The Changing Shape of the Care Diamond

The Case of Child and Elderly Care in Japan

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Acronyms

GDP	gross domestic product
JILPT	Japan Institute of Labour Policy and Training
LTCI	Long-Term Care Insurance
MHLW	Ministry of Health, Labour and Welfare
OECD	Organisation for Economic Co-operation and Development

Summary/Résumé/Resumen

Summary

Traditionally in Japan, the care needs of children, the elderly, sick or disabled have been met within the family. As one of the welfare states with the highest proportion of elderly people (defined as those who are 65 years and older) the state provided a few care services, but they were limited and the coverage was restricted to those with the most intense care needs. However, a number of social forces have made it necessary to expand the public role in care provision. These forces include demographic change (ageing), changes in family structures (the increasing proportion of one-person households and households that include only elderly persons) and, to some degree, changes in the labour market (the increase in female labour force participation).

For elderly care, the rapid expansion of demand for public care services coincided with the retrenchment of social spending caused by a rapidly deteriorating fiscal deficit. It became clear that the government would not be able to meet the future increase in care demands without radical reform. As a result, Long-Term Care Insurance (LTCI) was introduced in 2000.

In the case of childcare, the state response was triggered by declining fertility. The main rationale, in order to raise fertility, was that it was necessary to ease the pressure of child-rearing on women, and one of the ways of doing so was to encourage women to work. However, the relationship between state provision of care and fertility was never clearly spelled out or understood, and the policy response to childcare was half-hearted and confusing.

This paper by Aya Abe describes the scale of the elderly care problem in Japan, examines the government's role in providing care and, to a lesser extent, considers the market's role before and after the introduction of the LTCI. It also looks at changing patterns in state provision of childcare. The paper expands on the idea of the "care diamond" introduced by Razavi and applies it to care for the elderly and children in Japan in order to compare the two.

Three main findings of the paper can be highlighted.

First, both for elderly care and childcare, the author finds that gender inequalities in care provision remain strong. The bulk of care is provided by women in the immediate family, whether it is the wife, daughter or step-daughter in the case of elderly care, or mother, in the case of childcare. The introduction of the LTCI reinforced traditional tendencies by emphasizing home care over institutional care, and a combination of cultural and socioeconomic factors has kept the gender bias in place. One reason is the weak representation in, and influence on, the policy-making process by women's—as well as other—social movements. Another is the fact that the value of women's time in the labour market is quite low compared to that of men. A growing proportion of the female labour force is composed of non-permanent workers whose wages are significantly lower than those of permanent workers. This is reinforced by care policies that leave women with no alternative but to interrupt their careers in their 20s and 30s in order to take care of their children. Because these women have already given up their permanent job earlier in their life, they are pushed into taking care of the elderly when they are in their 50s and 60s. Thus, care policies and employment policies reinforce women's role as caregivers.

Second, the care diamonds for elderly care and childcare are quite different in Japan, mainly because of different policy objectives. The stated objective of the LTCI is to "socialize the burden of care among the entire society". But according to the author, the hidden motive is to cut the governmental fiscal outlay for elderly care. In contrast, the policy objective for childcare is "to balance work and family", ultimately aiming at increasing fertility rates and women's labour force participation. The result of these different objectives is that the LTCI tries to emphasize home-based solutions, while childcare policy emphasizes institutional care. Another notable

difference between elderly care and childcare policies is the role of markets. In elderly care, there is an almost complete overlap of state and market spheres. Indeed, Abe argues, the LTCI works as a market solution to the fiscal burden of state-provided care services. The money for care services is thus collected (from all citizens over 40) and distributed (according to the state's classification of care needs) by the state, while service provision is almost entirely carried out by private institutions. In contrast, childcare provision is divided between the public and private spheres.

Finally, Abe says, what is conspicuously missing in the development of both elderly and childcare policies is the voice of caregivers, notably women, and those receiving care themselves. Here, care policies do not differ from other social policies in Japan, which are notably bureaucracy-driven.

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Résumé

Il est de tradition au Japon que les soins aux enfants, aux personnes âgées, malades ou handicapées soient dispensés dans la famille. Comme l'un des Etats providence comptant la plus forte proportion de personnes âgées (ayant atteint ou dépassé l'âge de 65 ans), l'Etat était prestataire de certains services de soins mais ils restaient limités et n'accueillaient que ceux dont les besoins en la matière étaient les plus pressants. Cependant, plusieurs forces sociales ont obligé les pouvoirs publics à prendre une plus grande part à la prestation de ces services. Ce sont notamment le changement démographique (vieillissement), les modifications de la structure familiale (proportion croissante de ménages d'une personne et de ménages composés uniquement de personnes âgées) et, dans une certaine mesure, les changements survenus sur le marché du travail (augmentation de la part des femmes dans la population active).

Pour les soins aux personnes âgées, l'expansion rapide de la demande de services publics a coïncidé avec la réduction des dépenses sociales, conséquence d'un déficit budgétaire qui ne cessait de se creuser. Il est apparu évident que le gouvernement ne pourrait pas répondre à l'augmentation future de la demande de soins sans une réforme radicale. Aussi a-t-on créé, en 2000, l'assurance soins de longue durée (ASLD).

S'agissant de la garde des enfants, la baisse de la fécondité a fait réagir l'Etat. Son raisonnement a été essentiellement celui-ci: pour que la fécondité remonte, il fallait alléger la charge de l'éducation des enfants pour les femmes et l'un des moyens de le faire était de les encourager à travailler. Cependant, le rapport entre la prestation de services de garde par l'Etat et la fécondité n'a jamais été explicité ni vraiment compris, et les politiques mises en place pour la garde des enfants l'ont été sans enthousiasme ni cohérence.

Ce document d'Aya Abe décrit l'échelle à laquelle se pose le problème des soins aux personnes âgées au Japon, examine le rôle des pouvoirs publics dans la prestation des services de soins et, dans une moindre mesure, celui du marché avant et après l'introduction de l'ASLD. L'auteur cherche aussi à montrer ce qui a changé dans la prestation des services publics de garde d'enfants. Elle développe l'idée du "carré des soins" introduite par Shahra Razavi et l'applique aux soins aux personnes âgées et à la garde des enfants au Japon afin de comparer les deux.

On retiendra trois conclusions essentielles.

Premièrement, pour ce qui est tant des soins aux personnes âgées que de la garde des enfants, l'auteur trouve que la charge des soins est encore très inégalement répartie entre les hommes et les femmes. La plus grande partie des soins est dispensée par les femmes de la famille directe— l'épouse, la fille ou la belle-fille dans le cas des soins aux personnes âgées, et la mère, dans le cas de la garde des enfants. L'introduction de l'ASLD a consacré les tendances traditionnelles en

donnant la préférence aux soins à domicile plutôt qu'aux soins en institution, et divers facteurs culturels et socioéconomiques continuent à jouer contre les femmes. L'un d'eux est la faible représentation et le peu d'influence des femmes et d'autres mouvements sociaux en politique. L'autre est la très faible valeur attachée au temps de travail rémunéré des femmes par rapport à celui des hommes. Une proportion croissante d'actives travaillent à titre non permanent, avec des salaires bien inférieurs à ceux des employés permanents. Cette inégalité est encore creusée par les politiques des soins qui ne laissent pas aux femmes d'autre solution que d'interrompre leur carrière entre 20 et 30 ans ou entre 30 et 40 ans pour élever leurs enfants. Comme ces femmes ont déjà, jeunes, abandonné leur emploi permanent, elles sont poussées à prendre soin des personnes âgées lorsqu'elles ont 50 à 60 ans et plus tard. Ainsi les politiques des soins et de l'emploi renforcent le rôle des femmes comme dispensatrices de soins.

Deuxièmement, le carré des soins se présente très différemment au Japon selon qu'il s'agit des soins aux personnes âgées ou de la garde des enfants, essentiellement à cause d'objectifs politiques différents. L'objectif déclaré de l'ASLD est de "répartir la charge des soins sur l'ensemble de la société". Mais, selon l'auteur, l'assurance en question en a un autre, inavoué, celui de réduire les crédits publics à affecter aux soins aux personnes âgées. La politique en matière de garde des enfants, en revanche, a pour but de "parvenir à un équilibre entre travail et famille" et vise en définitive à redresser les taux de fécondité et le taux d'activité des femmes. Ces objectifs différents ont pour effet de privilégier les solutions à domicile, pour ce qui est de l'ASLD, mais de donner la préférence à la garde en institution pour ce qui est de la politique concernant la garde des enfants. Autre différence notable entre les soins aux personnes âgées et la garde des enfants: le rôle des marchés. S'agissant des soins aux personnes âgées, les sphères de l'Etat et du marché se superposent presque entièrement. En fait, explique Aya Abe, l'ASLD apporte une solution marchande au problème budgétaire que posent à l'Etat les services de soins. Ainsi les fonds destinés aux services de soins sont perçus (auprès de tous les citoyens de plus de 40 ans) et distribués par l'Etat (selon sa classification des besoins), alors que les prestataires de services sont presque exclusivement des établissements privés. Les dispositions prises pour la garde des enfants prévoient une répartition entre sphères publique et privée.

Finalement, ce qui fait le plus visiblement défaut, selon Aya Abe, dans l'élaboration des politiques concernant à la fois les soins aux personnes âgées et la garde des enfants, c'est la voix des dispensateurs de soins, qui sont surtout des femmes, et de ceux qui reçoivent ces soins. A cet égard, les politiques des soins ne diffèrent pas d'autres politiques sociales du Japon, qui sont essentiellement conçues par des bureaucrates.

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Resumen

En el Japón, el cuidado de los niños, los adultos mayores, los enfermos o las personas con discapacidades ha recaído tradicionalmente en la familia. Siendo uno de los estados benefactores con la proporción más alta de adultos mayores (definidos estos como personas mayores de 65 años), el Estado japonés prestaba ciertos servicios de cuidados, pero estos eran limitados y la cobertura se restringía a aquellos que tenían las necesidades más intensas de cuidados. Sin embargo, un conjunto de fuerzas sociales ha convertido en una necesidad la expansión del papel del sector público en la prestación de cuidados. Estas fuerzas son el cambio demográfico (envejecimiento), cambios en las estructuras familiares (proporción creciente de hogares de una persona y hogares compuestos únicamente por adultos mayores) y, en cierta medida, cambios en el mercado laboral (incremento de la participación de la mujer en la fuerza de trabajo).

En el caso del cuidado de los adultos mayores, la rápida expansión de la demanda de servicios públicos de cuidados coincidió con el recorte del gasto social producto de un déficit fiscal en acelerado deterioro. Se hizo patente entonces que el gobierno no podría satisfacer el aumento

futuro de las demandas de cuidados sin emprender una reforma radical. Como resultado, se introdujo en el 2000 el Seguro de Cuidados a Largo Plazo (SCLP).

Con respecto al cuidado infantil, la disminución de la fecundidad es lo que ha motivado la respuesta del Estado. La principal justificación era que, a fin de aumentar la fecundidad, era menester aliviar las presiones que la crianza de los hijos ejerce sobre las mujeres, y una manera de hacerlo era alentar a estas últimas a trabajar. Sin embargo, la relación entre la provisión de cuidados a cargo del Estado y la fecundidad nunca se aclaró ni entendió a cabalidad, por lo que la respuesta de política ante el cuidado infantil fue confusa y timorata.

En este documento, Aya Abe describe la dimensión del problema del cuidado de adultos mayores en el Japón, examina el papel del gobierno en la prestación de servicios de cuidados y, en menor medida, considera la función del mercado antes y después de la implantación del SCLP. También se aborda en este trabajo la dinámica de los cambios en la provisión pública de cuidado de menores. El autor amplía la idea del "diamante del cuidado" que propusiera Razavi y lo aplica al cuidado de adultos mayores y niños en el Japón con fines comparativos.

Cabría resaltar tres observaciones principales del documento.

En primer lugar, tanto para el cuidado de adultos mayores como de niños, el autor observa que las desigualdades de género en la prestación de cuidados siguen siendo marcadas. El grueso de los cuidados corre por cuenta de las mujeres que componen la familia inmediata, trátese de la esposa, la hija o hijastra en el caso de los adultos mayores, o bien de la madre en el caso de los niños. La introducción del SCLP reforzó las tendencias tradicionales al enfatizar el cuidado doméstico en detrimento del cuidado institucional, y una combinación de factores culturales y socioeconómicos perpetúan el sesgo de género. Uno de dichos factores es la limitada representación e influencia de los movimientos de mujeres y otros movimientos sociales en el proceso de formulación de las políticas. Otro factor es el hecho de que el valor asignado al tiempo de la mujer en el mercado laboral es muy bajo en comparación con el del hombre. Una proporción creciente de la fuerza laboral femenina se compone de trabajadoras no permanentes cuyos salarios son mucho más bajos que los de las trabajadoras permanentes. Esto se ve reforzado con las políticas de cuidados que no dejan a la mujer otra alternativa más que interrumpir sus carreras a la edad de entre 20 y 30 años para cuidar de sus hijos. Dado que estas mujeres ya han debido abandonar sus empleos permanentes con anterioridad, se ven empujadas hacia el cuidado de los adultos mayores cuando llegan a los 50 ó 60 años. Así, las políticas de cuidados y de empleo refuerzan el papel de la mujer como proveedora de cuidados.

