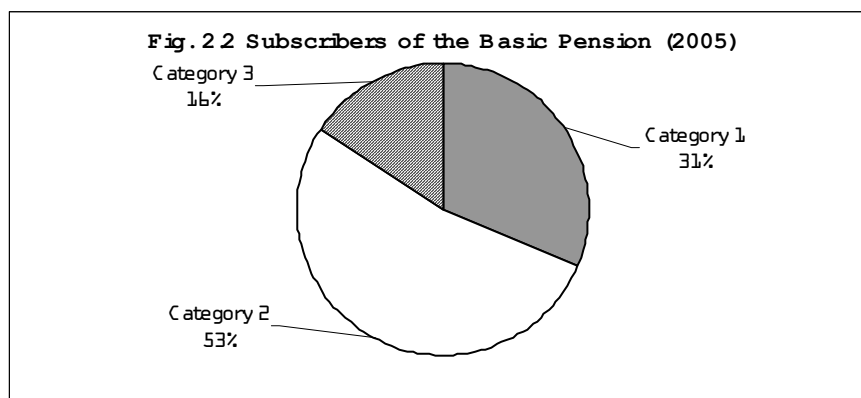
For the *Employee's Pension Insurance* (the public pension for employees), the premium is paid by both employees and employers, and is set at a fixed rate of the salary. The same

rate covers the premium for his/her dependent spouse who does not make more than ¥1.3 million/year. If dependent spouse loses her husband/his wife before age 60 by death or by divorce, she/he would have to pay the rest of the years.

All those not covered by the employer provided Employee's Pension has to subscribe to the National Pension. A fixed amount (¥13,860 per month in 2007) is levied on each subscriber as a premium. There is no provision for dependent spouse, so those who have dependent spouses will have to pay twice the premium. However, low-income persons (about 15.0% in 2004) and non-working spouses of employees are exempt from paying premiums, partially or entirely.

The pension benefit (old-age, survivors and disability) for Category No.2 subscribers (the employees themselves) is indexed according to the amount of his/her previous salary and years of contribution (and thus the premium amount paid). The pension benefit for Category No.3 (dependent spouse) and Category No.1 (National Pension subscribers) is the same and is a fixed amount (called *Kiso Nenkin* = Basic Pension) regardless of his/her spouse's previous salary. This is because the premium levied is fixed for Category No.1 and none for Category No.3. The pension benefit amount is much more generous for Category No.2 compared to Category No.1 or No.3. The Basic Pension is a little less than the poverty line for single-person households, and is a little above for two-person households. However, many of the retirees actually receive less than full amount of Basic Pension because they did not pay-in required 40 years of premiums. Most of elderly who are poor are No.1 and No.3 Category.

Figure 2.6 Subscribers of the Basic Pension by Category



Category 1: All residents who are not Category 2 or 3, i.e. self-employed, farmers, students, etc.
Category 2: All employed persons whose workplace has more than 5 employees
Category 3: Non-working spouses of Category 2

Source: MHW, 2006

● Employment Insurance

The *Employment Insurance* covers for labour related accidents and events of unemployment Insurance, as well as some training schemes. By far the most significant portion of the scheme is the unemployment benefits. For general employees, it is necessary

to have been insured for at least 6 months within one year prior to leaving the job. The duration of the benefits ranges according to the age of the beneficiary and the years of being insured. Since April 2001, the duration of the benefits also depends on the reason for unemployment, i.e. whether the termination was voluntary (including retirees) or involuntary and without enough time period to arrange re-employment (due to lay-off or bankruptcy of the firm). Even though the number of insured days can be higher for special cases, in general, it is less than 6 months.

Table 2.5 Duration of Basic Allowance (Involuntarily terminated Employees)

(unit: days)

Age of beneficiary	Years of being insured				
	Less than 1 year	1<= and <5 years	5<= and <10 years	10<= and <20 years	More than 20 years
Less than 30	90 (90)	90 (90)		180 (150)	-- --
30□44		90 (90)	180 (150)	210 (180)	240 (210)
45□59		180 (90)	240 (210)	270 (240)	330 (300)
60□64		150 (150)	180 (150)	210 (180)	240 (210)
For those difficult to get employed (disabled, etc.)					
Less than 45	150	300			
45□64	150	360			
Less than 30	(150)	(240)			
30□64	(150)	(270)			

* numbers in () are for part-time workers

Table 2.6 Duration of Basic Allowance (General Employees)

(unit: days)

	Years of being insured			
	Less than 5 years	5<= and <10 years	10<= and <20 years	More than 20 years
General	90	120	150	180
Short-term	90	90	120	150

● Child Allowances

This is an area which has seen significant reforms over past few years. The new interest in reforming Welfare for Children is spurred mainly by the concern about low fertility, now estimated to be at 1.26 (2005). Previously, the Child Allowance was granted to parents (or guardians) who are raising children less than 3 years old and whose income is less than a specified amount. Since 2000, the age limit has been raised to 6 years, then to 9 years and currently in 2008, to 12 years. The income threshold was also raised, and thus the Child Allowance today covers close to 90% of children under 12. The amount of the Child Allowance is ¥5,000 per month for the first two, and ¥10,000/month/child for subsequent children, except for children under 3 for whom the amount is ¥10,000 for all. The financial burden of the Child Allowance for children 0 to 3 years old is born by employers, central, prefectural and municipal governments, but the expansion of the scheme in the last few years

has been totally financed by the central government.

Table 2.7 Number of Child Allowance Recipients and Expenditure (2004)

(2004)	Number of Recipients	Number of Children covered	Expenditure (unit: million yen)
Total	7,473,761	9,644,674	593,336
(of which SCA)	(537,164)	(595,915)	(39,066)
Employee	4,935,807	6,337,127	387,372
(of which SCA)	(401,043)	(438,447)	(28,473)
Non-Employee	1,932,029	2,500,727	155,747
Public Servants	605,925	806,820	50,217
(of which SCA)	(136,121)	(157,468)	(10,593)

Source: Kose no Shihyo (Journal of Health and Welfare Statistics) 2004

● Child Rearing Allowance (for single-mother families)

Even though increasing rapidly, single-mother families, and even more so, single-father households, are still a minority. About 6% of children are being raised in single-mother households (Abe and Oishi 2002). However, single-mother households are the most vulnerable household type in Japan, their poverty rate is estimated to be about 60% (OECD 2008).

Child Rearing Allowance is a means-tested cash benefit programme for single-mother households (who are raising a child less than 18 years old, who does not share a common household income with the father of the child²). It is estimated that about 80% of single-mother households receive this benefit³. The monthly allowance is ¥41,880 in case of one child, ¥5,000 for the second child, and for third and subsequent children additional ¥3,000 for each child (2006). This amount is not enough for any family to live on, and thus, most of the Japanese single mothers are in the labour force. Japan has one of the highest rates of labour force participation for single-mothers among OECD countries, being around 85-90% (Abe and Oishi 2002). However, due to their disadvantaged position in the labour market (being women, having children, being stigmatized), it is difficult for them to get a full-time permanent job and thus even though they receive Child Rearing Allowance in addition to their salary, their economic situation is bleak.

The Child Rearing Allowance is one of the first targeted programmes which has been reformed to cut down costs. In 2002, its reform stipulated that the government may reduce the amount of the benefit up to 50% after a single-mother has been a recipient for 5 years. The 5-year time limit was to be implemented from April 2008. The idea behind this reform

2 In fact, there is a strong gender bias in the program setting, since Child Rearing Allowance is only for single-mother families and not single-father families.

3 In Japan, about one third of single-mothers live together with her parent(s) and form three-generation households. Such households are not eligible to receive Child Rearing Allowance. The figure is only for those single-mother families consisting of children and their mother only.

was to convert the benefit to a temporary measure to assist the initial phase of being a single-mother. It is expected that single-mothers will gain enough experience to achieve self-sufficiency after 5 years, and various schemes of job training have also been put in place. However, there has been a severe outcry against the reform from the single-mother community and the introduction of the time limit was postponed in 2008.

● **Public Assistance (*Seikatsu Hogo*)**

Enacted in 1950, *The Public Assistance* is one of the oldest schemes that is still in effect. It is an all-inclusive means-tested programme for the poor. Both in-cash benefits to meet the “minimum cost of living” as well as in-kind benefits such as medical, care and other social services are provided at no costs. However, to qualify for the *Public Assistance*, the applicant must meet very strict means and asset tests. The law states that the *Public Assistance* must only come into effect when an applicant’s best efforts and available resources are spent. In other words, he/she is required to use all available resources, including assets, ability to work, as well as assistance from those who are required to support him/her by *the Civil Law*. Assets such as land, houses and farms must be sold, except in the case where the person is actually living or utilizing them and when the value of the assets is higher when they are utilized than when they are sold. Household goods such as TV are allowed if the diffusion rate of the goods is more than 70% in the region. The bank deposit must be lower than 1/2 of the minimum cost of living for one month.

As for the utilization of the ability, the person will not be able to receive assistance if he/she is judged as capable to work. If the person has a will and ability to work, but is unable to find work, it is unlikely that he/she would be given assistance. The *Civil Law* stipulates that certain relatives and family members are required to support a person in need. Thus, the *Public Assistance* is given only after it is judged that this support is not available.

In 2004, 998 thousand households or 1,423 thousand persons (1.1% of the population) received some type of public assistance (monthly average). The share of the population receiving the assistance had been declining until 1995, but since then there has been a continuous rise. Among those receiving the assistance, elderly households make up the largest share, accounting for 46.7% of all recipient households, and their share has been increasing for some years. The share of households with a disabled or sick person is also large, at 35.1%. About 8.8% are single-mother households, and the rest, 9.4%, are classified as “other types of households”. The large share of households with elderly, disabled or sick persons may be the reason why most recipient households (87.6% in 2004) do not have any working member.

3. Policy for Elderly Care (*Kaigo*)

In this section, the report will provide basic statistics for *Kaigo (caring for physically and mentally frail persons, mostly elderly)* in the hope of illustrating the enormity of the problem in Japan.

3.1 Care Needs and the Main Care Provider

As stated earlier, Japanese society has traditionally taken care of the elderly, the sick and the disabled who cannot manage day-to-day living on their own within the family. However, due to increasing life expectancy, smaller household size and women's increasing rates of labour force participation, taking care of the elderly within the family has become increasingly difficult. Especially with the advance of medical technology which allows individuals to live longer, sometimes the care of elderly can last for many years. Many of the elderly are bed-ridden and need extensive care throughout the day, making it difficult for their caregivers to engage in any other activities such as employment or even to go outside the house. Such a situation was derogatory termed "Care Hell (*Kaigo Jigoku*)" by the media, which captures the seemingly never-ending nature of hardship.