En segundo lugar, los diamantes del cuidado para los adultos mayores y los niños son bastante diferentes en el Japón, debido principalmente a las diferencias en cuanto a sus objetivos de política. El objetivo enunciado del SCLP es "socializar la carga del cuidado entre los distintos componentes de la sociedad entera". Pero de acuerdo con el autor, el motivo oculto radica en cortar los desembolsos fiscales gubernamentales para el cuidado de adultos mayores. En contraste, el objetivo de política del cuidado de niños es "equilibrar el trabajo y la familia", con el fin postrero de aumentar las tasas de fecundidad y la participación de la mujer en la fuerza laboral. El resultado de estas diferencias de objetivos es que el SCLP intenta enfatizar las soluciones domésticas, mientras que la política de cuidados a la infancia enfatiza el cuidado institucional. Otra diferencia notable entre las políticas de cuidados de adultos mayores y de niños es el papel de los mercados. En el cuidado de los adultos mayores, se observa un traslape casi total de las esferas del Estado y el mercado. En efecto, sostiene Abe, el SCLP opera como solución de mercado para la carga fiscal de los servicios de cuidados prestados por el Estado. De allí que el dinero asignado a los servicios de cuidados sea recaudado (entre todos los ciudadanos mayores de 40 años) y distribuido (de acuerdo con la clasificación que hace el Estado de las necesidades de cuidados) por el Estado, mientras que la prestación de servicios es responsabilidad casi total de instituciones privadas. En contraste con lo anterior, la provisión de cuidados a la infancia se divide entre la esfera pública y el ámbito privado.

Finalmente, explica Abe, en el desarrollo de las políticas de cuidados tanto para adultos mayores como para niños, brillan por su ausencia las voces de los proveedores de cuidados, en particular de las mujeres, así como de aquellos que reciben los cuidados. En este caso, las políticas de cuidados no difieren de otras políticas sociales en el Japón, que son notablemente burocráticas.

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Introduction

Traditionally in Japan, the care needs of children, as well as those who are elderly, sick or disabled, have been met within the family.[1] As 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, although these were limited and only covered those with most intensive care needs. However, a number of social forces have made it necessary to expand the public role in providing care. These forces include changes in demography (ageing of the society), family structure (an increasing number of one-person households and households that include only elderly persons), and the labour force (an increase in female labour force participation). For elderly care, the impetus to increase the state provision of care occurred mainly because of the change in family structure. Even though the percentage of the elderly who live with their grown-up children (and their spouses) is still much larger compared to Western nations, it has decreased dramatically. An increasingly large number of the elderly either do not have children, or their children live too far away to provide care. Thus, the burden of care often falls upon the spouse—sometimes husbands, often wives—who are themselves elderly. It had soon become apparent that the ongoing welfare schemes for the elderly provided by the government were inadequate in both quantity and quality. At the same time, the current practice was costly for the government and was not financially sustainable, given the fiscal constraints faced by the government. These social changes culminated in the introduction of the Long-Term Care Insurance (LTCI) in 2000. The LTCI incorporated the market mechanism into state provision of elderly care services and 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 Japan's care provision for the elderly remain unchanged: the bulk of personal care demand is still met within the family, and overwhelmingly by a female member of the household.

On the other hand, the state provision for childcare has developed mainly as a response to declining fertility, not as a response to a decrease in potential caregivers. After all, it is rare for a child not to be taken care of, either by the mother or father, or both. Compared to Western nations, the single-parent household is still rare, accounting for around 6 per cent of total households with children (Abe and Oishi 2005). The main rationale for providing state care was that to raise fertility, it was necessary to ease the pressure of child-rearing on women, and one of the ways to do this was by encouraging women to work. Thus, the state provision of childcare was perceived as a way for women to achieve self-realization (and to increase fertility), rather than a way to provide care for children who would otherwise be without it. The declining of fertility levels—which hit a record low of 1.29 in 2004—to below replacement rates was a shock to Japanese society, and there was a public consensus that the government needed to implement policies to combat low fertility. However, the relationship between the state provision of care and an increase in fertility was never clearly connected and understood, and the policy response to childcare was executed in a half-hearted and confused manner.[2]

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[1] It should be noted that, in Japanese, there are two words for care. One is *hoiku* (rearing), which refers specifically to childcare. While children of all ages need some degree of supervision by adults, hoiku usually refers to caring for preschool children (under six years of age) who actually need someone to watch over them at all times. It is felt that children above six can usually be left alone for a few hours, at home after school, or on weekends. Nearly all the children attend nine years of compulsory education (from ages six to 15), followed by three years of secondary (non-compulsory) education. This paper will mainly discuss childcare for children under six years of age.

The other term for care is *kaigo* (meaning assistance), which refers to caring for those with intensive care needs, mostly elderly persons, but it may also include caring for disabled and sick persons (which may include children). Kaigo refers to assistance, such as helping the elderly to go to the toilet, bathing, eating, turning over (for bedridden persons), doing some non-technical procedures for medical needs (such as phlegm removal) and/or simply watching over those who are frail physically and/or mentally (for example, with dementia). Since the introduction of Long-Term Care Insurance (LTCI), some daily needs for less acutely frail persons who are living alone are also included (such as doing their grocery shopping or cooking for those who cannot do it on their own). Elderly care is getting to be a much bigger social issue than childcare 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 who are not elderly and for children.)

[2] For example, in 2004, the central government subsidy to local governments to run childcare centres was stopped, and instead a subsidy to construct "child-rearing centres" was established. A child-rearing centre is a meeting place for non-working mothers and their children to exchange information or just spend time together. It was expected that these centres would mitigate the isolation of child-rearing (and non-working) mothers.

The paper will describe the enormity of the problem of elderly care (and childcare, to a certain extent) 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 the LTCI. The paper expands on the idea of the care diamond introduced by Razavi (2007) and applies it to Japan's elderly care and childcare in order to be able to compare the two diamonds.

The outline of the paper is as follows. The first section describes the characteristics of Japan's social policy regime in order to provide some insight into the principles governing its various social programmes. The second section provides a contextual background by giving a brief description of the Japanese social policy regime, including information on the coverage and benefit incidence of key programmes, such as public pension, public health insurance and public assistance. The third section provides an overview of the elderly care problem in the country and describes state policy vis-à-vis elderly care, with special emphasis on the LTCI. The fourth section discusses the prevalent childcare arrangements in Japan and the state's role therein. The last section constructs care diamonds for elderly care and childcare and compares the two.

1. The Japanese Social Policy Regime

Japan, as a welfare state, has been analysed by scholars, both Japanese and non-Japanese. Goodman and Peng (1997) conducted one of the first analyses in English which clearly positioned the Japanese welfare state among the welfare states of other industrialized countries. They 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 1997:207).

They offer an explanation for the so-called Asian model of the welfare state (Japan, Republic of Korea and Taiwan Province of China) which differs 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" (Goodman and Peng 1997:210). For example, Japan imported the Bismarckian social insurance system, but supplemented it with theoretical ideas found in the English Poor Law of 1834 and social work practices influenced strongly by the American model. From these examples, Goodman and Peng (1997) conclude that Japanese social welfare developed from multiple sources instead of being 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 the welfare state. Some analyses have pointed out that: (i) the main force that propels the welfare system is the bureaucracy—that is, the welfare state is a product of top-down decision making, rather than a product of political forces such as the labour movement, or liberal or conservative forces;[3] (ii) even though each scheme is "mimicked" from different welfare models in an ad hoc way, the overlaying principle is the 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) ("male breadwinner model"), Sainsbury (1996) or Fraser (2000) ("caregiver parity model")—Japan can be categorized as a strong male-breadwinner, female-caregiver model. This model is

[3] Kamimura 1999; Tominaga 2001; Miyamoto 2003.

reinforced not only by dominant ideologies, but also by the weak position of women in the labour market, as will be seen 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 be necessary to introduce some changes to the current welfare model. Even though it still retains the main features and scheme that 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, a 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 can no longer be relied upon to "negate the need for social welfare" because of changing family structures. The social insurance system is on the verge of losing its universality; the coverage of occupation-based social insurance is shrinking; and default rates of premiums for the National Pension and the National Health Insurance are increasing; so that what is now emerging, therefore, is 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 replaced by "non-core" (that is, temporary and part-time) workers. Thus, fewer households can sustain a decent standard of living with just one income earner. The male breadwinner model household is no longer the norm, but is becoming a luxury. Even for core workers, corporate welfare provision—such as life-long employment, corporate housing and a generous retirement package—is drastically reduced.

The retrenchment of family and corporate welfare support means that there is a greater need for the provision of public support and social services, especially by those who are at the lower end of the income strata. However, so far this need has not been met by the expansion of public support. The government has been unable to implement necessary reforms to fill the gaps left by the retrenchment of family and corporate welfare for two reasons. The main reason is budgetary constraints. Japanese social expenditure has been increasing rapidly because of the ageing of the population. In 2002, Prime Minister Junichiro Koizumi enacted a policy to reduce the natural increase in expenditure (that is, an increase caused only by demographic change) by 220 billion yen[4] from fiscal years 2003 to 2006, and then extended this policy in 2006 to cover fiscal years 2006 to 2011 (known as the Koizumi reform[5]). This policy is still in place, and almost all aspects of social provision—including in-cash and in-kind benefits (such as old age pension, health services for elderly, public assistance, benefits for disabled persons and benefits for single mother households)—have been cut back. The second reason is the institutional constraints. Japanese welfare is designed with the assumption of strong family and corporate welfare provision. Thus, it is extremely rigid and resists the implementation of major reform that expands the state's role in social welfare. For example, social insurance schemes have created a sense of "ownership" and "rights" among their subscribers, many of whom are against the idea of providing benefits to those who have not contributed premiums, using "their" contributions.

2. Description of the Social Security System in Japan

Overview

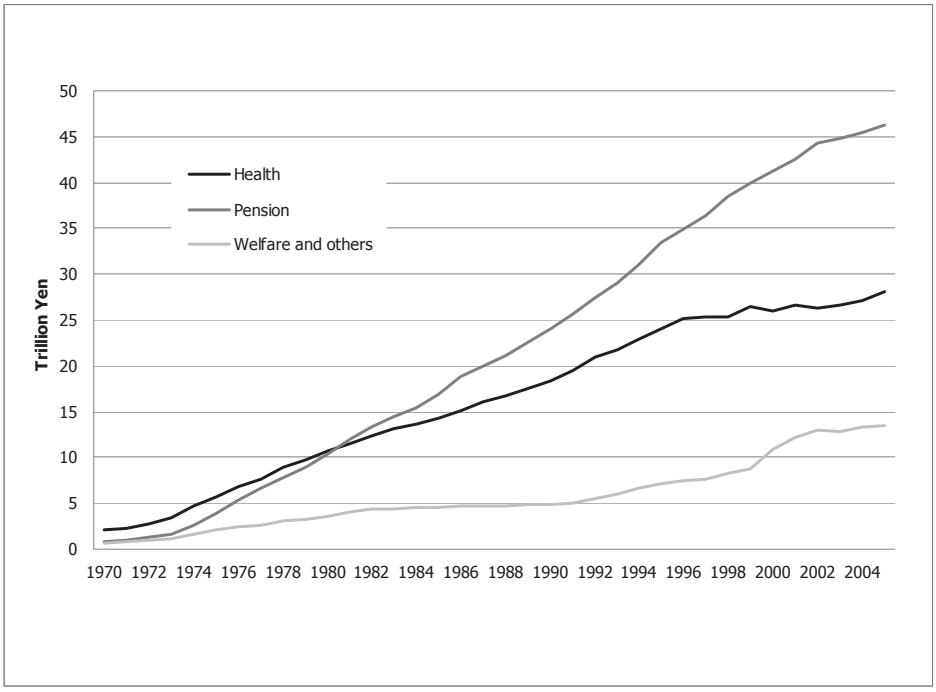
The fundamental design of Japanese social policy is a system of universal social insurance schemes supplemented by fairly small social assistance and welfare programmes. The social insurances are, as pointed out by Goodman and Peng (1997), segregated by the status of the

[4] 100 yen = $1 approximately (August 2009).

[5] The policy prioritizing budgetary restraint was relaxed in late 2008 in response to the financial and economic crisis which increased the public and the government's awareness of poverty in Japan. The trend was reinforced by the election of the Lower House in August 2009 when the main political party–the Liberal-Democratic Party–was overthrown and the Democratic Party took over the government. While it was in opposition, the Democratic Party tried to draw attention to issues of poverty and inequality, but it is still too soon to determine its policies as the leading party.

profession, yet it is a widely held notion in Japan that social insurances are universal because all citizens are covered by at least one of the following: pension (retirement, disability and survivors), health, unemployment and long-term care. Public pension and public health insurance systems take up the bulk of social security expenditure, which amounts to 24 per cent of the national income. Of this, the expenditure on public pension is 12.59 per cent, nearly half the entire social expenditure, and health insurance is a little more than one-third (7.65 per cent of national income). Others, including unemployment and long-term care insurance, and other social services, amount to 3.68 per cent of national income. Overall, social security programmes have taken up an increasingly large share of the national income (figure 1) and are forecasted to grow even more due to population ageing. In 2001, therefore, the government announced that it would curb the natural growth of social security–related expenditures, and it started to implement a series of measures to cut down the costs.

Figure 1: Social security expenditure by category, 1970–2005



Source: NIPSSR 2008.

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

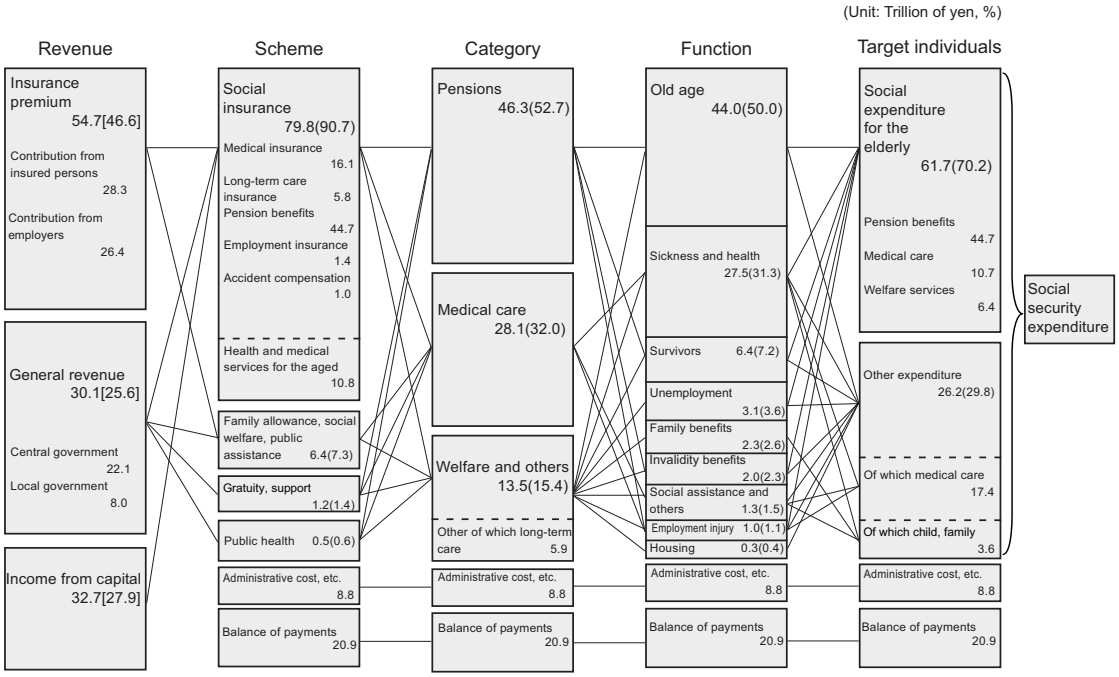
Figure 2 shows a breakdown of the social security revenue and expenditure as defined by the International Labour Organization (ILO). Insurance premiums account for nearly 60 per cent of the total revenue, and government and other contributions for the rest.

Universal coverage through the male breadwinner model

The year 1961 is a memorable year in the history of the Japanese social security system because it witnessed the start of new schemes for public pension and health insurances, which covered—at least in principle—the entire population. Prior to the new system, there were public pension and health insurance schemes, known collectively as Employees' Insurances, but they were not mandatory and covered mainly full-time and formal employees (and their spouses) 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 were not covered by the Employees' Insurances, namely the self-employed, farmers and elderly who had retired (in case of health insurance). Since women were less likely than men to be employed formally and full-time, many women who did not have a formally employed partner also subscribed to the National Pension and the National Health Insurance.[6]

Figure 2: Social security expenditure by revenue, scheme, category, function and target individuals, fiscal year 2005



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 2008.

Since 1981, most women were, and continue to be, covered by the Employees' Insurances. This is because the Employees' Pension Insurance and Employees' Health Insurance not only cover the workers (typically men) but also their dependent spouses, and in the case of health insurance, other dependants as well (children, and elderly parents who are financially dependent on the worker). Since the premium is a fixed rate of the salary, it is not contingent on the number of dependants that the worker may have. The system creates an incentive for a woman to become (or remain) a housewife. If the woman decides to work, she will no longer be her husband's dependant since, according to tax laws, a person cannot be another's dependant if he/she earns more than 1.3 million yen per year. She will therefore have to pay premiums of her own. Similarly, the tax policy reinforces women's secondary role in the workforce through the preferential income deduction for spouses.[7] In this respect, the social insurance scheme strongly embodies and reinforces the male breadwinner model. Not only does the social security system in Japan reflect social reality (in a society where many families conform to the male breadwinner model), but it also is a driving force that perpetuates this type of family structure.

[6] In order to qualify for coverage by Employees' Insurances, one had to work a minimum of 30 hours per week.

[7] A spouse who earns less than 1.03 million yen is given a special income deduction in her/his spouse's income tax.

From a gender perspective, one advantage in introducing universal social insurance is that it has become 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. Indeed, persons who have been dependants of the spouse (known as category 3) are entitled to the same pension as National Pension subscribers (known as category 1). This is so even if the dependant is widowed or divorced (if the dependant divorces before the age of 60, she/he would have to pay the premium for the remaining years until 60).

Incorporating the poor into social insurance schemes

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

First, there were concerns that the poor were not able to pay the premiums because of the regressive premium structure. The premium for the National Pension is a fixed sum for all subscribers regardless of their incomes. The premium structure for the National Health Insurance is partly based on the subscriber's income, but mostly on the number of dependants in the household regardless of incomes. Thus, as a percentage of income, premium rates (the premium amount divided by income) are much higher for poor households than for rich households (that is, the premium structure is regressive). This regressive premium structure had been designed mainly for the state to know the exact income of the self-employed who were supposed to constitute the biggest pool of subscribers to National Pension and National Health Insurance, since the state suspected that sometimes income was not reported. This, in turn, meant that those whose income was really low might not be able to pay the premiums, even though it was likely that they would benefit in the long run. Thus, a scheme was introduced where, for qualifying recipients, the premium was reduced or exempt: the poor were incorporated into the scheme, but their pension benefits were also reduced accordingly. For those with either long periods of exemption, or without a continuous record of premium payments, the pension was not enough to bring them out of poverty when they grew old. This is one of the main reasons for the high rate of poverty among elderly women. The pension amount, when combined with the husband's, is usually adequate, but when a woman loses her husband or has never married, the pension is most likely to keep her below the poverty line.

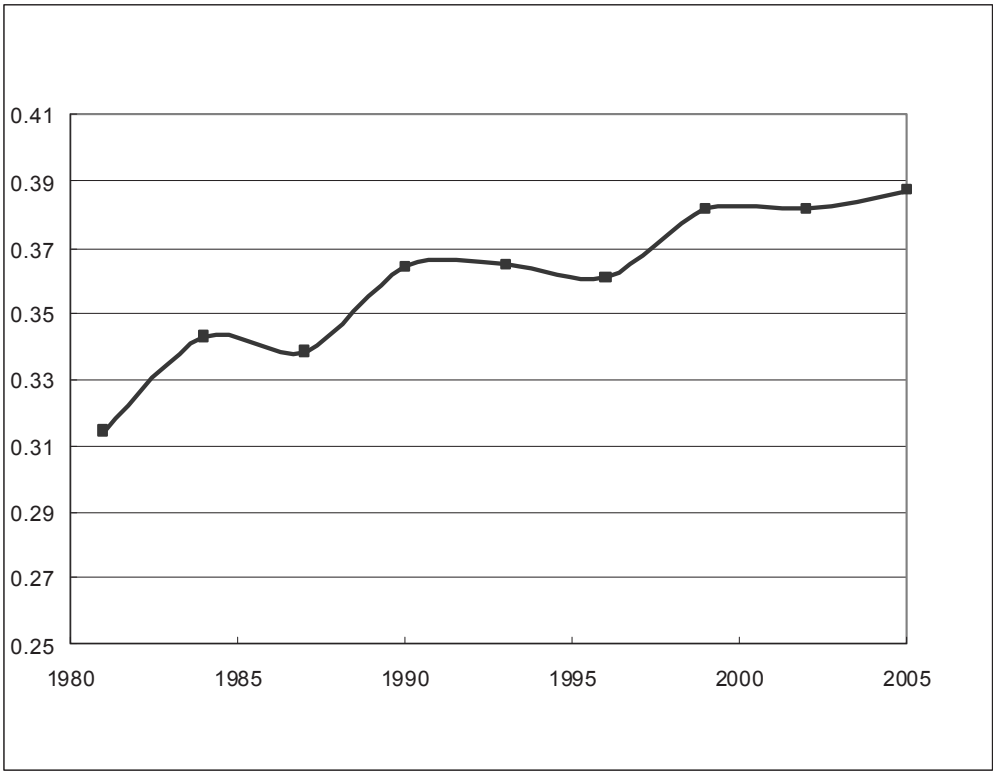
Effectiveness in fighting poverty and inequality

Even though the national pension could not cover the entire living cost of the elderly, it was expected to reduce poverty, which was seen mainly as a problem of the elderly. In any case, poverty and inequality did not surface on the political agenda during the 1970s or 1980s, because of the two-digit growth rates of the Japanese economy and rapidly rising living standards. It was 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 2001). Consequently, social programmes became more universal, and their main target shifted from the disadvantaged to the middle class. The effectiveness of social policy in fighting poverty and inequality was never questioned, and poverty was "forgotten" (Iwata 2007).

When the bubble economy burst in the mid-1990s, rising income inequality became a social issue. The Gini coefficient increased rapidly in the 1990s and into the 2000s (figure 3). The official statistics, for example, from the Ministry of Health, Labour and Welfare (MHLW), show that the Gini coefficient increased from 0.314 in 1980 to 0.3812 in 2001. This is a big increase, making Japan one of the most unequal countries, ranking next to the United States among the countries of the Organisation for Economic Co-operation and Development (OECD). In the 2000s, poverty also became an issue. While there is no official poverty line, and thus no official poverty rate in Japan, some estimates by scholars using the nationally sampled surveys are available (for example, Abe 2006). Table 1 is an estimate of the poverty rate for Japan from the 1990s to the early 2000s by Abe (2006), using 50 per cent of median equivalized income as the

poverty line. The poverty rate among elderly persons is higher than the rest of the population, although it stabilized at around 20 per cent in the 1990s. In contrast, the poverty rate for children and the working-age population has been increasing.

Figure 3: Inequality trends, 1981–1999 (Gini coefficient)



Note: "Redistributed income" is the market income minus taxes and net social security transfers, including in-kind benefits (health care, institutionalization and so on). **Source:** MHLW 1981–1999.

Table 1: Poverty rate by age group, 1984–2002 *(per cent)*

	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 (per cent of poor among the population in that age bracket)							
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 mainly on social insurance programmes. More than 70 per cent of social security expenditure, as seen in figure 2, goes to the elderly population. Thus most of the fiscal transfer is intergenerational, that is, it occurs from the working-age population to the

elderly population, and not from the rich to the poor. Also, the benefits through social insurance schemes are not necessarily progressive. They 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 as much as those who are richer, do not receive as many benefits (for example, pension benefits, although health service benefits are supposedly equal). Need-based benefits are given in the form of limited means-tested benefits, such as the Public Assistance and Child-Rearing Allowance, but the levels are set very low.

The pre-transfer and post-transfer poverty rates of some OECD countries (table 2) demonstrate the Japanese social security system's ineffectiveness in reducing poverty. Pre-transfer poverty rates refer to market-income poverty, before tax and social security premiums are levied and before benefits, such as pensions and child allowances, are assigned. Post-transfer poverty rates refer to disposable income poverty, after tax and premiums are deducted and benefits received. According to table 2, while Japanese social policy is fairly effective in reducing the poverty among the elderly (from 61.9 per cent to 22 per cent), it is dismal in the case of people who are of working age (from 16.4 per cent to 12.3 per cent), and actually increases the poverty rate among children (from 12.8 per cent to 13.7 per cent).

Why is Japan's social security system allowed 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 for inequality or poverty reduction programmes. Due to population ageing, social outlays continue to rise, and the government has prioritized curbing the natural increase of these outlays. Prime Minister Koizumi 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. This led to the 2002 Koizumi Reform mentioned earlier. Second, there is an academic controversy on the cause of the rise in inequality. Some researchers claim that the rise in inequality is a natural consequence of population ageing and therefore is not a real "inequality".[8] Many politicians and bureaucrats have become involved in this debate, making it difficult to achieve a consensus about what should be done.

Third, and probably the most important reason, is that Japanese society—both politicians and public alike—believe very strongly that Japan is an egalitarian society. This notion is quite widespread in Japanese society, mainly due to a well-publicized public opinion survey in the 1970s, known as the Social Stratification and Mobility Survey. The survey coined a popular phrase, "100 million all middle-class (*Ichioku So Churyu*)" (Murakami 1984). It was in keeping with the general opinion at a time when Japan was experiencing phenomenal economic growth without a worsening of income inequality. However, inequality started to rise in the 1980s and continued to do so well into the 2000s. While Japan's Gini coefficients are currently the highest among OECD countries (OECD 2008), many people prefer to believe that Japan is an equal society and has overcome poverty. It came as a big surprise when organizations such as the OECD pointed out that Japan's poverty rate was the fourth highest among the OECD countries. This lack of awareness clearly hampered social discussion on the reform of the social protection system.

[8] See Ohtake (2005) for an extended discussion on this.

Table 2: Poverty rates of OECD countries before and after tax and transfers *(per cent)*

		Children (0–17)		Working Age (18–65)		Elderly (65+)	
	Year	Before	After	Before	After	Before	After
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
Ireland	2000	24.9	15.7	18.8	11.9	68.4	35.5
Israel	2005	15.8	8.3	13.0	7.0	71.9	5.0
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
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
Republic of Korea	2005	12.2	10.2	13.9	11.7	55.1	45.1
Slovak Republic	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.

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, daycare centres for children and the elderly, and social services for the disabled and unemployed, are mostly provided by private institutions. 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

listed in table 3 should give readers an insight into the extent of the coverage. Because it is impossible to describe all of the programmes and schemes, this section will describe briefly some of the programmes more closely related to care.

Table 3: The social security system in Japan

	Cash transfers (cash benefits)		Social services (in-kind benefits)	
To whom	**What is provided**	**Scheme**	**What is provided**	**Scheme**
Sick	–	–	Health services (70 per cent coverage)	Public health insurance (Employees' Health Insurance and National Health Insurance)
Elderly	Old-age and survivor's pension	Public pension (Employees' Pension and National Pension)	Institutional and home care for the frail elderly (70–100 per cent coverage)	Long-Term Care Insurance and services for the elderly
Disabled	Disability pension	Public pension (Employees' Pension and National Pension)	Institutional and home care services for the disabled (70–100 per cent coverage)	Long-term Care Insurance and services for the disabled
Poor	Livelihood support	Public assistance	Health and care services	Public assistance
Unemployed	Unemployment benefits	Employment insurance	Employment services	Employment insurance
Children	Child allowance	Child allowance	Daycare centres for preschool children	Daycare centres (*Hoikuen*)

Social services, with an emphasis on 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 dependants, with both employers and employees contributing a fixed percentage of the employee's salary. Housewives, children and elderly parents (and even sisters and brothers) who are economically dependent 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 scheme, called the National Health Insurance, for which the municipalities act as independent insurers. These include the self-employed, farmers, workers in smaller firms and their families, with participants tending to overlap with those of the National Pension. A portion of the premium for the National Health Insurance is based on income, but is largely 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 dependants of those who are subscribers to the National Health Insurance are also covered effectively, since the subscription is by "household", not by "individuals" (that is, either the entire household is covered or none of its members). However, the premium increases with the number of dependants 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 cost. 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 more economically disadvantaged than men. The premium rate, which is the share of the premium payment from income, is notably higher for the National Health Insurance compared to the Employees' Health Insurance. Single women are much more likely to be covered by the National Health Insurance, rather than the Employees' Health Insurance. Further, there are larger numbers of National Health Insurance subscribers who fail to pay their premiums. In 2008, this figure rose to 19 per cent of all National Health Insurance subscribers (MHLW 2008a). If these subscribers fail to pay premiums consecutively for a few years, their health insurance card will be withdrawn.