Table 3.1 captures some of the basic statistics of care needs (*kaigo*, elderly care and care of sick and disabled aged over 6. Please note caring of healthy children is not considered *Kaigo* and is not included in the statistics.) in Japan. In 2004, about 7.5% (3.47 million households) of all households had at least one household member⁴ who is above 6 years old and needs "help and/or watching-over", totaling 3.57 million persons⁵. Of these, single-person households comprised 17.5%, and couple-only households 18.8%. The largest share was made up of three-generation households, constituting over one quarter of all households with care needs. Nearly two thirds of those who need care are women, and one third men, and most of them are elderly (above 65 years old) (84.2%). Women represent a higher share of those needing care than men simply because of their higher life expectancy than men (for men 79 years old, for women 86 years old. 2006, MHLW 2008) and the fact that the proportion of frail persons increases sharply with age, especially in their 70s and 80s. Nearly 27% of them are bed-ridden and need day-to-day care. 12.8% of them need help in eating, excretion and changing.

On the other hand, those who provide care are mostly a family member. The largest proportion of "main care provider" is spouse (28.0%), followed by children (25.4%) and their spouses (18.1%). The professional care providers comprise only 9.9%, a share even smaller than the proportion of single-person households, indicating that even when the person in need of care lives alone, family members who reside separately provide the care. In fact, about 89% of the main care providers live with the person in need of care while about 11% live separately. The gender of the main care providers is overwhelmingly female (71.8%) and many of them are themselves elderly or nearly so. Those who are in their 50s comprise

⁴ The break-down of 7.5% according to the number of frail persons is not available.

⁵ It should be noted that this number does not include those who are in institutions on permanent basis.

29.1%, in their 60s 26.9%, and above 70 years old 26.2%.

It is evident from these numbers that the bulk of elderly care (*kaigo*) needs in Japan is still being met within the family, notably by a female member. An overwhelmingly large proportion of family caregivers themselves are old; over one-quarter are aged above 70, indicating the “old caring for older” phenomenon.

Table 3.1 Overview of Care (kaigo) Needs in Japan : for people above 6 years old

(Excluding child care of healthy children, but includes care for sick and disabled children above 6)

Number of Households with Care (Kaigo) Needs (1000 households)	3476	7.5% as % of all households
Type of Household:		
Single-person Household	610	17.5% as % of (A)
Couple-only Household	654	18.8%
Couple and Unmarried children	405	11.7%
Single-parent and Unmarried children	229	6.6%
Three Generation Household	911	26.2%
Other types of Household	668	19.2%
Number of persons requiring care (kaigo) (1000 persons)	3569	
Male	1343	37.6% as % of (B)
Female	2226	62.4%
Degree of care needs:		
Requires care but can manage most of daily activities on their own	1136	31.8%
Manages most of inside activities on their own, but cannot manage without care outside	1206	33.8%
Requires care for most activities inside, but can manage to sit up straight	501	14.0%
Bed-ridden all day, requires care for eating, excreting, and changing	457	12.8%
Age of the Person requiring care:		
6 to 39 years old	218	6.1%
40 to 64 years old	345	9.7%
65 to 69 years old	241	6.8%
69 to 74 years old	396	11.1%
75 to 79 years old	592	16.6%
80 to 84 years old	705	19.8%
above 85 years old	1071	30.0%
(those above 65)	3005	84.2%
Relationship of Carer to the person requiring care:		
Spouse	999	28.0%
Children	908	25.4%
Children's spouse	645	18.1%
Parents	229	6.4%
Other relative	133	3.7%
Professional care provider	355	9.9%
Other	130	3.6%
Unknown	170	4.8%
Living Arrangement of Main Carer		
Cohabiting (Live together)	2596	89.1% % of all carer (family)
Separated	319	10.9%
Sex of Main Carer (1000)		
Male	809	27.8%
Female	2092	72.8%
Age Group of Main Carer who live together	2594	100.0%
Under 40	135	5.2%
40-49	326	12.6%
50-59	755	29.1%
60-69	698	26.9%
Above 70	680	26.2%

Source: (HLW 2006) *Kokumin Seikatsu Kiso Chosa 2004*

3.2 Institutional Care Provision for the Elderly

However, the above statistics (Table 3.1) only count the care needs of those who are basically still living at home. A significant number of those requiring care, especially those who require intensive care, are placed in institutional care facilities. **Table 3.2** shows the number of persons who are in institutional care facilities in 2004-2006. In sum, 0.78 million persons were in the institutional care facilities in 2006, a slight increase from previous years. In addition, some elderly are living at care homes and private nursing homes. It should be noted that all three types of institutions in Table 2 are public and their service charge is determined by the government according to the income status of the patient's own and his/her family's income and assets. Since the introduction of the LTCI, usually there is 10% co-payment (user-fee) on all services including institutional services⁶. On the other hand, user charges for private nursing homes are borne entirely by the patient and his/her family⁷.

Table 3.2 Number of Persons in Institutional Care Facilities (2006)

	persons
Care Welfare Homes	392,547
Care Elderly Health Institutions	280,589
Care Hospitals	111,099
Total	784,235

Source: MHLW *Shakai Fukushi Shisetsu Chosa 2006*

Comparing the numbers in Tables 3.1 and 3.2, it can be deducted that about 17% of those who need care are in institutions, while the rest received care while still living at home. If we only count those who require assistance in day-to-day living ("Bed-ridden all day, requires care for eating, excreting and changing", and "Requires care for most activities inside, but can manage to sit up straight"), about 950 thousand persons are being cared for at home, while around 780 thousand persons are in institutions such as those in **Table 3.2**. Thus, it is roughly estimated about one half of severe care needs is met outside the family.

For those staying at home, even though the overwhelming share of care needs is met within the family, it does not mean that there is little or no demand for care provision outside the family. In many cases, the main care provider within a family is supplemented by a few hours a day or a few days of a week by professional care providers. **Table 3.3** shows the total number of those who used such professional care services in 2004-2006. Professional care provision can be either in the form of visiting services or in the form of facilities (or centres) to which users are taken. Roughly the same number of persons, about 0.9 million, use the visiting care services and the day care facilities. It should be noted that one person can use more than one type of service.

As in the case of institutional services, in most cases the user of these services has to pay 10% of the cost and their use is strictly restricted by the Long-Term Care Insurance (please

⁶ There are some cases where the government bears the entire costs. This is when the person is on Public Assistance.

⁷ Most private nursing homes and apartment houses with care services require a lump-sum up-front payment plus monthly charges. They are very costly and old persons usually sell their homes in order to retire into a private nursing home.

see the section on the LTCI for details)⁸. The mix of services (how many times per week of visiting service, how many visits to day-care centres per week, etc.) is determined by the LTCI's care managers after consultation with the user and taking into consideration what is available within the locality.

Table 3.3 Number of Persons Using Care Services

(as of September each year)			
	Number of Users		
	2004	2005	2006
Those Who are Primarily Living at home:			
(Visiting Care Services)			
Visiting Care	972 266	1 090 112	882 556
Visiting Bathing Service	67 208	67 288	62 219
Visiting Nursing Service	274 567	279 914	281 160
Day care facilities)			
Day Care	995 903	1 097 273	955 506
Rehabilitation Services	439 754	461 687	412 044
Care Elderly Nursing Service	258 235	270 436	244 585
Hospitals	181 519	191 251	167 459
(Other)			
Short-Stay Care Service	192 781	210 688	224 163
Short-Stay rehabilitation service	60 277	60 633	58 069
Care Elderly Nursing Service	53 371	54 118	52 711
Hospitals	6 906	6 515	5 358
Special Institutions Care Service	33 921	49 927	66 070
Equipment rental	739 212	965 245	652 262
Equipment sales	□E	□E	□E
Regional special services			
Visiting Night Service	□E	□E	51
Day Care centers for Dementia	□E	□E	37 017
Smallscale multi-purpose At-home services	□E	□E	1 643
Group homes for Dementia	70 161	94 907	115 644
Special institutions	□E	□E	396
Special Care facilities for the Elderly	□E	□E	878
At-home Service Care Management	2 083 382	2 264 525	1 889 213

Source: MHLW, *Kaigo Service Shisetu Jijyousho Chousa (Care Service Providers and Facilities Survey) 2006*

Perhaps, a more illuminating source of statistics is the share of those requiring care (and living primarily at home) who make use of professional care services. **Table 3.4** provides such data. It shows the usage pattern of professional care services by household type, and by type of service. In total, 73% of all those who need care used some kind of professional care services in 2006. The utilization rate is higher for single-person households (87%) compared to other household types, as is expected. However, the utilization rate is more or less the same across all other household types (68 to 73%), suggesting that the even when there are multiple household members as in the case of three-generation household, it is rare that all the care need are met entirely within the family. The visiting service is utilized more in single-person households, and relatively less in three-generation households and other

⁸ If the user decides to go over the maximum amount of services stipulated by the LTCI, he/she will have to bear the 100% of the costs.

households. Instead, day-care services are utilized more in three-generation and other households.

Also notable from **Table 3.4** is that almost all care provision is received through the Long-term Care Insurance or other government programmes (Welfare for the Elderly, Public Assistance) and only about 1% of the care provision is “purchased” using only private funds.

Table 3.4 Utilization of Professional Care Services (2004)

	(for every 100 000 persons requiring care)						
	Total	Single person HH	Nuclear HH	Couple only HH	Three generation	Other	(of them) elderly HH
	100 000	18 917	32 054	21 360	29 146	19 883	41 175
Use professional care service	73 131	16 449	21 877	14 821	20 475	14 331	32 040
Visiting	54 159	14 187	17 050	11 540	13 554	9 368	25 872
Day Care	38 876	5 549	10 105	6 319	13 886	9 336	12 521
Short-Stay	10 019	635	1 802	1 343	4 301	3 181	2 522
Meal	6 729	3 001	2 625	1 833	494	609	4 877
Assistance to go outside	3 448	847	1 281	894	932	388	1 645
Laundry and other	1 499	574	695	544	180	49	1 076
Do not use prof. care service	26 869	2 469	10 178	6 439	8 671	5 552	9 135
Public service only	29 673	10 414	10 684	7 165	4 815	3 760	17 131
Private service only	998	189	363	232	294	151	428
Mix	2 303	836	987	763	213	267	1 563

	Total	Single person HH	Nuclear HH	Couple only HH	Three generation	Other	(of them) elderly HH
	100%	100%	100%	100%	100%	100%	100%
— 総計	73%	87%	68%	70%	70%	72%	78%
訪問介護	54%	75%	53%	54%	47%	47%	63%
施設介護	39%	29%	32%	30%	48%	47%	30%
短期入所	10%	3%	6%	6%	15%	16%	6%
食事	7%	16%	8%	9%	2%	3%	12%
送迎等	3%	4%	4%	4%	3%	2%	4%
その他	1%	3%	2%	3%	1%	0%	3%
— 介護受けない	27%	13%	32%	30%	30%	28%	22%
公費負担あり	30%	55%	33%	34%	17%	19%	42%
公費負担なし	1%	1%	1%	1%	1%	1%	1%
その他	2%	4%	3%	4%	1%	1%	4%

(*) Elderly household is a household where all members are aged 65 and over.