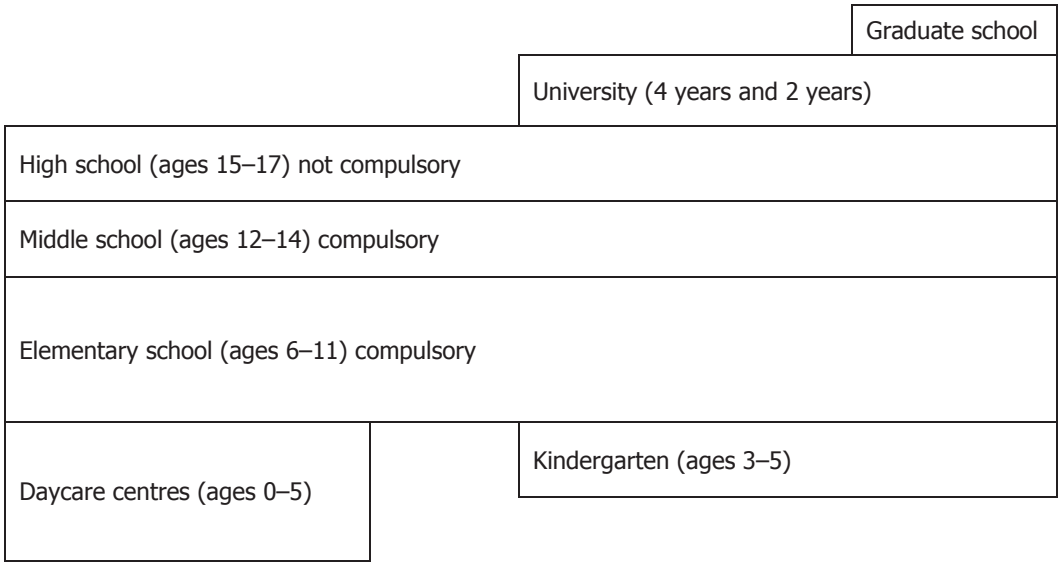
The relevance of public health insurance to the problem of care is its treatment of elderly persons and their care needs. Retired persons are expected to subscribe to the National Health Insurance of their residing community. However, this has put serious financial pressure on the National Health Insurance, since the elderly are overrepresented among its subscribers, and their medical costs are much higher than those of working-age persons. Thus, a financing mechanism has been put in place to transfer some of the funds from occupation-based Health Insurance to National Health Insurance. Despite this, it is apparent that the rising cost of medical services for the elderly could bankrupt the National Health Insurance. One of the big components of the rising cost was long-term care. To rectify this problem, the government introduced a mandatory Long-Term Care Insurance (LTCI) in April 2000, which will be described later in the paper.

Education and care services for children

This section will give a brief overview of the Japanese education system, focusing on the education system for children above six years old. The childcare system (up to ages five or six—until entry into elementary school) will be discussed in later sections.

The Japanese education system consists of nine years of compulsory education (six years in elementary school and three years in middle school). High school, which is not compulsory, is another three years. Further studies comprise four years of university or two years of junior university or graduate schools (see figure 4).

Figure 4: Japanese education system



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, in principle, free of charge but there are some costs such as school

lunch fees and extracurricular activities (school outings and so on) for which municipalities provide grants for children from poor households. Besides public schools, there are numerous private schools which are expensive. All children between ages six to 15 go to either a public school (financed and run by municipal governments) or a private school (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 per cent, and it drops to 92 per cent for the middle school level (table 4). Children of wealthier families tend to go to private schools more often than children of poorer families (although there are no statistics available).

Table 4: Number and share of public schools by children enrolled

	All schools	Public	Private	Share of public (per cent)
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	569,763	1,935,122	23

Source: Statistics Bureau website, www.stat.go.jp/data/nihon/22.htm.

Even though free and compulsory education is available up to middle school, most children choose to go on to high school. Currently, nearly 95 per cent of all students enrol in high school upon graduating from middle school. The high schools are both public (operated by municipality, prefecture and state) and private (financed privately). Currently, about 70 per cent of all high schools are public (table 4). While tuition fees tend to be lower in public schools than in private schools, the financial burden on households is heavy even when children are enrolled in public schools, as there are few scholarships and student loans provided by the state. Some high schools are more occupation-oriented (for example, technical and engineering schools), while others are preparatory schools for university education.

About 50 per cent of high school graduates go on to higher education, either for two or four years of university. Japan is one of the countries with the highest rates of education in the world. Fifty-three per cent of 25–34 year olds attain tertiary education—the second highest next to Canada (54 per cent) (OECD 2007). However, university enrolment varies according to household incomes. Universities are both publicly and privately run. Public universities make up about 23 per cent of the total (table 4). As in high schools, the tuition is quite expensive, even for public universities, and most of the cost is borne by the parents, and not by the state or any other public source.

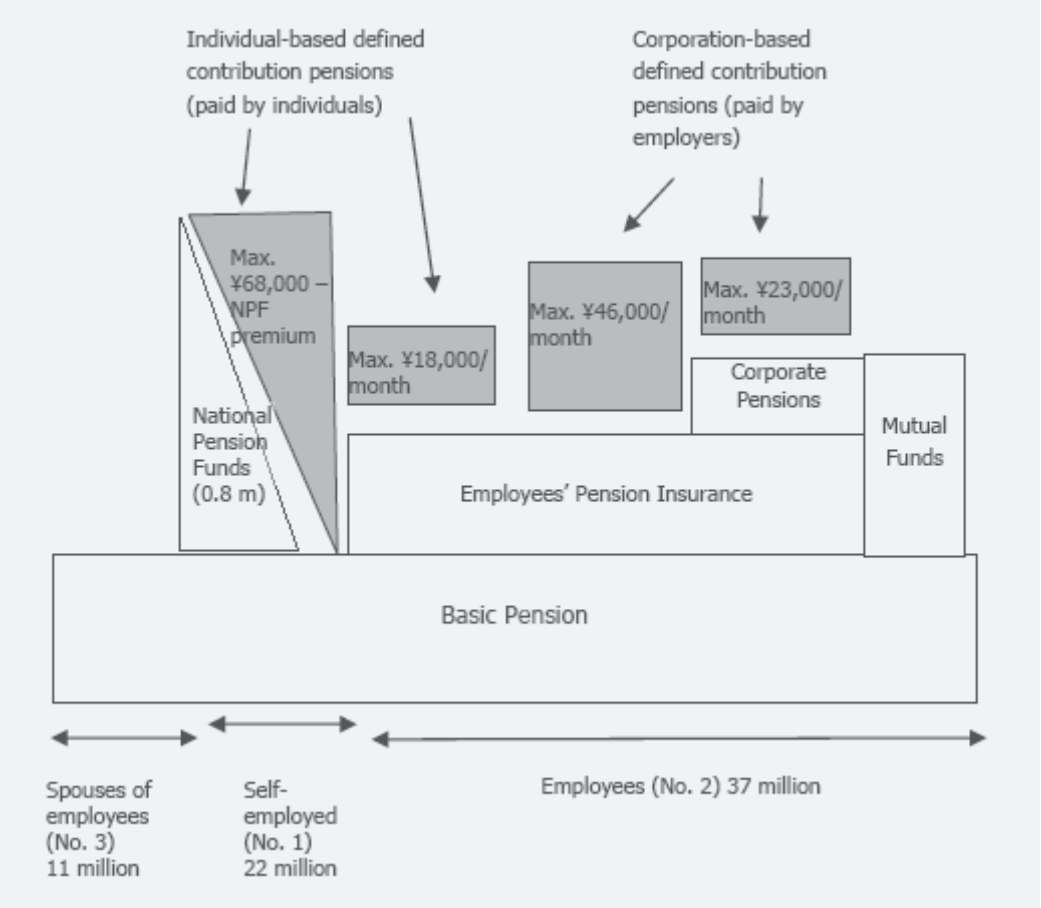
Cash transfers (especially pensions, unemployment and child allowances)

Pensions

The Japanese pension system is multitiered, consisting of public and private pension schemes (figure 5). The first tier is the Basic Pension (*Kiso Nenkin*), which provides the flat rate basic pension with universal coverage. As a non-income-related pension, it aims to provide a basic income guarantee for 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 structures. Its provision is mandatory for all firms over a certain size, and the premium is shared between employers and employees. The first- and the second-tier pensions are operated publicly, that is, by the state. 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 and covers employees (known as category 2) and their spouses (known as category 3) (see figure 5).

Figure 5: Pension system in Japan



Note: Shaded boxes indicate optional defined-contribution pensions. The amount shown in the box is the maximum premium. Numbers in parentheses are numbers of subscribers. Nos. 1, 2, and 3 denote categories of subscribers: no. 1 is for the self-employed, farmers, students and so on; no. 2 is for employees; and no. 3 is for their spouses. (All numbers are as of March 2005.)
Source: MHLW 2006c.

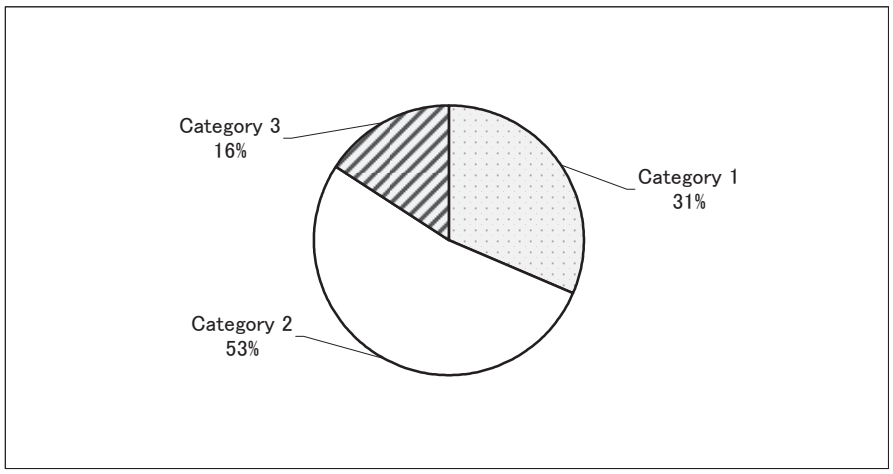
Similarly, the Basic Pension for the self-employed, farmers and the unemployed (known as category 1) is called the National Pension (*Kokumin Nenkin*), which is operated by municipalities (and thus known as regional-based pension). The civil servants have a separate scheme called Mutual Aid Pensions, which covers both the Basic Pension portion and the income-related portion. The entire adult population, in principle, is insured either by the Employees' Pension Insurance, the National Pension or Mutual Aid Pensions. Currently, only about 1 to 2 per cent of the eligible population fails to participate in the Basic Pension, and 96 per cent of all persons aged 60 and over receive the Basic Pension. Thus the scheme has achieved near-perfect universality.

For the Employees' 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. It also covers the premium for the employee's dependent spouse (that is, if the spouse does not earn more than 1.3 million yen a year). If the spouse dies or gets divorced before the age of 60, the dependent spouse would have to pay the premium until she/he reaches retirement age.

All those not covered by the Employees' Pension have to subscribe to the National Pension. A fixed amount (13,860 yen per month in 2007) is levied on each subscriber as a premium. There is no provision for a dependent spouse, so those with dependent spouses will have to pay twice the premium. However, those with low incomes (about 15 per cent of subscribers in 2004) and the non-working spouses of employees are partially or entirely exempt from paying premiums.

The pension benefit (old age, survivors and disability) for category 2 subscribers (the employees themselves) is indexed according to the amount of their previous salaries and years of contribution (and thus the premium amount paid). The pension benefit for category 3 (dependent spouse) and category 1 (National Pension subscribers) is the same fixed amount (Basic Pension), regardless of the spouse's previous salary. This is because the premium levied is fixed for category 1, while there is none for category 3. The pension benefit amount is much more generous for category 2 compared to categories 1 or 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 the full amount of the Basic Pension because they do not fulfil the required minimum years of contribution (40 years). Most elderly poor are in categories 1 and 3.

Figure 6: Basic pension subscribers by category, 2005



Source: MHLW 2006c.

Employment insurance

The Employment Insurance covers labour-related accidents and periods of unemployment, as well as some training schemes. Unemployment benefits are by far the most significant portion of the scheme. For general employees, it is necessary to have been insured for at least six months of the year prior to leaving the job. The duration of the benefits varies according to the age of the beneficiary and the years of having been insured. Since April 2001, the duration of the benefits also depends on the reason for unemployment, for example, whether the termination was voluntary (including for 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 six months.

Table 5: Duration of basic allowance for those whose employment was involuntarily terminated

	No. of years of being insured[a]				
Age of beneficiary	**Less than 1 year**	**From 1 year to less than 5 years**	**From 5 to less than 10 years**	**From 10 to less than 20 years**	**More than 20 years**
Under 30	90 (90)	90 (90)[b]		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 who have difficulties in getting employment (for example, the disabled)					
Under 45	150		300		
45–64	150		360		
Under 30	(150)		(240)		
30–64	(150)		(270)		

Notes: [a] Unit: days. [b] Numbers in parentheses are for part-time workers.

Table 6: Duration of basic allowance for general employees

	No. of years of being insured[a]			
	Less than 5 years	**From 5 to less than 10 years**	**From 10 to less than 20 years**	**More than 20 years**
General	90	120	150	180
Short-term	90	90	120	150

Notes: [a] Unit: days.

Child allowances

This is an area which has seen significant reform in the past few years. The new interest in reforming welfare for children is spurred mainly by concerns over low fertility, estimated in 2005 to be at 1.26. Previously, Child Allowance was granted to parents (or guardians) who were raising children under three years old and whose income was less than a specified amount. Since 2000, the age limit has been raised to six years, then to nine years and in 2008, to 12 years. The income threshold has also been raised. Thus the Child Allowance today covers close to 90 per cent of children under 12. The allowance is 5,000 yen per month for the first two children, and 10,000 yen per month per child for subsequent children, except for children under three for whom the amount is 10,000 yen. The financial burden of the Child Allowance for children up to three years old is borne by employers, and central, prefectural and municipal governments, but the expansion of the scheme in the last few years has been completely financed by the central government.

Table 7: Number of child allowance recipients and expenditure, 2004

	Number of recipients	**Number of children covered**	**Expenditure** *(unit: million yen)*
Total	7,473,761	9,644,674	593,336
Employee	4,935,807	6,337,127	387,372
Non-employee	1,932,029	2,500,727	155,747
Public servants	605,925	806,820	50,217

Source: Kose Tokei Kyokai 2004.

Child-Rearing Allowance (for single-parent families)

Although the number of single-parent families is increasing rapidly, they still constitute a minority in Japan, especially single-father families. About 6 per cent of children are being raised in single-mother households (Abe and Oishi 2005). These households are the most vulnerable: their poverty rate is estimated to be about 60 per cent (OECD 2008).

The Child-Rearing Allowance is a means-tested cash benefit programme for single-mother households (which raise a child under 18 years old and who do not share a common household income with the father of the child).[9] It is estimated that about 80 per cent of single-mother households receive this benefit.[10] The monthly allowance is 41,880 yen for the first child, a supplementary 5,000 yen for the second child, and another 3,000 yen for each additional child (2006). This amount is not enough for any family to live on. As a result, most 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, at around 85–90 per cent (Abe and Oishi 2005). However, due to their disadvantaged position in the labour market (especially since they have children), it is difficult for them to get a full-time permanent job. Thus, even though they receive Child-Rearing Allowance in addition to their salary, their economic situation remains bleak.

The Child-Rearing Allowance is one of the first targeted programmes to be reformed to cut down costs. In 2002, its reform stipulated that—from April 2008—the government may reduce the amount of the benefit by up to 50 per cent after a single mother has been a recipient for five years. The idea behind this reform was to convert the benefit from an entitlement into a temporary assistance during the first phase of being a single mother, after which it is expected that she would become self-sufficient. The assumption was that single mothers would gain enough experience to achieve self-sufficiency after five years, and various schemes of job training were put in place. However, there was a strong outcry against the reform from single mothers, and the introduction of the time limit was postponed in 2008.

Public Assistance (Seikatsu Hogo)

Enacted in 1950, the Public Assistance scheme 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 charge. To qualify for Public Assistance, the applicant must meet very strict means and asset tests. The law states that the Public Assistance scheme must only come into effect when an applicant's best efforts and available resources are spent. In other words, the applicant 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 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 these assets is higher when they are utilized than when they are sold. Household goods such as a television set are allowed if the diffusion rate of the goods is more than 70 per cent in the region. The bank deposit must also be lower than half the minimum cost of living for one month.

As for ability, an applicant will not be able to receive assistance if he/she is considered to be capable of working. If the person has the 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, Public Assistance is given only after it is judged that this support is not available.

In 2004, nearly 1 million (998,000) households or 1.4 million persons (1.1 per cent of the population) received some type of public assistance (monthly average). The share of the

[9] There is, in fact, a strong gender bias in the programme setting, since the Child-Rearing Allowance is only for single-mother and not single-father families.

[10] In Japan, about one-third of single-mothers live with their parent(s) and form three-generation households. These households are not eligible to receive Child-Rearing Allowance. The figure is only for those families that consist only of a mother and her children.

population receiving assistance had been declining until 1995, but since then there has been a continuous rise. Among those receiving assistance, elderly households make up the largest share, accounting for 46.7 per cent 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 per cent. About 8.8 per cent are single-mother households, and the rest, 9.4 per cent, 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 per cent 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) to illustrate the enormity of the problem in Japan.

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 rising rates of women's participation in the labour force, taking care of the elderly within the family has become more difficult. With the advance of medical technology which allows individuals to live longer, the care for the elderly can often last for several years. Many of the elderly are bedridden and need extensive care throughout the day, making it difficult for their caregivers to engage in other activities, such as employment or even leaving the house. This situation has been derogatorily termed "care hell (*kaigo jigoku*)" by the media—a term that captures the seemingly never-ending nature of the hardship that caregivers sometimes undergo.

Table 8 captures some of the basic statistics of care (kaigo) in Japan. (The caring of healthy children is not considered kaigo and is not included in the statistics.) In 2004, about 7.5 per cent (3.47 million) of all households had at least one member[11] who was over six years old and needed "help and/or watching over", totalling 3.57 million persons[12] (MHLW 2007a: table 8). Of these, single-person households comprised 17.5 per cent and couple-only households 18.8 per cent. 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 are men. Most of them—84.2 per cent—are elderly (above 65 years old). Women represent a higher share of those needing care simply because of their higher life expectancy (79 years for men, 86 years for women in 2006; MHLW 2008a) and the fact that the proportion of frail persons increases sharply with age, especially when they are in their 70s and 80s. Nearly 27 per cent of them are bedridden and need day-to-day-care, and 12.8 per cent of them need help in eating, excretion and changing.

On the other hand, those who provide care are mostly family members. Spouses make up the largest number of main care providers (28 per cent), followed by children (25.4 per cent) and their spouses (18.1 per cent). Professional care providers comprise only 9.9 per cent, 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 per cent of the main care providers live with the person in need of care while about 11 per cent live separately. The gender of the main care providers is overwhelmingly female (71.8 per cent), and many of them are themselves elderly or nearly so. Those who are in their 50s comprise 29.1 per cent, those in their 60s 26.9 per cent, and those over 70 years old 26.2 per cent.

[11] The break-down of 7.5 per cent according to the number of frail persons is not available.

[12] It should be noted that this number does not include those who are in institutions on a permanent basis.

Table 8: Overview of care (kaigo) needs in Japan for those over six years old[a]

	No. of households *(thousands)*	**Per cent**
Number of households with care (kaigo) needs	3,477	7.5 (per cent of all households)
Type of household		**Per cent of all households with care needs**
Single-person	610	17.5
Couple only	654	18.8
Couple and unmarried children	405	11.6
Single parent and unmarried children	229	6.6
Three generations	911	26.2
Other	668	19.2
	No. of persons *(thousands)*	**Per cent of people requiring care**
Number of persons requiring care	3,569	–
Male	1,343	37.6
Female	2,226	62.4
Degree of care needs[b]		
Requires care but can manage most daily activities on their own	1,136	31.8
Manages most inside activities on their own, but cannot manage without care outside	1,206	33.8
Requires care for most activities inside, but can manage to sit up straight	501	14.0
Bedridden all day, requires care for eating, excreting and changing	457	12.8
Age of the person requiring care[b]		
6–39 years old	218	6.1
40–64 years old	345	9.7
65–69 years old	241	6.8
69–74 years old	396	11.1
75–79 years old	592	16.6
80–84 years old	705	19.8
Above 85 years old	1,071	30.0
Total of those above 65	3,005	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
Main carer's living arrangements[b]		**Per cent of all carers (family)**
Living with person cared for	2,594	89.0
Living separately	319	11.0
Sex of main carer		
Male	809	27.8
Female	2,092	71.8
Age group of main carer living with person cared for		**Per cent of total**
Total	2,594	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

Notes: [a] Excluding childcare of healthy children, but including care for sick and disabled children above six. [b] Excluding those for whom this information is not available. **Source:** MHLW 2006b.

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 are themselves old; over one-quarter are aged above 70, indicating the "old caring for older" phenomenon.

Institutional care provision for the elderly

However, the above statistics (table 8) only take into account 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 9 shows the number of persons who were in institutional care facilities in 2006. In sum, 0.78 million persons were in institutional care facilities in 2006, a slight increase from previous years (MHLW 2007b). In addition, some elderly are living in care homes and private nursing homes. It should be noted that all three types of institutions in table 9 are public, and their service charge is determined by the government, according to the income status of the patient and his/her family's income and assets. Since the introduction of the LTCI, usually there is a 10 per cent co-payment (user fee) on all services, including institutional services.[13] On the other hand, user charges for private nursing homes are borne entirely by the patient and the patient's family.[14]

Table 9: Number of persons in institutional care facilities, 2006

	No. of persons
Care welfare homes	392,547
Care elderly health institutions	280,589
Care hospitals	111,099
Total	784,235

Source: MHLW 2007b.

Comparing the numbers in tables 8 and 9, it can be deduced that about 17 per cent of those who need care are in institutions, while the rest receive care while living at home. If only those who require assistance in day-to-day living are counted ("Bedridden all day, requires care for eating, excreting and changing", and "Requires care for most activities inside, but can manage to sit up straight"), about 950,000 persons are being cared for at home, while around 780,000 persons are in institutions, such as those in table 9. Thus, it is roughly estimated that about half the intensive care needs are met outside the family.

Even though the overwhelming share of care needs of those staying at home is met within the family, there is still a demand for care provision outside the family. In many cases, the main care provider within a family is supplemented by professional care providers for a few hours a day or a few days a week. Table 10 shows the total number of those who used this kind of professional care services in 2004–2006. Professional care provision can either be 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 visiting care services and daycare facilities. It should be noted that one person can use more than one type of service.

As in the case of institutional services, the user of these services usually has to pay 10 per cent of the cost, and their use is strictly restricted by the LTCI.[15] The mix of services (such as the frequency of the visiting service and visits to daycare centres) is determined by the LTCI's care managers after consulting with the user and taking into consideration what is available within the locality.

[13] When the person is on Public Assistance, the government bears the entire cost.

[14] 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.

[15] If the user decides to go over the maximum amount of services stipulated by the LTCI, he/she will have to bear the entire cost.

Table 10: Number of persons using care services *(as of September each year)*

	No. of users		
	2004	**2005**	**2006**
Those who are primarily living at home			
Visiting care services			
Care	972,266	1,090,112	882,556
Bathing service	67,208	67,288	62,219
Nursing service	274,567	279,914	281,160
Daycare facilities			
Daycare	995,903	1,097,273	955,506
Rehabilitation services	439,754	461,687	412,044
Elderly care 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
Regional special services			
Visiting night service	–	–	51
Daycare centres for dementia	–	–	37,017
Small-scale multipurpose home services	–	–	1,643
Group homes for dementia	70,161	94,907	115,644
Special institutions	–	–	396
Special care facilities for the elderly	–	–	878
Home service care management	2,083,382	2,264,525	1,889,213

Source: MHLW 2006b.

Table 11 provides data on the share of those requiring care (and living primarily at home) who make use of professional care services. It shows the usage pattern of professional care services by household type and by type of service. In total, 73 per cent of all those who need care have used some kind of professional care service in 2006. The utilization rate is higher for single-person households (87 per cent), 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 per cent), suggesting that even when there are multiple household members, as in the case of three-generation households, it is rare that all the care needs are met entirely within the family. The visiting service is utilized more in single-person households, and relatively less in three-generation and other households, which tend to use daycare services more often.

Also notable from table 11 is that almost all care provision is received through the LTCI or other government programmes (Welfare for the Elderly, Public Assistance) and only about 1 per cent of the care provision is purchased, using only private funds. Unlike in some developed and developing countries, hiring a private nurse at home to take care of the elderly or the sick is very rare in Japan.

Table 11: Utilization of professional care services, 2004 *(for every 100,000 persons requiring care)*

			Type of household											
	Total	**Per cent**	**Single person**	**Per cent**	**Nuclear**	**Per cent**	**Couple only**	**Per cent**	**Three generation**	**Per cent**	**Other**	**Per cent**	**(Of which) elderly[a]**	**Per cent**
Total	*100,000*		*18,917*		*32,054*		*21,360*		*29,146*		*19,883*		*41,175*	
Use professional care service	73,131	73	16,449	87	21,877	68	14,921	70	20,475	70	14,331	72	32,040	78
Visiting	54,159	54	14,187	75	17,050	53	11,540	54	13,554	47	9,368	47	25,872	63
Daycare	38,876	39	5,549	29	10,105	32	6,319	30	13,886	48	9,336	47	12,521	30
Short-stay	10,019	10	635	3	1,902	6	1,343	6	4,301	15	3,181	16	2,522	6
Meal	6,729	7	3,001	16	2,625	8	1,933	9	494	2	609	3	4,977	12
Assistance to go out	3,448	3	847	4	1,281	4	894	4	932	3	388	2	1,645	4
Laundry and other	1,499	1	574	3	695	2	544	3	180	1	49	0	1,076	3
Do not use professional care service	26,869	27	2,469	13	10,178	32	6,439	30	8,671	30	5,552	28	9,136	22
Public service only	29,673	30	10,414	55	10,684	33	7,165	34	4,815	17	3,760	19	17,131	42
Private service only	998	1	189	1	363	1	232	1	294	1	151	1	428	1
Mix of public and private	2,303	2	836	4	987	3	763	4	213	1	267	1	1,563	4

Note: [a] An elderly household is one in which all members are aged 65 and over. **Source:** MHLW 2006b:table 21.