Source: MHLW (2006) *Living Conditions Survey (Kokumin Seikatu Kiso Chosa) 2004*, Table 21.

3.3 Social Forces behind the introduction of Long-Term Care Insurance

Statistics in the previous section show that elderly care in Japan is a huge social issue affecting nearly one in thirteen families and as much as 960 thousand persons who require assistance in day-to-day activities are being taken care of within the family. It is fair to say that Japan, more than other developed nations in the West, relies on family members, especially women, to assist frail elderly within a family instead of placing them in institutions. However, this practice is becoming increasingly difficult due to three social forces described below.

One of the main forces is rapid demographic change, so called “*Korei ka*”, i.e. ageing of the society. The population over 65 reached 20.1% in 2005, nearly four times the rate in 1960 (5.7%) (**Table 3.5**) (NIPSSR 2008). There are, simply, fewer and fewer young people to care for more and more elderly persons. From 1971 to 2006, the Total Fertility Rate (TFR) of Japanese women fell from 2.16 to 1.32, indicating that there are fewer children to care for ageing parents. In some cases, one person (often a woman) may be responsible for up to 4 ageing parents, two of his/her own and another two of the spouse.

Table 3.5 Population composition by Age Groups

Year	Age Group(%) @		
	0 to 14	15 to 64	Over 65
1884	31.6	62.7	5.7
1888	33.7	60.8	5.5
1898	32.8	61.7	5.5
1908	34.2	60.5	5.3
1920	36.5	58.3	5.3
1930	36.6	58.7	4.8
1940	36.7	58.5	4.8
1947	35.3	59.9	4.8
1950	35.4	59.7	4.9
1955	33.4	61.3	5.3
1960	30.0	64.2	5.7
1965	25.6	68.1	6.3
1970	23.9	69.0	7.1
1975	24.3	67.7	7.9
1980	23.5	67.4	9.1
1985	21.5	68.2	10.3
1990	18.2	69.7	12.1
1995	16.0	69.5	14.6
2000	14.6	68.1	17.4
2005	13.8	66.1	20.2
2006	13.6	65.5	20.8

Source: NIPSSR(2008) *Jinko Tokei Shiryoshu* 2008

Another factor forcing the change is the change in household structure. The extended family with more than two adults has become less prevalent, and typically there is only one household member to care for another household member. Thus, the financial, physical and psychological burden of caring for the elderly has become unbearably large. Furthermore, an increasingly large number of elderly persons do not have any family members living with them. Among the households with at least one elderly person over 65, the share of

single-person households has increased dramatically from 8.6% in 1975 to 22.4% in 2006 (MHLW, 2007, see **Table 3.6**). The elderly couple only households (those containing only 65 years old and above) increased from 6.2% to 22.5%. On the other hand, the prevalence of three-generation households decreased from 54.4% to 20.5%, and this kind of household is no longer the most prevalent household type for the elderly. In 2006 nearly one-half (46.1%) of all households containing elderly members had no working-age household member (MHLW, 2007).

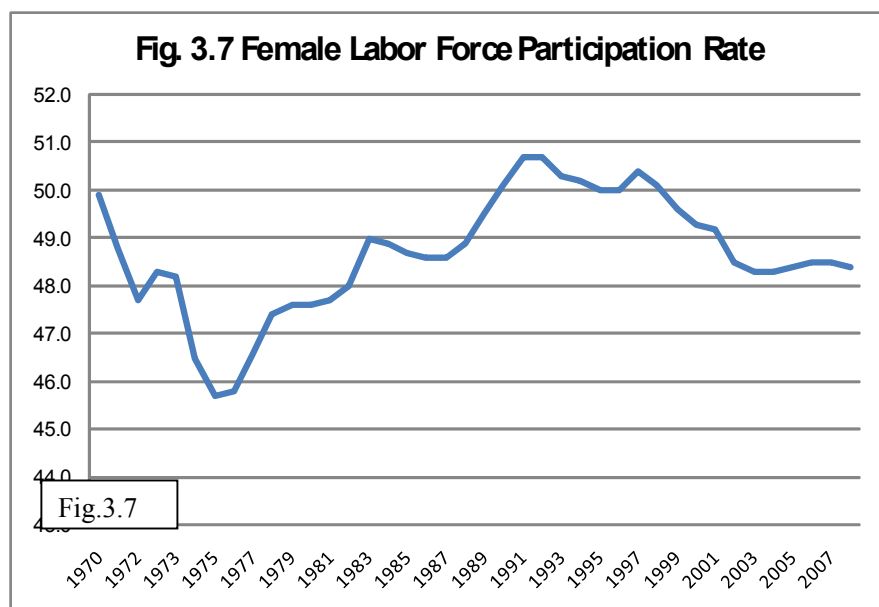
Table 3.6 Types of Households with at least 1 person above 65 years old

	Single-person household	Couple-only Household			Couple and unmarried children	Lone parent and unmarried children	Three-generation	Other (%)	
		Total	One of them above 65	Both above 65					
1975	8.6	13.1	6.8	6.2	6.7	2.9	54.4	14.4	
1980	10.7	16.2	7.7	8.5	6.7	3.8	50.1	12.5	
1986	13.1	18.2	8	10.3	6.6	4.5	44.8	12.7	
1989	14.8	20.9	8.2	12.8	6.8	4.9	40.7	11.9	
1992	15.7	22.8	8.4	14.3	7.3	4.8	36.6	12.8	
1995	17.3	24.2	8.1	16.1	7.9	5	33.3	12.2	
1998	18.4	26.7	8.4	18.3	8.3	5.3	29.7	11.6	
2001	19.4	27.8	7.9	19.9	9.7	5.9	25.5	11.6	
2004	20.9	29.4	7.6	21.8	10.2	6.2	21.9	11.4	
2006	22.4	29.5	7	22.5	9.9	6.2	20.5	11.4	

Source: MHLW, *Kokumin Seikatsu Kiso Chosa 2006*

The third factor affecting care within the family is the rise and change in women's labour force participation. Prior to the 1970s, the agricultural sector was still fairly big in Japan and many women were involved in farming activities. This contributed to the high rate of female labour force participation. It dropped drastically in the 1970s during which Japanese industrial mix changed dramatically. However, from the late 1970s to 1990s, it again started to increase because increasingly more women were involved in non-farm occupations (away from home). It was during this time that the conflict of "care" and work began to surface and it became increasingly stronger. Perhaps, this conflict may be one of the reasons why the female labour force started to decline in the 1990s and also the reason that part-time work among women has increased so rapidly during the same period. In any case, such forces have depleted the care resources within the family.

Figure 3.7 Female Labor Force Participation Rate>



Source: Statistics Bureau, Labor Force Survey

Another impact of population ageing is the budgetary crisis of social security systems. The ageing of the population has put a serious strain on government resources. The absolute amount of social services for the elderly, as well as health and pension expenditure has increased dramatically. Since the main pillars of Japanese social security systems are social insurances, run on pay-as-you-go basis, population ageing leads directly to financial strains. In order to meet the increased demand for the elderly population, the government is forced to pour more and more resources into the social security systems, pushing the already alarmingly high public debt further into the red. This, in turn, necessitated the cut-back of social security provisions in all aspects. Such social changes have culminated to the introduction of the Long-Term Care Insurance (LTCI) in 2001.

3.4 The Introduction of the Long-term Care Insurance

In 2001, the government introduced the Long-Term Care Insurance (LTCI). The LTCI's so called purpose is "Socialization of Care" by which the government meant sharing of the burden of elderly care among all members of the society. It aims to establish a system that responds to society's major concern about aging, and to assure the citizens that they will receive care, if necessary, and be supported by society as a whole.

The LTCI covers the long-term care of the elderly and the disabled. Prior to the introduction of LTCI, the government provided social services to those requiring elderly (and other) care at minimal or no costs (funded by the general budget), but on a scale much smaller than LTCI. The programme for institutional care is termed Welfare for the Elderly (See **Table 3.8**), and it is still in place after the LTCI, but its size was reduced significantly and its recipients were moved to the LTCI. It is a means-tested programme for elderly persons with severe care needs, whose income is low and who are living alone and with limited assets.

The institutions are public and the municipality decided who is eligible to enter.

Table 3.8 Differences between New and Old Care Systems

	Old		New
	Welfare for the Elderly	Insurance for the Elderly	Long-Term Care Insurance
Service Target	Low-income, living alone or other requirements	Those aged 70 years old and over and those between 65 and 70 with disabilities	Those aged 65 years old and over and those between 40-64 who are subscribers of medical insurance
Eligibility for Service	Care needs and conditions of family structure, income, etc.	Care needs	Care needs
Co-payment	According to ability to pay	\530/visit, \1,200/day of hospitalization	10% of service fee
Service Providers	Public welfare facilities	Medical facilities	Public or private care facilities, medical facilities
Freedom of choice by user	No	Yes	Yes

Source: Nihon Iryo Kakaku, "Iryo Hakusho, 1998"

In addition, a significant number of elderly were occupying the hospital beds even though they did not need day-to-day medical services, but because they did not have family resources to be taken care of outside the hospital. This is termed “social hospitalization” and medical services provided were covered by the Insurance for the Elderly (See **Table 3.8**). The Insurance for the Elderly is the Public health insurance for the elderly. It is basically the same as the National Health Insurance for non-elderly, but the co-payment is much lower and it is a nominal fixed fee. “Social Hospitalization” was creating a huge problem financially for the health insurance system, since a stay in a hospital with full medical staff and services is quite expensive⁹. The co-payment is low and the health insurance paid most of these medical expenses.

As stated in the introduction, the demographic change, the family structure and the women’s involvement in the formal labour market have created demand for more state involvement in providing elderly care. However, a real force behind the enactment of the LTCI did not come from people’s movements or women’s movements but from the bureaucracy’s own budgetary concerns. Social Hospitalization was a major drain on governmental resources, because it costs much more to care for someone in a hospital than providing care services in less formal settings (at home or in a group-home). The social services (Welfare for the Elderly) were essentially free of charge to users, while the government, especially the municipalities, were bearing the main responsibility for providing social services; fiscal outlays were thus increasing. *The 2000 White Paper on Health and Welfare (Kosei Hakusho)* states that “the universal problem of elderly care” needs “a wide array of social assistance in providing care”, yet “the mere extension of existing social services funded by the general budget can hardly be expected to increase the amount of elderly care provision much” (MHLW 2000, as cited by Ogata 2000). The shift from social services to social insurance was a way to expand the elderly care provision at the same time reducing the financial pressure on the public outlay. From the government’s point of view, it was a strategy 1) to collect more revenue in terms of premiums, and 2) to introduce

⁹ Even though they may not require intensive medical procedure, their costs is almost as high as other patients since costs such as a over-night stay is the same.

co-payment in care services and thereby restraining the care demand. From the public's point of view, given the state of budgetary crisis and population ageing, it was presented as the only way to expand the care service provision which was needed badly. And the government found a solution by importing a system modelled after the German long-term care insurance.