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 13 families, with as many as 960,000 persons who require assistance in day-to-day activities 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 the frail elderly within a family instead of placing them in institutions. However, this practice is becoming increasingly difficult due to the three social forces described below.

One of the main forces is rapid demographic change, called *Korei ka*, that is, the ageing of society. The population over 65 reached 20.1 per cent in 2005, nearly four times the rate in 1960 (5.7 per cent), as shown in table 12 (NIPSSR 2009). There are simply fewer young people to care for a growing number of the elderly. From 1971 to 2006, the total fertility rate of Japanese women fell from 2.16 to 1.32, which means that there will be fewer children to care for ageing parents. In some cases, one person (often a woman) may be responsible for caring for up to four ageing parents, her/his own and those of the spouse.

Table 12: Population composition by age group

Year	Age group (per cent)		
	0–14	15–64	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

Note: The percentages do not always add up to 100, due to rounding. **Source:** NIPSSR 2009.

Another social force 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 per cent in 1975 to 22.4 per cent in 2006 (MHLW 2007a, see table 13). In the same period, households with only an elderly couple (both being 65 years old and above) increased from 6.2 per cent to 22.5 per cent. On the other hand, the prevalence of three-generation households decreased from 54.4 per cent in 1975 to 20.5 per cent in 2006, and this

kind of household is now no longer the most prevalent household type for the elderly. In 2006 nearly one-half (46.1 per cent) of all households containing elderly members had no working-age household member (MHLW 2007a).

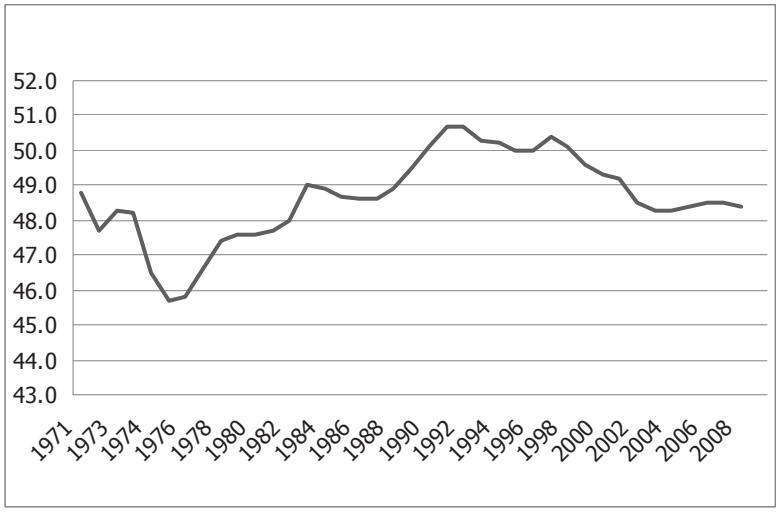
Table 13: Types of households with at least one person above 65 years *(per cent)*

	Type of household							
		Couple only						
	Single-person households	Total	One of them above 65	Both above 65	Couple and unmarried children	Lone parent and unmarried children	Three-generation	Other
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	8.0	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	5.0	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	7.0	22.5	9.9	6.2	20.5	11.4

Source: MHLW 2007a.

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 with the rise of Japanese industry. However, from the late 1970s to the 1990s, it started to increase again because 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 grow. Perhaps this conflict may be one of the reasons why the female labour force started to decline in the 1990s and also why part-time work among women increased so rapidly during the same period. In any case, these forces have reduced the availability of care resources within the family.

Figure 7: Female labour force participation rate



Source: Statistics Bureau Labor Force Surveys.

Population ageing has also provoked a budgetary crisis among social security systems, putting a serious strain on government resources. The absolute amount of social services provided for the elderly, as well as health and pension expenditure for this segment, has increased dramatically. Since the main pillars of Japanese social security systems are social insurances, run on a pay-as-you-go basis, population ageing has led directly to financial strains. In order to meet the increased demand for the elderly population, the government has been 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. These social changes culminated in the introduction of the LTCI in 2000.

Introduction of the LTCI

In 2000, the government introduced the LTCI. The LTCI's purpose was the "socialization of care": sharing the burden of elderly care among all members of society. It aimed to establish a system that responds to society's major concern about ageing, and to assure citizens that they would receive care, if necessary, and be supported by society as a whole. The system was based on the German model.

The LTCI covers the long-term care of the elderly and the disabled. Prior to the introduction of the LTCI, the government provided social services to those requiring elderly (and other) care at minimal or no charge (funded by the general budget), but on a scale much smaller than the LTCI. The programme providing institutional care, Welfare for the Elderly (see table 14), is still in place, but its size has been significantly reduced and its recipients have been moved to the LTCI. It is a means-tested programme for elderly persons with intensive care needs, who are living alone and with limited assets and low income. The institutions are public, and the municipality decides who is eligible to enter.

Table 14: Differences between new and old care systems

	Old care system		New care system
	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 and over and those between 65 and 70 with disabilities	Those aged 65 years and over and those between 40–64 who are subscribers of medical insurance
Eligibility for service	Care needs and conditions of family structure, income and so on	Care needs	Care needs
Co-payment	According to ability to pay	530 yen per visit, 1,200 yen per day of hospitalization	10 per cent 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: Nishimura 1998.

In addition, a significant number of the elderly were occupying hospital beds—even though they did not need day-to-day medical services—because they could not be taken care of outside the hospital by their family. This is termed "social hospitalization", and medical services provided were covered by the Insurance for the Elderly (see table 15), which is the public health insurance for the elderly. It is basically the same as the National Health Insurance for the non-elderly, but the co-payment is much lower and takes the form of a nominal fixed fee. Social hospitalization was creating a huge financial problem for the health insurance system, since a

stay in a hospital with full medical staff and services is quite expensive.[16] The co-payment is low, and the health insurance pays for most of these medical expenses.

As stated in the introduction, demographic change, transformed family structures and women's involvement in the formal labour market have created a demand for more state involvement in elderly care. However, the driving force behind the enactment of the LTCI was not the mobilization of people's or women's movements but the bureaucracy's own budgetary concerns. Social hospitalization was a major drain on governmental resources because it cost much more to care for someone in a hospital than provide care services in less formal settings (at home or in a care home). The social services (such as Welfare for the Elderly) were essentially free of charge to users, while the government—especially the municipalities—bore the main responsibility for providing social services, which meant rising fiscal outlays. 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 2000b). The shift from social services to social insurance was a way of expanding elderly care provision while reducing the financial pressure on the public outlay. From the government's point of view, it was a strategy to (i) collect more revenue in terms of premiums, and (ii) introduce co-payment in care services and thereby restrain care demand. Given the state of the budgetary crisis and population ageing, it was presented to the public as the only way to expand the provision of care services, which were badly needed.

An overview of the LTCI

The LTCI is a mandatory social insurance programme, like the public pension and public health insurance. All persons aged 40 and above must subscribe to this insurance regardless of their care needs. Those who are aged 65 and over are referred to as category 1 and those between ages of 40 to 64 are referred to as category 2. For category 2 subscribers, the premium is levied as an add-on to public health insurance. Thus, if a person (who is a full-time and permanent employee of a large firm) is subscribing to Employees' Health Insurance, the premium amount is a fixed rate (from 0.8 to 0.95 per cent) of the salary, which is added to the premium for the health insurance. If a person (who is either self-employed, or a farmer, retiree or part-time employee of a firm) is subscribing to the National Health Insurance, the premium is a fixed amount (on average about 3,000 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 Employees' Health Insurance subscribers are automatically covered by the spouse's premium. Women who are not married and those who make more than 1.3 million yen per year have to pay their own premiums either to the National Health Insurance or the Employees' Health Insurance.

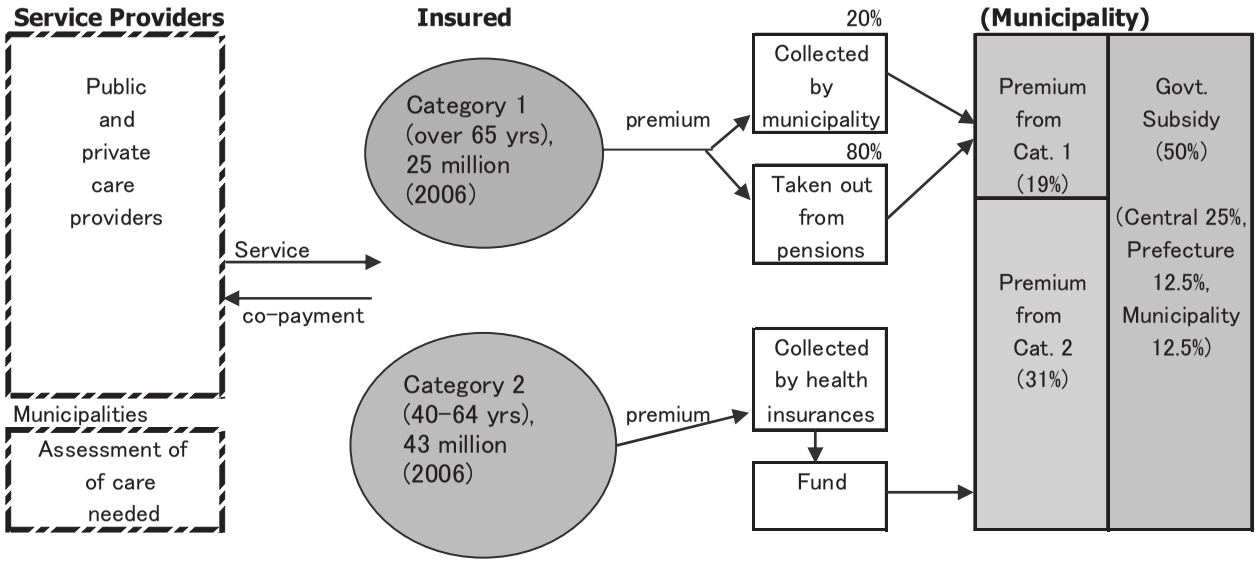
For category 1 subscribers, the premium is collected differently. Since most of the subscribers are already retired and receiving pensions, the premium is deducted from the pension payments. Currently, about 27 million persons are subscribed under category 1 and about 43 million under category 2 (as of April 2006). This number translates to nearly 100 per cent of the population in the respective age groups.[17]

Overall, the cost incurred by the LTCI is financed by premiums, government subsidies and co-payment. Apart from the co-payment, which can range from zero to 30 per cent according to the income level, the cost is financed 50 per cent by premiums (19 per cent by category 1, 31 per cent by category 2) and 50 per cent by government subsidy. The overall financing mechanism of the LTCI is shown is figure 8.

[16] Even though they may not require intensive medical procedures, the expenses are almost as high as those of other patients, since the cost for an overnight stay, for example, is the same in both cases.

[17] There are a few cases where subscription to the LTCI is not required, such as for those in prison and those living abroad.

Figure 8: Long-term care insurance



Source: Kenko Hoken Kumiai Rengokai 2006.

Subscribers can receive care services at a reduced price if they are above 65 (category 1), and after their care needs have been assessed by the municipality. To receive care service, the applicants first have to get an assessment of their needs from the municipal government. When the LTCI was first introduced, the assessment by the municipality was divieded into five levels, but was later revised to seven. A public health professional conducts an interview with the person in question and the family to determine the person's ability to conduct everyday activities and then determines the care level. According to the assessment level, a ceiling of maximum care service is determined. Then in consultation with care managers appointed by the municipal government, the person selects the combination of care services he/she will receive. These care services can then be bought from private care providers. The person is free to choose the kind of care and its providers, and up to 90 per cent of the service fee is paid by the insurance (that is, the co-payment is 10 per cent).

A list of care services is shown in table 15.

Table 15: 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
Bathing	
Nursing	Long-term care at health facilities for the elderly
Rehabilitation	
Out-patient rehabilitation	Long-term care at medical care facilities at a sanatorium
Medical care management counselling	
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: Kenko Hoken Kumiai Rengokai 2002.

The LTCI and the poor

There has been much debate about the additional burden of the LTCI on the poor. Before its introduction, services covered by the insurance were often offered by municipalities as part of their welfare services either free or at a nominal charge. The LTCI, in contrast, now requires those above 40 to pay additional premiums and co-payments. Even though the premium amount is set according to the income level, it has been considered too high for many elderly people in the lower income strata. To reduce the burden on the poor, several municipalities have introduced premium exemption systems for the elderly poor, despite the Ministry of Health, Labour and Welfare's notice, which has stated that such a measure would seriously undermine the insurance principle underpinning the system. For example, some municipalities set up six levels of insurance premiums for subscribers aged 40–65, as opposed to the government recommendation of five levels.

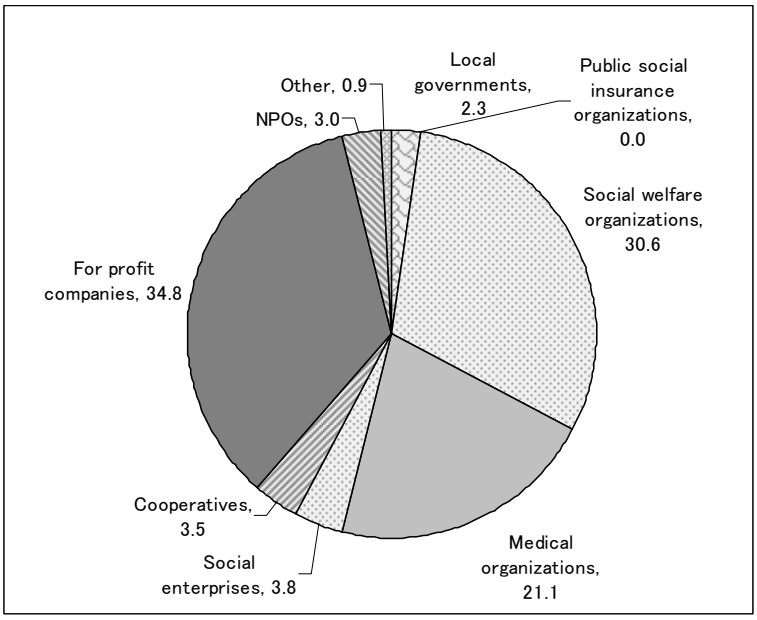
Delivery of care services

So far, this section has described the financing of long-term care through the LTCI. Given the large government subsidy injected into the system, it is clear that the state plays an important role in financing of long-term care. This section will now look at the delivery of long-term care services. What is the public role in delivering these services?

The home care service providers are mostly non-profit organizations, such as social welfare and medical organizations, and social enterprises and cooperatives. However, these organizations are different from volunteer or community ones. Even though they are non-profit, they charge and operate in the same way as for-profit organizations, and most of them do not have a community base. Since it would be misleading to treat them as community organizations, this paper will consider them as private market suppliers. They receive special tax treatments and other preferential arrangements from the government, which makes their operations more advantageous than those of the for-profit organizations. Less than 3 per cent of the service providers are directly run by local governments. About one-third are run by for-profit organizations, that is, 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 whether public or private organizations provide the service. Even for privately-run service providers, the government regulates the market. It sets the standards for care services, and levies service fees if the care is to be paid out of the LTCI. As stated earlier, almost all care services are financed through the LTCI, which effectively means that private service providers have no say in how much they can charge the users (this is also true 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 non-profit organizations make up 3 per cent.

Figure 9: Types of home care providers, 2006



Source: MHLW 2006a.

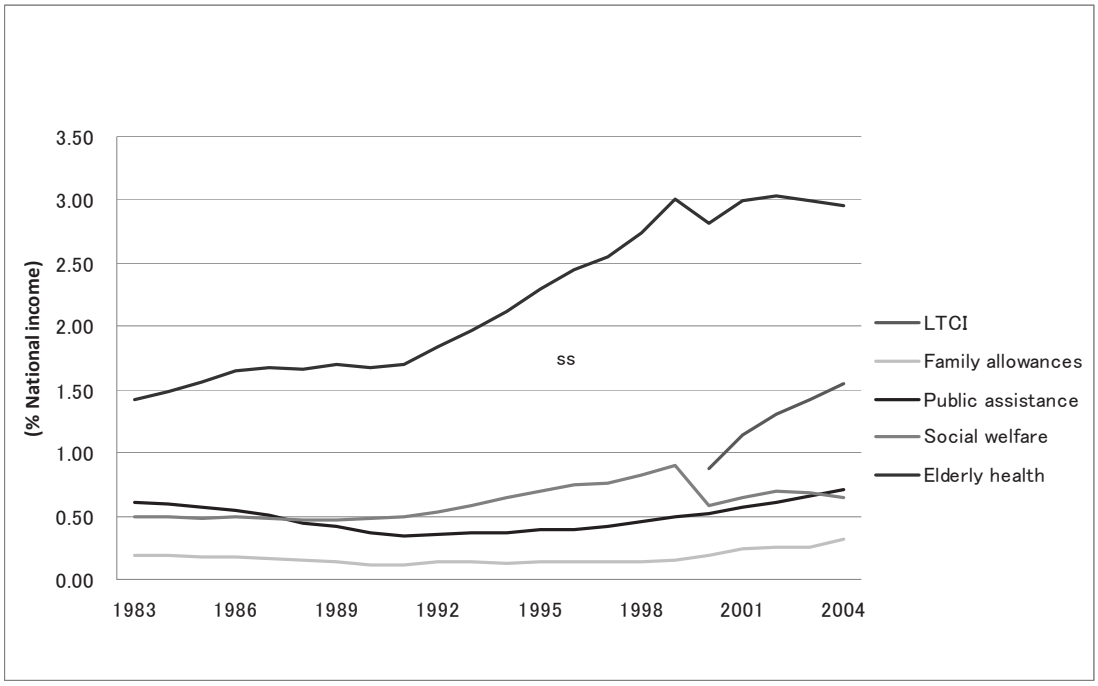
Impact of the LTCI on government outlay

From the government's perspective, the main purpose of introducing the LTCI was to cut down the public cost of elderly care. But soon after its enactment, it has become evident that the initial financial arrangement was not enough to meet the cost of long-term care. The number of care recipients grew from 1.49 million (0.52 in institutions and 0.97 in home care) in September 2000 to 3.29 million (0.78 in institutions and 2.51 in home care) in April 2005. The financial outlay grew steadily from 3.6 trillion yen (2000) to 7.1 trillion yen (2006 estimate) (figure 10). As in figure 10, even though the increase in spending for elderly health insurance and social welfare

(including elderly welfare) was suspended after 2001, it was more than offset by the increase in spending on the LTCI.

Further, the baby boom generation will start to become elderly in 2015. With such financial pressure, the LTCI has been reviewed and several reforms have been put in place five years after its enactment. One of the main reforms was the change in "care need" classification. In the LTCI, all potential service users must first be classified by the government according to how intensive their care needs. Then the amount of care services is "allocated" for each user according to the severity. The bulk of the increase in care services (after the LTCI was introduced) was due to the increase in users with "less severe" care needs, that is, those who did not use any care services earlier, but started to use them after they were covered by the LTCI. Thus, the government's intention was to restrict the use of care services for these people. In order to do so, the reform increased the number of categories of "severity" from 5 to 7, and what was the lightest case (severity 1 = needs modest care) is now subdivided into two categories which are now called potential need 1 and potential need 2 ("May need assistance in future" categories). Those in these categories who are no longer eligible to receive care services, but are instead encouraged to prevent further deterioration of their condition (for example, by exercising, swimming and counselling, which are offered in local care management centres).

Figure 10: Public social spending on certain programmes



Source: NIPSSR website, www.ipss.go.jp.

The impact of the LTCI on care provision for the family

While the government's real motive for introducing the LTCI was financial, the reason given to the public was that it would mitigate the care burden borne mainly by the family, and typically by the women, by introducing market-based solutions. After all, the idea of social insurance is to share the risk of heavy care needs among the entire population and pool their resources (that is, premiums) so that families are able to buy care services at reduced costs. The public, therefore, expected that the LTCI would achieve this goal, and one of the first questions to be asked was whether the care burden of families had been reduced after the LTCI's introduction.

The answer to this question is not easy. First, in order to evaluate the policy impact, it would be necessary to construct a quasi-experimental framework for analysis or at least a panel survey

where the care provision before and after the introduction are measured. However, such data is extremely rare. Second, even when the data is available, it is necessary to control for time variant variables. For example, a family may increase the amount of services it buys from professional care providers, but the condition of an elderly family member may deteriorate over that same time period, with the result that the care burden on the family does not actually change.

There have been some empirical studies that examine the impact of the LTCI, and control for such changes. A study by Shimizutani and Noguchi (2004) used quasi-panel data in which about 1,000 families with one elderly member needing daily care provision were asked how many hours the main caregiver spent in caring for the elderly person before and after the introduction of the LTCI (table 16).

Table 16: Change in extremely long care provision by family[a] (*per cent)*

	More than eight hours	More than 10 hours	More than 12 hours
Around 1999	25.6	18.67	10.24
April 2000	25.58	19.38	10.34
April 2001	23.57	18.65	10.04
October/November 2001	21.86	16.03	9.65
October/November 2002	23.02	16.55	10.07

Note: [a] Households with all data available only. **Source:** Shimizutani and Noguchi 2004:169: 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 eight hours a day) on caring for the elderly (including daily chores, such as washing clothes and bed linen, preparing meals, bathing, and/or simply watching over them). There has been a slight decrease in the share of households spending so much time between 1999 and 2002. The share of households that spend more than eight hours decreased from 25.6 per cent to 23.0 per cent, and those that spend more than 10 hours also decreased, from 18.7 per cent to 16.6 per cent. A multivariate analysis reveals that there is a 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 16, the decrease is fairly small, and a significant number of households still spend extremely long hours on caregiving. The relatively minor effect of the LTCI may be due to the fact that the data was collected soon after its introduction, and the service provision had not really taken off. The care provision under the LTCI has increased dramatically since 2002, and the effects now (in 2009) may be more significant.

4. Policy for Childcare *(Hoiku)*[18]

Childcare system for preschool children

Childcare and educational institutions for preschool age children in Japan can be classified into three types: (i) licensed daycare centres, (ii) non-licensed daycare centres and (iii) kindergartens. The number of childcare and educational institutions by type is summarized in table 17.

[18] This section of the paper reproduces, with significant updates, the report by Yoshimi Chitose (2003) "Child care system in Japan" in a booklet by the National Institute of Population and Social Security Research (NIPSSR), entitled *Child-Related Policies in Japan*, with the author's permission.

Table 17: Number of daycare centres and enrolled children

	Number of centres	Number of enrolled children	Per cent of enrolled children
Licensed daycare centres[a]	22,624	2,118,079	100
Public	11,752	1,006,544	48
Private	10,872	1,111,535	52
Non-licensed daycare centres[b]	6,694	181,627	100
In-house daycare centres	1,007	20,866	11
Baby hotels	1,525	38,121	21
Other	4,162	122,640	68
Kindergarten	13,835	1,726,520	100
Public	5,469	342,301	20
Private	8,366	1,384,219	80

Notes: [a] as of 1 October 2005. [b] as of 1 October 2006. **Source:** Nihon Hoiku Kyokai (Japan Child Care Association) 2009.

Daycare centres, regardless of whether they are licensed, provide full-day centre-based care for preschool children up to six years old. Differences between licensed and non-licensed daycare centres lie in standards and availability of government subsidies. Licensed daycare centres may be public (operated by the 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 MHLW. These standards cover mostly structural items, such as the child-staff ratio and the space available per child. If the centre complies with these regulations, a large share of its running costs are subsidized by local governments. As of April 2008, there were 22,909 licensed daycare centres in Japan. A total of 2.02 million children, or 31 per cent of preschool children in Japan, are enrolled in licensed daycare centres. More than half of these centres are under the direct management of local governments (and are therefore public), while the rest are managed by private organizations—mostly non-profit social welfare organizations. Licensed daycare centres, regardless of their public or private status, are subject to regulations and have little freedom in management. For example, the municipality's local welfare office decides who should be admitted, or how much the users should be charged. Usually the admission criteria are based on an assessment of the family's childcare needs, including the mother's working status and the household structure. The fee structure for licensed daycare services is uniform within a municipality, regardless of the type of service provider, but differs according to the 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 they can be as high as 60,000 yen per month per child. The fees tend to be lower for older children, and are progressively structured so that poor households pay less than well-to-do households.

In contrast, the majority of non-licensed daycare centres are operated either by private organizations or individuals and fill the gap left by licensed daycare centres. In fact, many parents use non-licensed daycare centres as a stopgap until their child is admitted to a licensed daycare centre, as many of the latter—especially in metropolitan areas—have long waiting lists. Others use non-licensed daycare because the services provided by licensed ones are not suitable (in terms of opening hours, for example). Many non-licensed daycare centres provide services in the evenings, while most licensed daycare centres are only open until 6 p.m. Some corporations provide daycare services for their employees as a part of the benefit package. More than a third (37 per cent) of non-licensed centres are in-house or childcare facilities located within firms established by employers for employees with children, for example, in-hospital daycare 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 per cent of the centres are so-called baby hotels.[19] The rest are generally small-scale daycare centres operated by not-

[19] The baby hotels are defined as childcare facilities that meet at least one of the following criteria: (i) the provision of childcare services during the night, or (ii) where more than half of the children are non-regular users.

for-profit and profit organizations. Baby hotels and other non-licensed daycare centres are strictly private. Because non-licensed daycare 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 daycare centres do not fulfil the minimum standards set by the government, since many of them are much smaller. Regarding the quality of childcare for child development, it is said that some non-licensed daycare centres provide high-quality care services comparable to or even higher than that of licensed daycare centres. On the other hand, some non-licensed centres, such as baby hotels, provide very low-quality care. The much-publicized death of a child in 2000 in a non-licensed daycare centre in Yamato city, a suburb of Kanagawa prefecture, provoked a wide public outcry for strengthening government regulation of childcare standards, even for non-licensed daycare centres. Non-licensed centres are said to be the best in terms of flexibility of services, which is why some mothers working full-time choose to leave their children there.

Another major concern regarding non-licensed daycare centres is the fee. Because these centres do not receive government financial support, the fees charged 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 educational services for preschool children aged three to six years old. Because kindergartens are considered as educational facilities, the Ministry of Education, Culture, Sport, Science and Technology is in charge of running them. Kindergartens can be public or private. Public ones tend to be smaller than private ones: about 40 per cent of kindergartens are public, yet only 20 per cent of children attending kindergartens go to a public one (Nihon Hoiku Kyokai 2009). Public kindergartens usually charge lower fees, varying between 6,000 to 7,000 yen per month, while private kindergartens 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 either do not work 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 daycare centres.

Childcare arrangements: Enrolment rates

Table 18 outlines the primary childcare arrangements in the daytime according to the mother's working status. According to the results, 44.6 per cent of working mothers use licensed daycare centres, and only 4.9 per cent use non-licensed daycare centres. For households with working mothers, grandparents also play an important role as caregivers, especially when the child is under a year old. In contrast, 68.3 per cent of non-working mothers take care of their children themselves. Kindergartens account for 16.4 per cent of childcare arrangements of all preschool children, but the ratio is lower for employed mothers (13 per cent). 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 flexibility to adjust their working hours than other working mothers do. Table 19 demonstrates the primary care arrangement by age of the youngest child. In short, the younger the child, the less likely it is that the child will be in a daycare centre, and the more likely it is that the mother will be the main carer of the child. For instance, only 4.3 per cent of children under one year are in licensed daycare centres, compared to more than 30 per cent of children older than three years.

Table 18: Primary childcare arrangement by mother's working status[a] *(per cent)*

			Working		
Type of arrangement	**Total[b]**	**Not 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 centres	19.8	7.2	44.6	48.8	34.6
Non-licensed daycare centres	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	99.9	100.0	99.9

Note: 34 per cent of mothers are working, and 24 per cent of working mothers are salaried workers. [a] (%)N=3,781. [b] The percentages do not always add up to 100 due to rounding. **Source:** Oishi 2002.