3.5 An Overview of LTCI

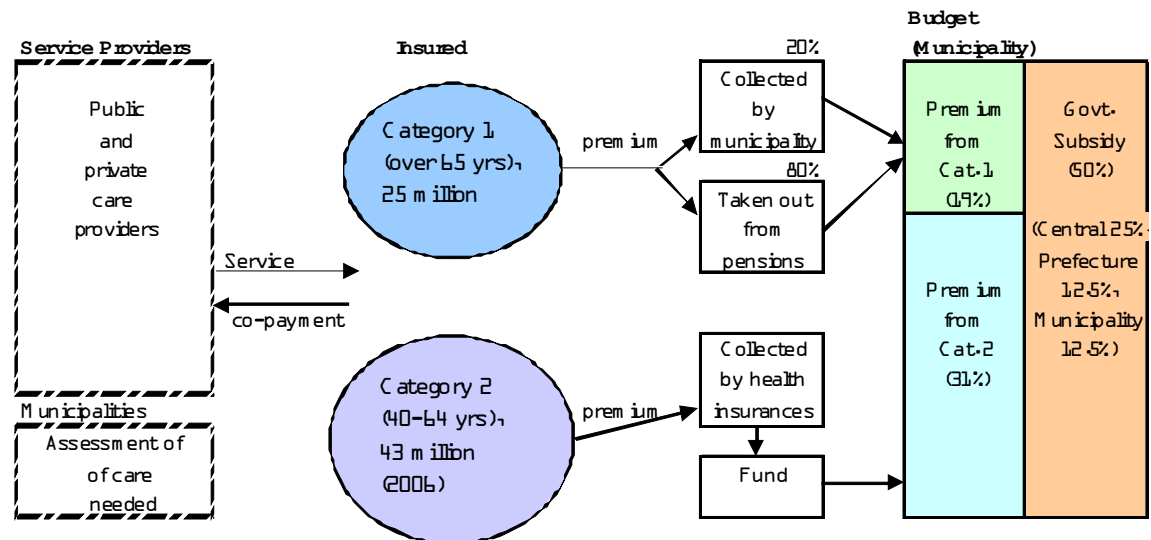
The Long-term Care Insurance is a mandatory social insurance programme, just as in the public pension and the public health insurance. All persons aged 40 and above must subscribe to the insurance regardless of their care needs. Those who are aged 65 and over are called Category 1 and those between ages of 40 to 64 are called Category 2. For Category 2 subscribers, the premium is levied as an "add-on" to the public health insurances. Thus, if a person is subscribing to Employees' Health Insurance (i.e. full-time, permanent employees of large firms), the premium amount is a fixed rate (about 0.8 to 0.95%) of salary which is added to the premium for the health insurance. If he/she is subscribing to the National Health Insurance (i.e. self-employed, farmers, retirees, and part-time employees of firms), the premium is a fixed amount (on average about 3000 yen per month) and is added to the premium for the health insurance. As in the public health insurance and public pension programmes, dependent spouses of Employee's Health Insurance subscribers are automatically covered by her/his husband/wife's premium. Women who are not married and women who make more than 1.3 million yen per year will have to pay their own premiums either in the National Health Insurance or the Employees' Health Insurance.

For Category No.1 subscribers, the premium is collected differently. Since most of them are already retired and are receiving pensions, the premium is deducted from the pension payments. Currently, about 27 million persons are subscribed as Category 1 and about 43 million persons, as Category 2 (as of April 2006). This number translates to near 100% of the population in the respective ages.¹⁰

Overall, the cost incurred by the Long-Term Care Insurance is financed by premiums, government subsidy and co-payment of users. Apart from the co-payment of the users, the cost is financed 50% by premiums (19% by Category 1, 31% by Category 2) and 50% by government subsidy. The overall financing mechanism of the LTCI is shown in **Figure 3.1**.

¹⁰ There are few cases where subscription to the LTCI is not required. Those who are not required to subscribe to the LTCI include those who are in prison, those who are living abroad, etc.

Fig.3.1 Diagram Representation of Long-Term Care Insurance



Source: Shakai Hoshō Nenkan 2006

A subscriber can receive care services at a reduced price if he/she is above 65 (Category 1) after assessment of his/her care needs by the municipality. There is no “minimal” amount of premiums that he/she has to pay in order to receive the service as long as he/she is not in arrears for paying his/her premium. If a person requires care service, she would first have to get an assessment of her needs from the municipal government. When the LTCI was first introduced, the assessment was categorized into 5 levels, but it was later revised to include 7 levels. A public health professional conducts an interview with the person in question and his/her family to determine his/her ability to conduct everyday activities and then determines his/her care level. According to his/her assessment level, a ceiling of maximum care service is determined. Then she needs to consult with care managers appointed by the municipal government and together, they decide what combination of care services she will receive. Then, he/she can then “buy” care services from for-profit or non-profit private care providers. He/she is free to choose the kind of care and its providers, and up to 90% of service fee will be paid by the insurance (i.e. co-payment is 10%).

A list of care services is shown in **Table 3.9**.

Table 3.9 Care under Long-Term Care Insurance

Service for those staying at home	Service for those who are institutionalized
Home-help	Special nursing homes for the elderly
At-home bathing	Long-term care at health facilities for the Elderly
At-home nursing	Long-term care at medical care facilities for sanatorium (sanatorium words etc.)
At-home rehabilitation	
Out-patient rehabilitation	
At-home medical care management counseling	
Day-service	
Short-stay service	
Group home for elderly with dementia	
Long-term care at private homes for the elderly	
Provision or subsidy for care equipment	
Subsidy for home alteration to meet care needs	

Source : Shakai Hoshō Nenkan 2002

The LTCI and the Poor

There has been much debate about the additional burden of the Long-term Care Insurance on the poor. Before the introduction of the Long-term Care Insurance, services covered under the Insurance were often offered by the municipalities, as part of their welfare services, at no or nominal charge. However, the introduction of the Long-Term Care Insurance necessitated those above 40 years old to pay additional premiums and the co-payments. Even though the premium amount is set according to the income level, it was considered to be too high for many elderly people in the lower income strata. To reduce the burden on the poor, many municipalities have introduced premium exemption systems for poor elderly, despite the Ministry of Health, Labour and Welfare's notice which stated that such a measure would seriously undermine the insurance principle underpinning the system. For example, some municipalities set up 6 levels of the insurance premiums for the subscribers aged 40-65, as opposed to the government recommendation of 5 levels.

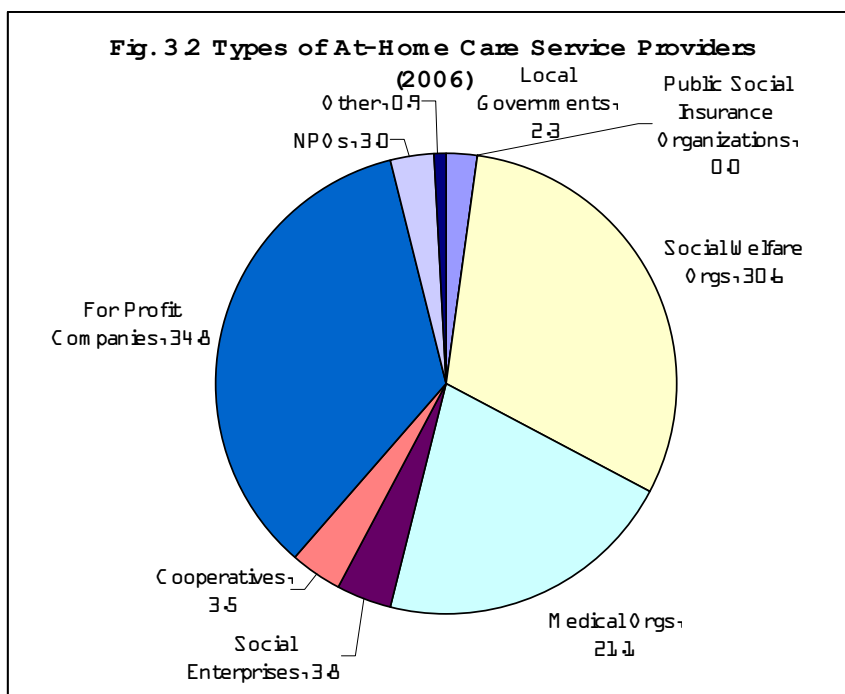
Delivery of care Services

Thus far, the report described the financing of the long-term care through LTCI. Given the large government subsidy injected into the system, it is clear that the state's role in financing of the long-term care is quite large. We now turn to the delivery of long-term care services. What is the public role in delivering the service?

The At-Home care service providers are mostly non-profit organizations such as social welfare organizations, medical organizations, social enterprises and cooperatives. These organizations are not public but are private, per se, but they receive special tax treatments and other preferential arrangements from the government. Less than 3% of the service providers are directly run by the local governments. About one third are run by for-profit organizations, i.e. private companies. Institutional Care is also provided by both public and

private organizations, but there is a higher share of direct local government management.

However, from the user's point of view, it does not matter what type of organization, public or private, provides the service. Even for privately run service providers, government regulates the market intensively. The government sets the standards for care services, as well as service fees that are levied if it is to be paid out of the LTCI. As stated earlier, almost 100% of all care services go through the LTCI, which effectively means that private service providers have no say in how much they can charge users (this is also true in the case of health care services). The government is trying to restrain the expansion of public service provision, since it believes that public services are not flexible in responding to the fluctuations in demand. For example, once established, it is nearly impossible to close a publicly run nursing home or lay-off service workers. Also private organizations are expected to come up with service provision much more quickly than the government if there is a demand for it.



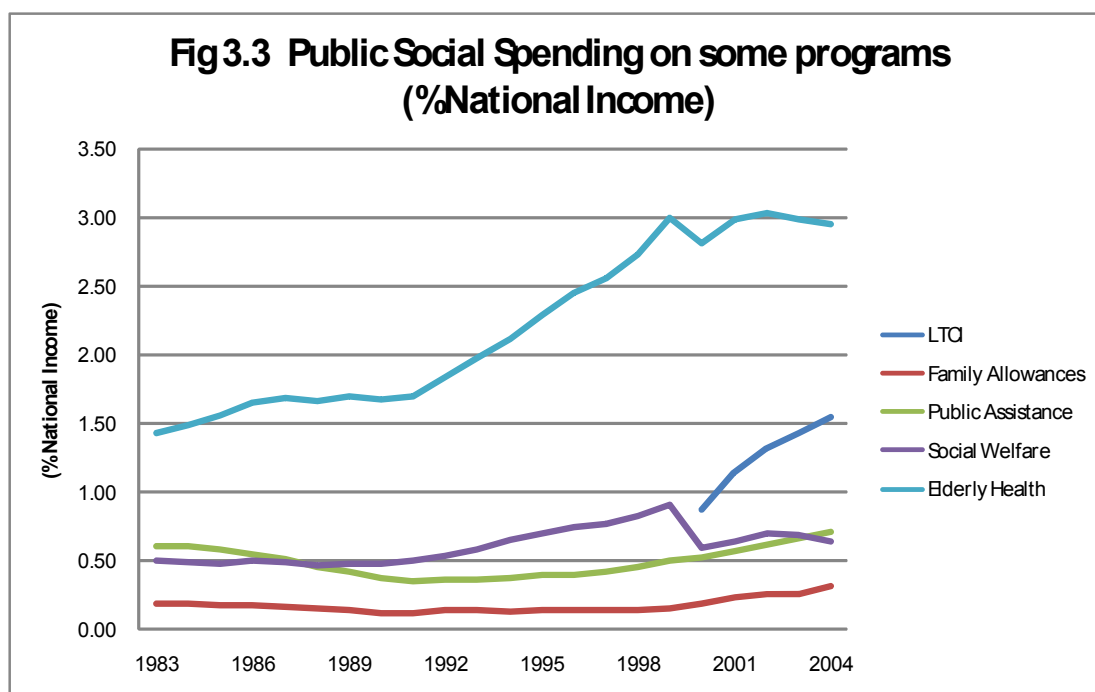
Other types of NPOs make up 3%.

3.6 Impact of the Long-term care Insurance on Government Outlay

The main purpose of introducing the LTCI was to cut down the cost of elderly care for the government, yet soon after its enactment, it has become evident that the initial financial arrangement was not enough to meet the cost of the long-term care. The number of care recipients grew from 1.49 million (0.52 in institutions and 0.97 at-home care) in September 2000 to 3.29 million (0.78 in institutions and 2.51 at-home care) in April 2005. The financial outlay grew steadily from ¥3.6 trillion (2000) to ¥7.1 trillion (2006 estimate) (**Figure 3.3**). As in **Figure 3.3**, even though the increase of spending for elderly health insurance and social welfare (including elderly welfare) were suspended after 2001, it was

more than offset by the increase in spending on the LTCI.

Further, the baby boom generation will begin to become elderly in 2015. With such financial pressure, the long-term care insurance was reviewed and several reforms were put in place five years after its enactment. One of the main reforms was the change in “care need” classification. Many of the new users of LTCI were non-severe cases, i.e. those who did not use any care services before, but started to use it after they were covered by the LTCI. Thus, the number of categories of “need classification” was increased from 5 to 7, and what was the lightest case (Need some care) is now divided into two (but this is only one rather than two!) “May Need Assistance in Future” categories. Those who are classified into these categories are no longer able to receive care services, but instead are recommended to utilize measures for prevention of further deterioration of their conditions (such as exercising, counselling, swimming etc. which are offered in local care management centres).



3.7 The Impact of the Long-term Care Insurance on Family's Care Provision

While the government's real intension of introducing LTCI was financial, it explained to the public that the Long-term Care Insurance would mitigate the care burden which is now borne mainly by the family, typically by the women members, by introducing market-based solutions. After all, the idea of social insurance is to share the risk of heavy care needs amongst the entire population and pool their resources (i.e. premiums) so that families are able to buy care services at reduced costs. Thus, there was a high expectation from the public that LTCI would achieve this goal, and one of the first questions to be asked is whether or not the care burden of families has been reduced after the introduction of the Insurance (LTCI).

However, the answer to this question is not easy. First, in order to evaluate the policy

impact, it is necessary to conduct a quasi-experimental framework for analysis or at the least, a panel survey where the care provision before and after the introduction are measured. However, such data is extremely rare. Second, even when such data is available, it is necessary to control for time variant variables. For example, a family may have increased the amount of services it buys from professional care providers, but the elderly's condition may have worsened during the same time, leaving the care burden on the family the same.

There have been some empirical studies which examine the impact of the LTCI, controlling for such changes. A study by Shimizutani and Noguchi (2004) uses a quasi-panel data in which about 1000 families with one elderly who needs daily care provision are asked how many hours the main caregiver spends in "caring" for the elderly before and after the introduction of LTCI (**Table 3.10**).

Table 3.10 Change in Extremely Long Care Provision by Family

	Households with all data available only		
	More than 8h	More than 10h	More than 12h
Around 1999	25.6	18.67	10.24
April 2000	25.58	19.38	10.34
April 2001	23.57	18.65	10.04
Oct/Nov 2001	21.86	16.03	9.65
Oct/Nov 2002	23.02	16.55	10.07

Source: Shimizutani & Noguchi (2004), p. 169, Table 6-A-2.

The table reveals that a significant number of households (around one quarter) reported that a family member spends extremely long hours (more than 8 hours a day) for the care of elderly (this includes daily chores such as washing clothes and bed linen, preparing meals, bathing, and/or simply watching over). There has been a slight decrease in the share of households spending so many long hours between 1999 and 2002. Households which spend more than 8 hours decreased from 25.6% to 23.0%, and those which spend more than 10 hours, from 18.7% to 16.6%. A multi-variate analysis reveals that there is statistically significant decrease in the number of hours spent on elderly care even after controlling for the age and care status of the elderly and the caregiver. However, as evident from **Table 3.10**, the decrease is fairly small, and still, a significant number of households spend extremely long hours caring. This relatively small effect of the LTCI may be due to the fact that the data was collected soon after the introduction of LTCI and the service provision under the LTCI had not taken off much. The care provision under the LTCI has increased dramatically since 2002, and we may be able to see bigger effects now (in 2009).

4. Policy for Child Care (Hoiku) ¹¹

4.1 Child Care system for Pre-School Children

Child care and educational institutions for preschool age children in Japan can be classified into three types: (1) licensed day-care centres, (2) non-licensed day-care centres and (3) kindergartens. The number of child care and educational institutions by type is summarized in Table 4.1.

Table 4.1 Number of Day-Care centers and Enrolled Children

	Number of centers	Number of Enrolled Children	(%)
Licensed day-care centers *	22 624	2 118 079	100%
public	11 752	1 006 544	48%
private	10 872	1 111 535	52%
Non-Licensed Day- Care centers **	6 694	1 816 277	100%
Inhouse day care centers	1 007	20 866	11%
baby hotels	1 525	38 121	21%
other	4 162	1 226 400	68%
Kindergarten	13 835	1 726 520	100%
public	5 469	342 301	20%
private	8 366	1 384 219	80%

* as of October 1, 2005

** as of October 1, 2006

Non Hoku Kyokai (Japan Child Care Association) HP.

*** as of 2006. Statistics Dept. *Shakaishokatu Tokei Shinryo* <http://www.stat.go.jp/data/ssds/5.htm>

Day-care centres provide full-day centre-based care for pre-school children aged 0–6 years old regardless of whether they are licensed or not. Differences between licensed and non-licensed day-care centres lie in standards and availability of government subsidy. Licensed day-care centres may be public (operated by municipal or central government) or private (operated by private institutions). Regardless of whether they are operated by public or private organizations, they fulfil minimum standards set by the government, or more specifically, the Ministry of Health, Labour and Welfare (abbreviated as MHLW hereafter). A set of items that are specified as the minimum standard is mostly structural, such as the child-staff ratio and the space available per child. In exchange for these regulations, a large share of the running costs of licensed day-care centres are subsidized by local governments.

¹¹ This section of the paper reproduces, with significant updates, the report by Yoshimi Chitose (DATE) “Child Care Policies” in a booklet by NIPSSR entitled *Child-Related Policies in Japan*, with the author’s permission.

As of April 2008, there are 22,909 licensed day-care centres in Japan. 2.02 million children or 31% of pre-school children in Japan are enrolled in these licensed day-care centres. More than half of the licensed day-care centres are under the direct management of local governments (public), while the rest are managed by private organizations, mostly non-profit social welfare organizations. Licensed day-care centres, regardless of their public or private status, are subject to regulations and have little freedom in management. For example, it is not licensed day-care centres themselves but the municipality's local welfare office that decides who should be admitted to licensed day-care centres, or how much the users should be charged. Usually, the admission criteria are based on the family's needs for child care, such as mother's working status and household structure. The fee structure for licensed day-care services is uniform within a municipality regardless of the type of service provider, but differs by applicant's household income, age of the child, number of siblings and the municipality where the family resides. Fees are heavily subsidized by the municipal government and cover only a portion of the running costs of the centres, yet it can be as high as 60,000 yen per month (\$600 US Dollars at 100yen=\$1) per child. The fees tend to be lower for older children, and it is progressively structured so that poor households pay less than well-to-do households.

In contrast, the majority of non-licensed day-care centres are operated either by private organizations or individuals. Non-licensed day-care centres fill the gap left by licensed day-care centres. In fact, many parents use non-licensed day-care centres as "filler" until their child is admitted to a licensed day-care centre as many licensed day-care centres, especially in metropolitan areas, have long waiting lists. Others use non-licensed day-care because the services provided by licensed day-care centres are not enough (in terms of opening hours for example). For example, many non-licensed day-care centres provide services in the evenings, while most licensed day-care centres only run up to 6 o'clock. Some corporations provide day-care services for their employees as a part of the benefit package. More than a third (37%) of non-licensed centres are "in-house" or child care facilities located within firms established by employers for employees with children, for example, in-hospital day-care centres for medical practitioners. The use of such facilities is restricted to employees of the firm and their fees are often subsidized by the employer. About 10% of the centres are so called "baby hotels."¹² The rest are generally small-scale day-care centres operated by various organizations including not-for-profit and for-profit ones. Baby hotels and other non-licensed day-care centres are strictly private. Because non-licensed day-care centres are not under the government's strict supervision on standards or financial support, the quality is quite varied. With respect to the structural aspects, the majority of non-licensed day-care centres do not fulfil the minimum standards set by the government, since many of them are much smaller in scale. With respect to the quality of

¹² The so-called "baby hotels" are defined as child care facilities that meet at least one of the following criteria: (1) facilities that provide child care services during the night time, or (2) facilities where more than half of the children are non-regular users.

child care for child development, it is said that some non-licensed day-care centres provide high-quality care services comparable to or even higher than that of licensed day-care centres. On the other hand, some non-licensed centres such as typical “baby hotels” provide very low quality care. After the much publicized child death in non-licensed day-care centre in Yamato-city, the suburb of Kanagawa prefecture in 2000, there was a wide public outcry for strengthening government regulation of child care standards, even for non-licensed day-care centres. In terms of flexibility of services, non-licensed centres are said to be the best. Because of the flexibility of child care services they provide, some mothers working fulltime dare to choose non-licensed day-care centres.

Another major concern regarding non-licensed day-care centres is its fee. Because non-licensed day-care centres do not receive government financial support, the user’s fees they charge can be quite high (and no consideration is given to issues such as parents’ income or family structure). Thus, even non-working mothers are able to utilize their services.

Kindergartens are centre-based pre-schooling educational services for children aged 3–6 years old. Because kindergartens are considered as educational facilities for pre-school children, the Ministry of Education, Culture, Sport, Science and Technology (MEXT) is in charge of running them. Kindergartens can be public or private. Public ones tend to be smaller than private ones: about 40% of kindergartens are public, yet only 20% of children attending kindergartens go to a public one (Statistics Dept?? 2006.). Public kindergartens usually charge lower fees of between 6,000 to 7,000 Yen per month, while private kindergartens usually charge 20,000 to 30,000 Yen per month. Since kindergartens operate only for half a day, the majority of mothers whose children are in kindergarten are either not working or work on a part-time basis. This puts mothers who work on a full-time basis in a disadvantaged position in terms of their ability to use early education facilities, since their choice is limited to day-care centres.

4.2 Child care Arrangements: Enrolment rates

Table 4.2 outlines the primary child care arrangements in the daytime by mother’s working status. According to the results, 44.6% of the working mothers are using licensed day-care centres for child care in the daytime, and only 4.9% of them are using non-licensed day-care centres. For households with working mothers, grandparents also play an important role as caregivers, especially when the child is under 1 year old. In contrast, 68.3% of non-working mothers are taking care of their children by themselves. Kindergartens account for 16.4 percent of child care arrangement of all pre-school children, but the ratio is lower for employed mothers (13%). It is interesting to see that self-employed mothers are more likely to use kindergartens than employed mothers. This may be because self-employed mothers have more freedom to arrange their working hours than other working mothers do. **Table 4.3** demonstrates the primary care arrangement by the age of the youngest child. In short, the younger the child, the less likely he or she is to be in a day-care centre, and the more likely is the mother to be the main carer of the child. For instance, only 4.3% of children under 1

year of age are in licensed day-care centres, while more than 30% of children older than 3 years old are in licensed centres.

Table 4.2 Percentage of Childcare Arrangement by Mothers Working Status

(N=3781)

Type of arrangement	Total	Not working	Working		
			Total	Employed	Self-employed etc.
Parent	49.7	68.3	12.9	8.6	23.5
Grandparent	9.1	5.8	15.5	17.2	11.4
Licensed daycare centers	19.8	7.2	44.6	48.8	34.6
Non-licensed daycare centers	2.1	0.7	4.9	5.9	2.4
Kindergartens	16.4	16.9	15.4	13.3	20.5
Other arrangements	1.1	0.8	1.8	1.9	1.6
Unknown	1.8	0.3	4.8	4.3	5.9
Total	100.0	100.0	100.0	100.0	100.0

Source: Oshii, 2006¹

Note: 34% of mothers are working and 24% of the working mothers are salaried workers.

Table 4.3 Primary Childcare Arrangement by Age of the Youngest Child

(N=3781)

Type of arrangement	Total	Age of the youngest child						
		0	1	2	3	4	5	6
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Parent	49.7	78.7	68.4	64.0	36.5	14.4	11.7	12.7
Grandparent	9.1	14.5	13.7	11.7	6.0	2.2	1.4	1.4
Licensed daycare centers	19.8	4.3	12.8	17.8	31.3	31.5	32.5	23.9
Non-licensed daycare centers	2.1	0.9	2.6	3.6	1.5	2.6	1.8	0.0
Kindergartens	16.4	0.0	0.0	0.0	22.5	45.3	47.4	56.3
Other arrangements	1.1	0.8	1.7	1.6	1.3	0.8	0.6	0.0
Unknown	1.8	0.9	0.9	1.3	0.9	3.2	4.5	5.6

Source: Oshii, 2002

Table 4.4 Household Yearly Income by Primary Childcare Arrangement

(million Yen)

Type of arrangement		Household income	Household income, EQV	Father's income	Mother's income
Total	Average	6.78	2.30	4.96	0.70
Parent	Median	5.40	2.04	4.90	0.00
Parent	Average	6.30	2.23	5.10	0.29
Grandparent	Average	8.02	2.31	4.30	1.08
Licensed daycare centers	Average	6.79	2.23	4.07	1.45
Non-licensed daycare centers	Average	7.20	2.54	4.88	1.57
Kindergartens	Average	7.36	2.52	6.05	0.53

Source: Oishi 2003

Note: EQV adjusted income = (average household income) / EQV, where EQV = $1 + 0.7 \times (\text{number of adults} - 1) + 0.5 \times (\text{number of children})$

Table 4.4 summarizes the economic situation of the household by the type of child care arrangement used. Household income is the lowest for those using licensed day-care centres when adjusted by an equivalence scale. On the other hand, household income for those using non-licensed day-care centres or kindergartens tend to be higher, not only in absolute value but also in the relative value of income adjusted by an equivalence scale. Turning to the incomes of mothers and fathers, it is clear that fathers using licensed day-care centres earn the least (4.07 million Yen per annum) on average, while fathers using kindergartens earn the most (6.05 million Yen per annum). Although the gap in fathers' earnings between the two types of households is nearly 2 million Yen, the difference in the total household income between the two is not so large due to mothers contribution: mothers using licensed day-care centres earn 1.45 million Yen on average, while mothers' using kindergartens earn 0.58 million Yen. In fact, median income of mothers using kindergartens is zero, because most of them are not working.

Table 4.5 Working Status of Parents by Type of Daycare Center

O.N = 26,978

	Licensed		Not-Licensed	
	Father	Mother	Father	Mother
Total	100.0	100.0	100.0	100.0
Full-time	72.8	41.3	79.7	47.7
Part-time	1.0	35.1	0.7	22.0
Self-employed	11.2	8.9	9.2	5.0
Temporarily living separately	1.0	0.1	1.0	0.1
Unemployed	1.0	8.5	1.0	21.3
Not present	12.0	1.5	7.2	1.1
Other	0.3	3.2	0.3	1.1
N.A.	0.7	1.4	0.9	1.7

Source: MHLW, 2000

Table 4.5 compares working status of parents using licensed day-care centres and those using non-licensed day-care centres. For both fathers and mothers, the largest share are in full-time employment in both types of day-care centres, but the percentage working full-time is higher for parents using non-licensed day-care centres. For example, while 41.3 percent of mothers using licensed centres are working full-time, nearly 50 percent (47.7%) of mothers using non-licensed centres are working full-time. For fathers, nearly 80 percent of non-licensed users are working full-time, while 72.8 percent of licensed centre users are working full-time. Other differences in mother's working conditions by type of child care arrangement used are also found. First, a higher proportion of mothers using licensed centres are working part-time, or are self-employed compared to mothers using non-licensed centres. Second, the share of single-parent families is higher among licensed centre users, while the share of unemployed mothers is about 2.5 times higher for non-licensed users. The fact that a larger share of mothers using non-licensed day-care centres are working full-time suggests the greater flexibility of these centres (in terms of working hours for example). Non-licensed centres are also functioning as a temporary shelter for unemployed mothers while they look for work. Though unemployed mothers are qualified to apply for licensed centres, in reality, it is very rare for them to be admitted especially in large urban areas, since priority is given to working mothers in need of child care. Consequently, many unemployed mothers face a dilemma, since without child care facilities unemployed mothers are not able to look for a job, but licensed day-care centres rarely admit children whose mother is unemployed. Because priority of admission to licensed day-care centre is placed on the need for care, higher share of single-parent family is found for licensed centres.

4.3 Government Policy for Child Care

Because of the financial difficulty caused by the two oil crises, child care related spending by the government shrank sharply during the early 1980s. It was not until 1989 when the total fertility rate of Japan registered the lowest record that the government began to allocate more resources into child care services. Along with the declining birth rate, the national budget allocated for licensed day-care centres has been increasing, reaching as high as 407 billion Yen in 2002. However the ratio of child care spending to GDP (0.08%), is still below the level of early 1980s. In addition, as will be explained below, only a small portion of total day-care expenditure is financed by the national budget.

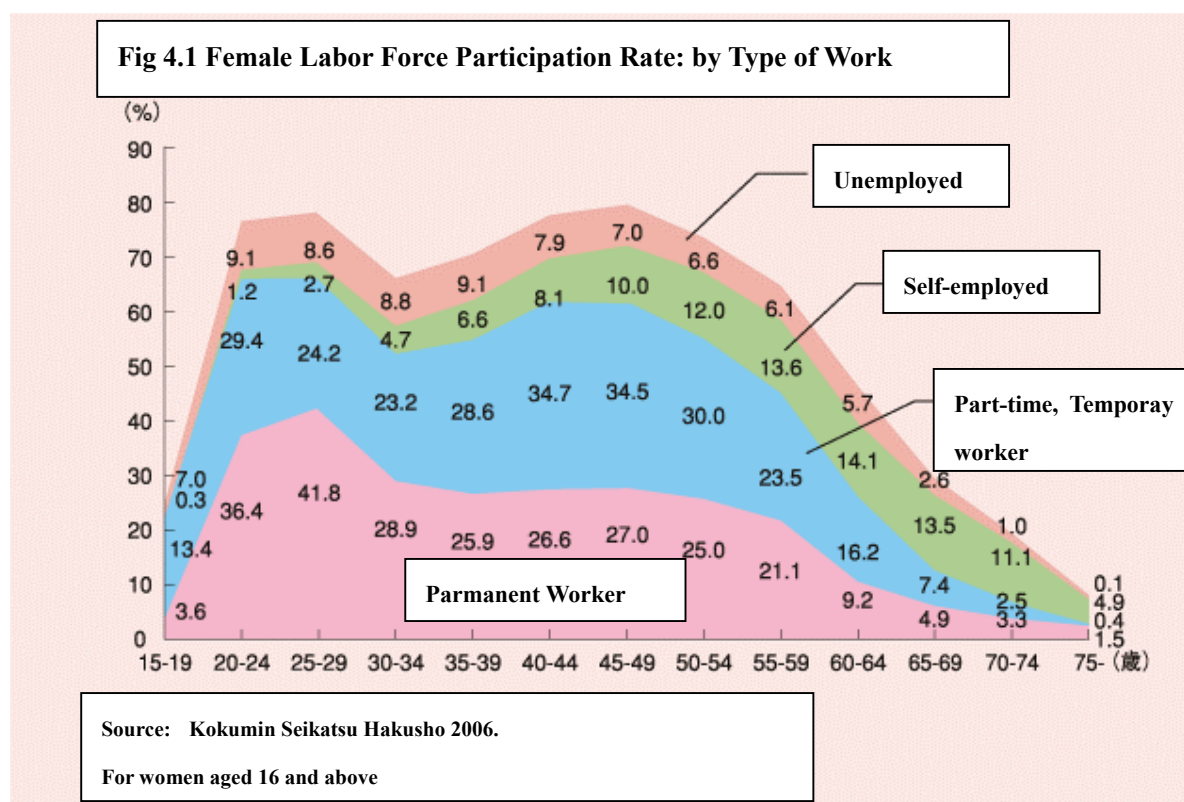
Who Bears the Child care Costs?

The running cost of licensed day-care centres in Japan is extremely high. Although there is no national level data on the detailed breakdown of child care costs, labour cost is obviously the largest item in overall expenditure of licensed day-care centres in many municipalities. For example, in Chiyoda-ward, Tokyo, the share of labour cost amounted to 80% in FY2000. Because many of the licensed day-care centres in Japan were established in the 1960s and 1970s, and because most child minders of public day-care centres are public servants and on a

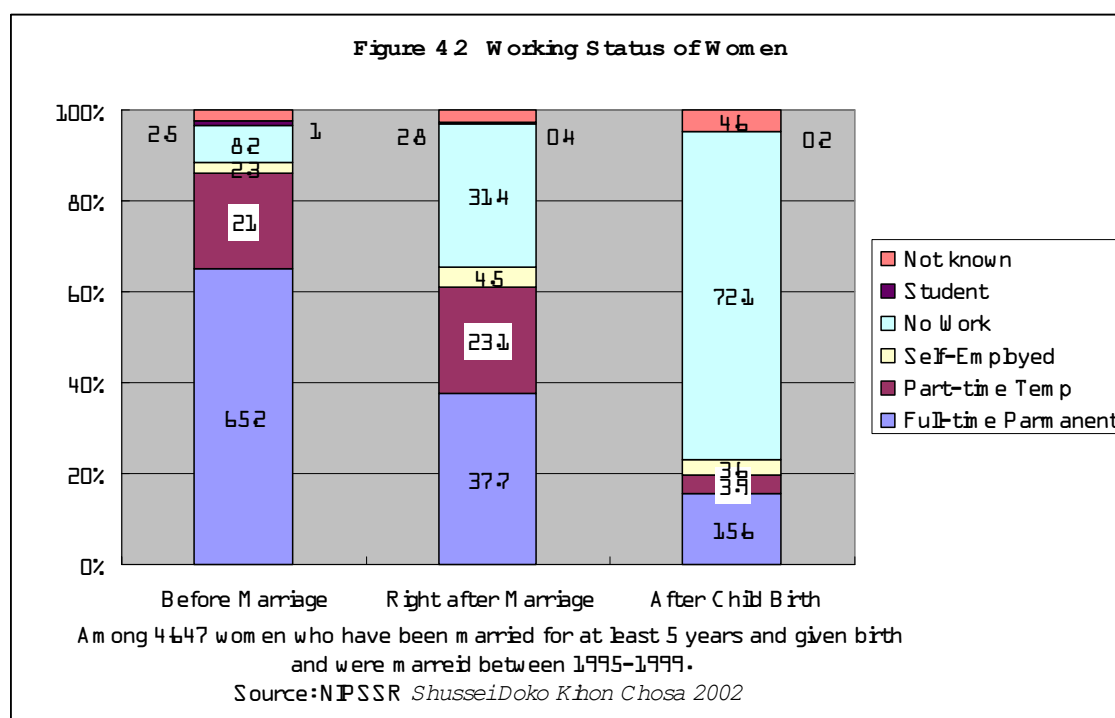
seniority-based wage system, labour costs rise with the average age of child minders. According to the MHLW estimate, total child care related expenditure for licensed day-care centres in 2001 amounted to 1,600 billion Yen, or 0.32% of GDP. These expenditures are shared among central government, local government and users. Specifically, 50% of the deficits (cost minus user fees) are covered by the national budget, 25% by prefecture budget, and 25% by municipality budget. To be emphasized, although the central government (MHLW) has set a standard expenditure criterion for licensed day-care centres, many municipalities have been infusing additional funds to reduce the burden on users and to subsidize labour costs of day-care centres in hiring temporary staff and improving benefits of child minders. When additional subsidies from municipalities are considered, the total operating expenses for licensed day-care services could exceed 2 trillion Yen.¹³

4.4 Child Care and Women's Labour Force Attachment

As seen above, even though there are several child care options available to women in Japan, the labour force participation rate of women in child bearing ages remains low. As in Korea, Japanese women's labour force participation rate is "M-shaped", and it drops in late 20s and early 30s when women are typically caring for pre-school children (**Figure 4.1**).



¹³ Fukuda (2001) estimates that the total operating expenditures of licensed day-care centres in 1998 may be around 2,000 billion Yen, or 0.4% of GDP in that year.



The reason for the “M-shaped” curve is quite clear. Women tend to quit work first at marriage, and then after the birth of their first child. As shown in **Figure 4.2**, nearly half of the women who have had full-time permanent jobs leave work after marriage, and again, nearly half of those who retained full-time work quit the labour force after the birth of their first child. Thus, the share of non-working women increases from 8.2% before marriage to 72.1% after child birth.

Why do they quit work? Table 4.5 shows the results of a survey conducted by Japan Institute of Labour Policy and Training (JILPT) in 2003 (multiple answers). According to this survey, more than half of surveyed women wanted to take care of their children on their own. At the same time, many also raised the difficulty of balancing work and family obligations. For example, 23.3% of women said that “it was impossible to raise children due to work and commuting hours”. 17.9% say that “maternity leave was not available”. This suggests that even if the child care arrangement is available, it is the high expectations from the “job” that make it impossible for women to choose to raise children while working at the same time. These expectations include long working hours, long commuting time, and uninterrupted work (no maternity leave¹⁴). There are also concerns about the quality of work, itself. 22.8% of women say that “the work was not worth continuing” and 8.9% say that “income was too little to pay for day care centres”.

¹⁴ It is mandatory for employers to give 8 weeks leave for female workers who have given birth. Many large corporations also have maternity leave where mothers (and fathers) can take up to one year leave (including the 8 weeks of mandatory leave) at 40% of salary. However, small corporations do not have such schemes, and also there is a considerable pressure for women not to take the full one year leave.

Table 4.5 Reasons for Quitting Work after Child Birth

Wanted to take care of children by myself	53.6
Was not sure I can manage work and family	32.8
Impossible to raise children due to work and commuting hours	23.3
The work was not worth continuing	22.8
Did not want putting children in day care centers	21.5
For health reasons	19.9
Maternity leave was not available	17.9
Can do without the extra income	16.9
No family member to help	13.7
The income was too little to pay for day care centers	8.9
The work place did not approve	8.3
No day care centers available	6.4
Could not get support from husband and family	5.7
Others	4.7

(Respondents are 614 women who have given birth during 1992 to 2001, and have quit work after giving birth)

Source: JILPT Kuji Kyugo Seido ni Kansuru Chosa (2003)

As the “M-shape” in **Figure 4.1** shows, many women do return to work when their children grow up a little. However, when they decide to return to work, they can usually get part-time or temporary work which tends to be paid at a much lower rate than permanent work. **Figure 4.1** shows that the increase in female labor force participation in the 30s and 40s only happens among part-time temporary workers, and not among those who have “permanent work”.

5. The Diamond for Care: Elderly Care and Child Care

5.1 Elderly Care

Figure 5.1 presents the Care Diamond for elderly care in Japan. An overview of the number of people who require some form of care and the number of people receiving professional care (both in institutions and at home) reveals that there is a significant and expanding role for the state in the provision of care for the elderly with severe care needs. However, an overwhelmingly large portion of the care needs are still met within the family (around half of the care for elderly with severe needs, and more than half of the care for elderly with fewer needs). The at-home care services were utilized by most households with care needs, yet, its provision only serves as a minor “supplement” to familial care. As seen in the empirical evidence presented above, the LTCI seems to have reduced some of the burden on families with extensive care needs, but its effect is fairly small.

The reasons for seemingly small effect of the LTCI are as follows. First of all, the LTCI is not a new service, but is a replacement of social services and hospitalization. Even though the care provision under LTCI has increased since its introduction, there are many reports that the total care provision from the state has actually decreased, especially for those with extensive care needs who were receiving social services prior to the introduction of LTCI. This is because 1) the LTCI places an upper limit on the amount of care one can receive, and 2) it imposes 10% co-payment, thereby those with financial restrictions “choose” not to receive care that they are entitled to. It should be noted that there is much difference in the utilization up to the “upper limit” allocated for each user (after assessment of care needs by the municipality) depending on income¹⁵. The upper limit is determined solely on the basis of how much care is required by the person in question (each applicant is put into either of 7 categories of need, or “not applicable”)¹⁶. But, even at 10%, the user charge (co-payment) is still expensive for poor elderly. Second of all, the LTCI rarely provides all-inclusive services. Caring for elderly with extensive care needs requires exceedingly long hours, as seen from the empirical evidence by Simizutani and Noguchi. Thus, even though a family may use the at-home care services provided by the state, the responsibility of the “main caregiver” still remains with a family member. The cost for all-inclusive care is also prohibiting for many households.

Second, the gender inequality in providing care is still strong. About 70% of family caregivers are women (an overwhelmingly large percentage of professional caregivers are also women--an issue that will be covered in RR4). Even though the time-use analysis by Tamiya and Shikata (RR2) shows that the family care provision of women decreased marginally between 1996 and 2001, yet, the family care provision of men remained almost the same and the care is still unequally divided with women taking a disproportionate share of the burden. One of the main reasons for this is that the “value” of women’s time in the labour

¹⁵ There has been many newspaper and other reports that poor elderly and their families, especially those with severe care needs had to cut down the amount of service they receive after the introduction of LTCI. However, there is no government statistics to support this.

¹⁶ The income of the person or the family does not go into the consideration.

market is still quite low compared to that of men. It should be noted that it rarely pays off for a woman to take up a job by utilizing professional care services to take care of the elderly. Women in the labour market rarely earn enough to cover the costs of hiring a caregiver full day or by putting the elderly person in an institution. The average user charge for institutional care is about 80,000 yen per month even at 10% co-payment¹⁷ (MHLW 2008). Most women who are caregivers are older than 40 years old and women in this age bracket can typically only get “part-time” jobs and earn less than 90,000 yen per month¹⁸. Thus nearly all of the salary of a female family carer would be taken to pay for institutional care. Thus, it is the disadvantaged position of women in the labour market which is binding women to the “caregiver role” as much as traditional cultural norms.

One of the main reasons that women earn so little in their 40s and 50s is that most of them have interrupted their career for child care in their 20s and 30s. As seen in the previous section, Japanese women’s labour force participation is “M-shaped”, and it drops when they are in their late 20s and early 30s when many women are typically caring for pre-school children. When they do decide to return to work, they can usually obtain part-time or temporary work which tends to receive relatively low pay. Thus, the forces that bind women to the caregiver role are multiple and reinforce each other. On the one hand, women are forced to interrupt their careers for child care in their 20s and 30s. On the other hand, they are again forced to choose to stay at home to take care of elderly parents because their career was interrupted earlier in life.

Another notable feature of the Japanese “care diamond” is that there is an almost complete overlap of “state” and “market” spheres. The LTCI is a “market” solution with financial backup of the “state”. Even though there are some private nursing homes which are not covered by the LTCI and care services paid 100% by the client, almost all elderly care provision is through the LTCI. The coverage, the determination of care needs (care management) and thereby deciding the upper limit of how much care service one can receive, is done by the state. The financing mechanism works through the coerced collection of premiums from all citizens above 40 years old, which operates very much like a tax. The payment structure for professional carers is strictly under the control of the state. Yet, the state’s role in delivering care services is limited, especially for care services delivered at home. In fact, it was government policy to expand the market’s role in delivering care services, so that expensive public services do not have to be increased in order to meet the demand for care. Also by including a “co-payment” portion into the system, the market mechanism was re-emphasized. A client “chooses” if and which professional service to “purchase” or “not purchase” the service, and the co-payment acts as a fiscal restraint on effective “demand” for care. The government has used this technique of raising the co-payment rate in health services (from 10% to 20%, and now to 30%), in order to reduce “moral hazard” in health

¹⁷ Plus meal and other expenses that are not covered by the LTCI.

¹⁸ The average wage rate for part-time female worker in their 40s is 960 to 980 yen per hour and average number of hours 5, average number of days 18(MLHW Chingin Kozo Kihon Chosa 2007).

care demand. The same mechanism is being used to dampen demand for elderly care.

Yet another notable feature is that there seems to be a very small or no role for the “relatives” and “community”. Almost all caregivers besides the professional care providers are immediate family members such as a spouse, children and spouse of children. And also, one can supposedly argue that the many of professional care service providers are non-profit organizations, and most of caregivers (“home helpers” in Japanese) are extremely low paid and can be considered to be partly “volunteers”, they still operate within the framework of market mechanism.

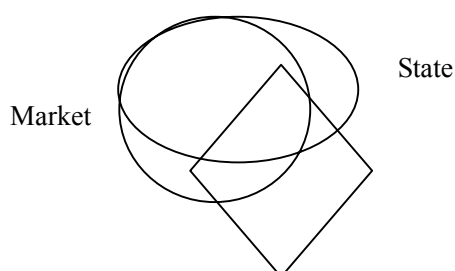
The care diamond that the author proposes for Japanese elderly care is captured in Figure 5.1.

Exclusion of Family Care in the LTCI

A word of caution should be added here. At the time when the LTCI was introduced, there was a controversial debate on whether the unpaid care work by a family member should be included in the framework of the Long-Term Care Insurance. On the one hand, some (on the conservative side) argued that covering professional care services while not covering the same care work done by a family member creates a bias toward care provision outside the family and prevents the family’s natural functioning as the primary care provider. They argued to include payment to family members when he/she cares for an elderly within the family, a provision incorporated in the German Long-Term care Insurance. On the other hand, some (on the feminist side) opposed the idea of “paying” for the unpaid care work done by a family member because such practice “binds” women even more to the role of care provider and it prevents them from being liberated from family responsibility which is too strong and biased towards women. In the end, the payment for family care provider was included but with very strict rules such that there is no professional care services available in the region, and that the family caregiver must possess the same qualifications as the professional caregivers.

What would the Japanese elderly care diamond look like if family care payment was included? Would there be an overlap of “state” and “family”? The overall picture would look very complicated for sure. This only shows that the distinction between “state” “market” “family” and “community” is becoming increasingly blurred and there is danger is simplifying the overall “mix” of care provision in a simple diagram.

Figure 5.1 The Care Diamond for Elderly care in Japan



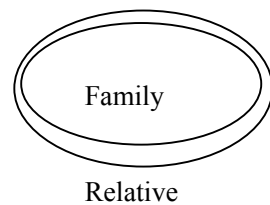
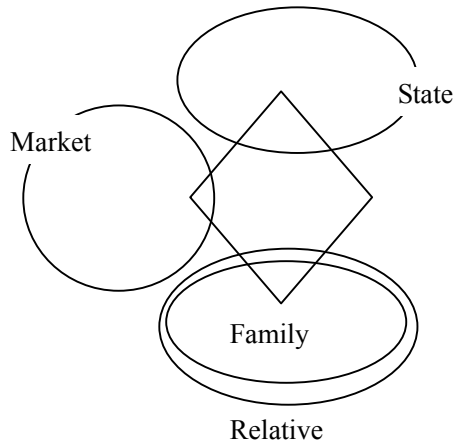


Figure 5.2 The Care Diamond for Child care in Japan



2. Child Care Diamond in Contrast to Elderly Care Diamond

While they share many commonalities as a care burden on women, elderly care (“kaigo”) and child care (“hoiku”) policies and consequently the care diamond are constructed quite differently. This is because the policy objectives of elderly care and child care are quite different. For elderly care, the “so-called” objective of the recent enactment of LTCI is to “socialize the burden of care among the entire society”, yet the hidden motive for the government is to cut down the governmental fiscal outlay for elderly care. The Japanese government was facing a dilemma. On one hand, as an industrialized “welfare state”, it is expected to take care of elderly care problem, and not doing so will be considered to be a failure of the government. Thus, Japan had been providing free elderly care services by establishing public nursing homes and admitting the elderly in hospitals for extended periods of time (until they die, i.e. social-hospitalization). On the other hand, it was becoming increasingly clear that this practice would cost the government unprecedented sum of fiscal commitment with the rapid ageing of the population and decrease of extended families. The government had to act wisely so that 1) it would not look as if the Japanese welfare state is retrenching, while at the same time 2) reducing government expenditure. The LTCI was a way to achieve both (even though cost containment did not succeed as seen in previous chapter).

In contrast, the policy objective for child care is “to balance work and family (work-life balance)”. This, in reality, can be interpreted to have two objectives. One is to increase

the fertility rate and thereby reverse the trend of ageing of population, and the other is to increase the labour force participation rates of women which has been decreasing and still retains the “dip” during child rearing years. However, the government’s effort in pursuing these objectives has been half-hearted through the 1990s and then 2000s. Cash benefits, tax concessions and other financial assistance to households with children were expanded in 2000s, yet they are still modest compared to other industrialized countries. The child care provision (by public sector) had also been increased, but the increase is far from meeting the demand for public child care. Furthermore, there has been no serious effort by the government to increase child care provision by the private sector either.

These differences in elderly care and child care policies have resulted in two different “care diamonds”. The first difference is that while the LTCI clearly tried to emphasize the “at-home” solution, i.e. elderly are being cared for at home with some assistance from professional care service providers¹⁹, the child care policy clearly places its emphasis on “institutional” solution, i.e. children being taken care of in institutions. There are very little public services or support to those who choose to take care of their children at-home (such as tax credit for at-home child care, financial compensation for mothers who stay at home²⁰, and regulations to promote baby-sitting or nanny service industry). This is because there was ambiguity as to whether the child care policy’s objective should include lessening some of the child care pressure on women who are not in the work force. Even though there has been a lot of public discussion on how mothers taking care of children at home are sometimes isolated from the society and are given sole responsibility to raise their children (without the father’s help), few (if any) programmes have been put in place to help these mothers. In order to place children in a public day-care centre, a mother has to be in the work force, and labour market entry is the only way to “lessen” the child care responsibilities (unless the household can afford to pay for a kindergarten).

Another notable difference between elderly care and child care policies is the utilization of market forces. The elderly care provision, especially at-home services, is mostly met through the LTCI. Thus, in financing and regulating, the market acts through the state. Even though actual delivery of services might be done by the private sector (and non-profit organizations, welfare societies, cooperatives, etc.), the state has a presence in every step of the way from assessment of needs, care management, and allocation of service amount. Even though there are some quality differences especially among private care providers, the service provided is more or less the same. However, the child care market is clearly divided into public (licensed day care centres) and private spheres (non-licensed day care centres). The licensed day-care centres, even though some of them are run by private entities, are

¹⁹ One of the main objectives of the LTCI is to encourage taking care of frail elderly at home, and not in institutions which are costly. Thus, the LCIT covers not only institutional care (nursing homes and other nursing facilities), but also adult day-care services, and at-home care services.

²⁰ There is a scheme of maternity leave by which mother (or father) can interrupt their work for up to a year after a child is born and is paid 40% of her/his salary. However, this covers only full-time permanent workers, and the take-up rate of maternity leave is 72.3% for women who work as full-time and permanent workers in 2005 (MHLW, *Josei Koyo Kanri Kihon Chosa 2005*).

strictly under the government's control, where the admission, placement and pricing are all decided by the government. At the same time, non-licensed day care centres are completely market driven, and prices, quality and quantity of services vary dramatically. Thus, unlike the care diamond for elderly, the care diamond for children consists of the state sphere and market sphere independent from each other.

The third difference between the care diamonds of elderly and children is the size of "relatives" sphere. The elderly care is almost entirely done by the immediate family members, while child care is very often supplemented by grand-parents (mostly grand-mothers). Nearly 10% of children under 6 are being taken care of by their grand-parents (**Table 4.3**). In many instances, grand-parents take care of children even if they do not reside in the same household.

Conclusion

In the words of Goodman and Peng (1997), the development of Japanese social welfare can best be described as "peripatetic adaptive learning", adapting different social schemes from other industrialized countries to meet the needs of the country at the moment. Development of elderly care and child care policies fit well to this description. Both elderly care and child care policies are formulated and changed to meet the immediate demands and issues of the society, and the government sought solution by selectively learning from Western nations, rather than being led by principles and theories. For elderly care, the introduction of Long-Term Care Insurance in 2001 is exactly such a case. As was described in previous sections, the LTCI, modeled after Germany, was adapted to meet immediate needs to cut down the rising cost of elderly welfare. For child care, the immediate need was to reverse the trend of declining fertility rate, but the state response to this need has been ambiguous. On the one hand, the state recognizes that to increase fertility, it is essential to foster work practices where family life and work life can be balanced, and it has expanded some schemes to do so (for example, increasing public child care facilities). On the other hand, the state is still strongly biased towards "male bread-winner, female housewife" households and it continues to give preferential treatment (in both tax and social security schemes) to such households over dual-worker households.

It has also been pointed out by many scholars that Japan's policy making is bureaucracy-driven (Kamimura 1999, Tominaga 2001, Miyamoto 2003), and it is also the case in elderly and child care policies. What is conspicuously missing in the development of both elderly and child care policies is the voice of caregivers, notably women, and those receiving care themselves. For elderly care, the government has been expanding the public provision in response to the demographic pressure, the change in family structures and the increase of women's labour force participation. However, the introduction of LTCI, even though it expanded the "total" amount of service provision, did little to lessen the burden on those women who carry the heaviest burden of elderly care (i.e. those who spend long hours

on elderly care at home). If the objectives of introducing the LTCI incorporated the voice of these women, it would also have expanded the public provision of institutional care. However, the number of public institutions, including hospitals and nursing homes, is being reduced in order to restrain social expenditure as a part of the Koizumi Reform. As a result, waiting lists for public nursing homes show no sign of getting shorter, and the care burden of women who take care of the elderly at home is still heavy.

For child care, the absence of women's voices in policy-making has resulted in a child care policy that has many discrepancies. For working mothers, the greatest need is for high-quality public day care centres. Yet, the services offered by the public day care centres are often not adequate to meet their needs both in quantity and in quality (e.g. hours of operation). Even more, the central government, in 2006, stopped subsidizing local governments for the operation of public day care services. Without the central government subsidy, many local governments are now cutting back their day care provisions. For non-working mothers, the government has put in place many preferential schemes for the male-breadwinner, female-housewife families, yet, it has done little to mitigate the burden of child care on mothers who stay at-home. Without the husband's support, many women are left on their own in carrying out the child care duties.

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