Table 19: Primary childcare arrangement by age of the youngest child[a]

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 centres	19.8	4.3	12.8	17.8	31.3	31.5	32.5	23.9
Non-licensed daycare centres	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

Note: [a] (%)N=3,781. **Source:** Oishi 2002.

Table 20: Household income by primary childcare arrangement *(million yen per annum)*

Type of arrangement		**Household income**	**Household income, EQV adjusted**	**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 centres	Average	6.79	2.23	4.07	1.45
Non-licensed daycare centres	Average	7.20	2.54	4.88	1.57
Kindergartens	Average	7.36	2.52	6.05	0.53

Note: Equivalent value (EQV)-adjusted income = (average household income)/EQV, where EQV=1+0.7 x (number of adults-1)+0.5 x number of children. **Source:** Oishi 2003.

Table 20 summarizes the economic situation of the household by the type of childcare arrangement used. Household income is lowest for those using licensed daycare centres when adjusted by an equivalence scale. On the other hand, household income for those using non-licensed daycare centres or kindergartens tends to be higher, not only in absolute value but also in the relative value of income adjusted by an equivalence scale. Regarding the incomes of mothers and fathers, it is clear that fathers using licensed daycare 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 the 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 the mothers' contribution: mothers using licensed daycare centres earn 1.45 million yen on average, while mothers using kindergartens earn 0.58 million yen. In fact, the median income of mothers using kindergartens is zero, because most of them are not working.

Table 21 compares the working status of parents using licensed and non-licensed daycare centres. For both fathers and mothers, the largest share is in full-time employment in both types of daycare centres, but the percentage of those working full-time is higher for parents using non-licensed daycare centres. For example, while 41.3 per cent of mothers using licensed centres are working full-time, nearly half (47.7 per cent) of those using non-licensed centres are working full-time. For fathers, nearly 80 per cent of non-licensed users are working full-time, while 72.8 per cent of licensed centre users are working full-time. There are also other differences in the mother's working conditions by type of childcare arrangement used. 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 daycare centres are working full-time suggests the greater flexibility of these centres (in terms of working hours, for example). Non-licensed centres also function 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. Consequently, many unemployed mothers face a dilemma: without childcare facilities they are not able to look for a job, while licensed daycare centres rarely admit their children. Because the priority of admission to licensed daycare centre is placed on the need for care, there is a greater number of single-parent families using licensed centres.

Table 21: Working status of parents by type of daycare centre[a]

	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
Not available	0.7	1.4	0.9	1.7

Note: [a] (%)N=26,978. **Source:** MHLW 2000a.

Government policy for childcare

Because of the financial difficulty caused by the two oil crises, government childcare-related spending declined sharply during the early 1980s. It was not until 1989, when the total fertility rate of Japan registered as the lowest on record, that the government began to allocate more resources to childcare services. Along with the declining birthrate, the national budget allocated for licensed daycare centres has been on the increase, reaching 407 billion yen in 2002. However the ratio of childcare spending to gross domestic product (GDP) (0.08 per cent), continued to be below the level in the early 1980s. In addition, as will be explained below, only a small portion of total daycare expenditure is financed by the national budget.

Who bears the childcare costs?

The running cost of licensed daycare centres in Japan is extremely high. Although there is no national-level data on the detailed breakdown of childcare costs, labour is obviously the largest item in overall expenditure of licensed daycare centres in many municipalities. For example, in Chiyoda-ward, Tokyo, the share of labour cost amounted to 80 per cent in the financial year 2000. Because many of the licensed daycare centres in Japan were established in the 1960s and 1970s, and because most child minders of public daycare 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 childcare-related expenditure for licensed daycare centres in 2001 amounted to 1,600 billion yen, or 0.32 per cent of GDP. These expenditures are shared by the central and local governments and by users. Specifically, 50 per cent of the deficits (cost minus user fees) are covered by the national budget, 25 per cent by the prefecture budget, and 25 per cent by the municipality budget. It needs to be emphasized that although the central government (MHLW) set a standard expenditure criterion for licensed daycare centres, many municipalities have been infusing additional funds to reduce the burden on users and subsidize labour costs of daycare centres by hiring temporary staff and improving benefits of child minders. When additional subsidies from municipalities are considered, the total operating expenses for licensed daycare services could exceed 2 trillion yen.[20]

Childcare and women's labour force attachment

As seen above, even though there are several childcare options available to women in Japan, the labour force participation rate of women in their child-bearing age remains low. As in the Republic of Korea, Japanese women's labour force participation rate is "M-shaped": it drops when they are in their late 20s and early 30s and are typically caring for preschool children (figure 11).

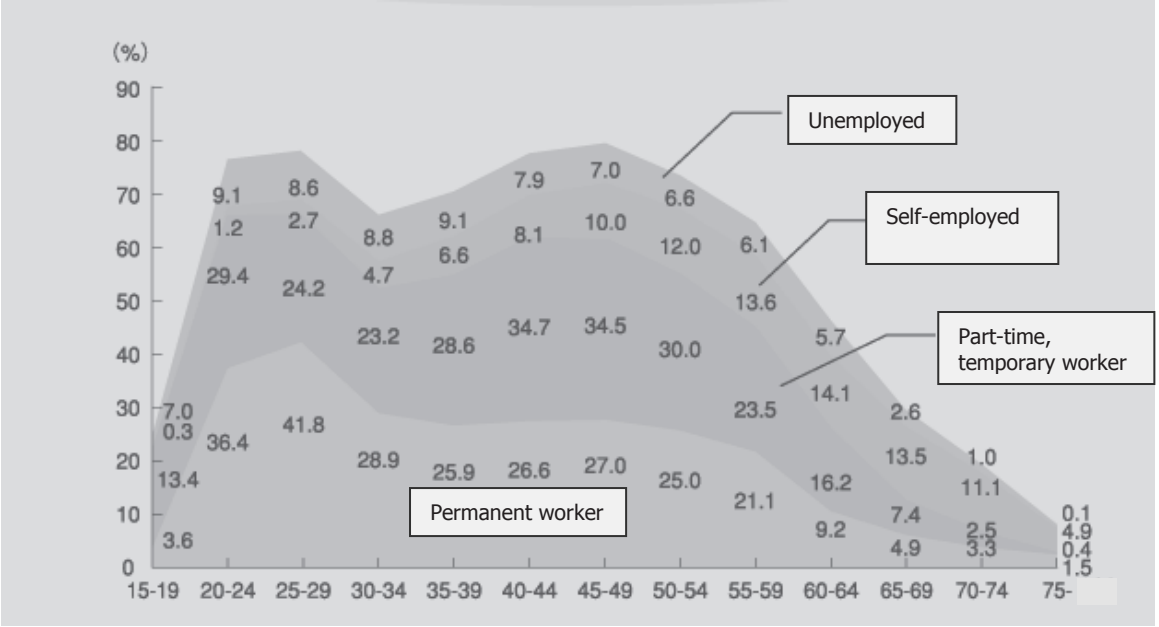
The reason for the M-shaped curve is quite clear. Women tend to quit work first at marriage, and then after the birth of their first child. As shown in figure 12, nearly half of the women who have had full-time permanent jobs leave work after marriage, and again, nearly half of those who retained full-time work quit the labour force after the birth of their first child. Thus, the percentage of non-working women increases from 8.2 per cent before marriage to 72.1 per cent after the birth of their first child.

Why do they quit work? Table 22 shows the results of a multiple-answer survey conducted by the Japan Institute of Labour Policy and Training (JILPT) in 2003. According to this survey, more than half of surveyed women wanted to take care of their children personally. At the same time, many also raised the difficulty of balancing work and family obligations. For example, 23.3 per cent of women said that "it was impossible to raise children due to work and commuting hours". Another 17.9 per cent say that "maternity leave was not available". This suggests that even if childcare arrangements are available, the job makes it impossible for women to choose to raise children while working. These expectations include long working hours, long commuting time, and uninterrupted work (no maternity leave). There are also concerns about the quality of work itself. A total of 22.8 per cent of women say that "the work

[20] Fukuda (2000) estimates that the total operating expenditures of licensed day-care centres in 1998 may have been around 2,000 billion yen, or 0.4 per cent of GDP in that year.

was not worth continuing", and 8.9 per cent say that their "income was too little to pay for daycare centres". Parental leave is also not well utilized. It is mandatory for employers to give eight weeks off to female workers who have just given birth. Many large corporations also have parental leave where mothers and fathers can take up to a year off (including the eight weeks of mandatory leave) at 40 per cent of salary. However, small corporations are exempt from these regulations, and the law does not cover non-regular (non-permanent) workers, which includes more than 50 per cent of the female labour force. Also, there is considerable pressure on women, and especially men, not to take the full year off. The take-up rate of paternity leave is abysmally low at 1.56 per cent, while that of maternity leave is 89.7 per cent of those eligible (2007 data, MHLW 2008b). Some suggest that this is because enforcement of these family-friendly policies is weak, and that the government uses "administrative guidance", rather than sanctions and punishments, to encourage employers.

Figure 11: Female labour force participation rate, by type of work



Source: Cabinet Office 2006.

Table 22: Reasons for quitting work after childbirth

Reason	Per cent
Wanted to take care of the children myself	53.6
Was not sure I could 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 to place children in daycare centres	21.5
For health reasons	19.9
Maternity leave was not available	17.9
Could do without the extra income	16.9
No family member to help	13.7
The income was too little to pay for daycare centres	8.9
The work place did not approve	8.3
No daycare centres available	6.4
Could not get support from husband and family	5.7
Others	4.7

Notes: The respondents were 614 women who gave birth during 1992–2001 and subsequently quit work. **Source:** JILPT 2003.

Figure 12: Working status of women

Note: Among 4,647 women who had been married for at least 5 years and given birth and were married between 1995–1999. **Source:** NIPSSR 2002.

As the M-shape in figure 11 shows, many women do return to work when their children are a little older. However, when they decide to return to work, they can usually only get part-time or temporary work which tends to be paid at a much lower rate than permanent work. Figure 11 shows that the increase in female labour force participation in the 30 and 40 age groups only happens among part-time temporary workers, and not among those who have permanent work.

5. The Care Diamond: Elderly Care and Childcare

This section will explain the relationship of state, market, family and community, using the care diamond diagram developed by Razavi (2007). It is apparent that the two very different policies for elderly care and childcare mean that the care diamond for elderly care is quite different from the care diamond for childcare. However, both policies reflect the gender-biased and unrealistic expectations from women regarding their labour force participation and provision of family care.

For both elderly and childcare, the gender inequality in care provision is still strong. About 70 per cent of family caregivers for the elderly are women (an overwhelmingly large percentage of professional caregivers are also women). Even though the time-use analysis by Tamiya and Shikata (2009) shows that the family care provision by women decreased marginally between 1996 and 2001, the family care provision by men remained almost the same, and the care is still unequally divided, with women taking on a disproportionate share of the burden. Women are also the ones who quit work to take care of their children.

One of the main reasons for this is that the "value" of women's time in the labour market is still low compared to that of men. It rarely pays for a woman to take up a job and utilize professional care services to take care of the elderly or pay for public, let alone private, child daycare services. Women in the labour market rarely earn enough to cover the costs of hiring a full-day-caregiver or of putting the elderly person in an institution. For elderly care, the average user charge for institutional care is about 80,000 yen per month even at 10 per cent co-

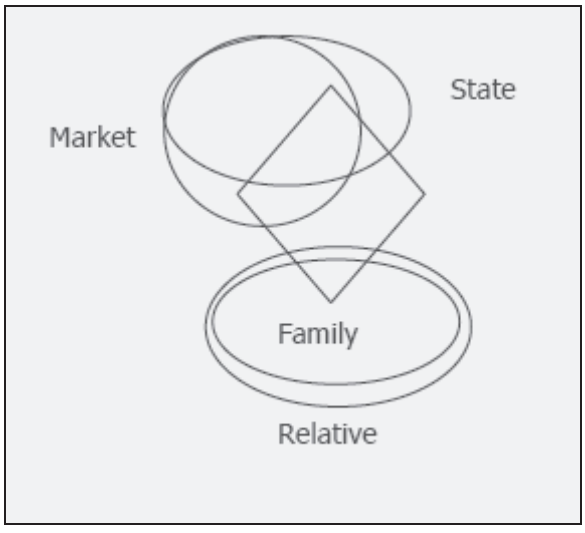
payment[21] (MHLW 2008a). Most women who are caregivers are older than 40, and women in this age bracket can typically only get part-time jobs and earn less than 90,000 yen per month.[22] Almost the entire salary of a female family carer could go into paying for institutional care. Thus, it is the disadvantaged position of women in the labour market, as much as traditional cultural norms, which binds women to the caregiver role.

One of the main reasons that women in their 40s and 50s earn so little is that most of them have interrupted their career for childcare in their 20s and 30s. They often interrupt their careers again to take care of elderly parents. In addition, the tax and social security systems reinforce women's secondary role in the labour market by setting a limit on how much they can earn before losing their status as a dependent spouse and therewith their exemption from paying tax and social security contributions. As a result, the forces that bind women to the caregiver role are multiple and reinforce each other. They are further reinforced by the state's expectations that a woman will be a housewife, a caregiver and a low-wage worker.

Elderly care

However, there are differences between policies for the elderly and for childcare. This section looks at the care diamond for elderly care. Figure 13 presents the care diamond for elderly care in Japan. An overview of the number of people who require some form of care and of people who receive 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 intensive care needs. However, an overwhelmingly large portion of care needs are still met within the family (around half of the care for the elderly with intensive needs, and more than half of the care for those with fewer needs). Home care services are utilized by most households with care needs, yet their 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 minor.

Figure 13: The care diamond for elderly care in Japan



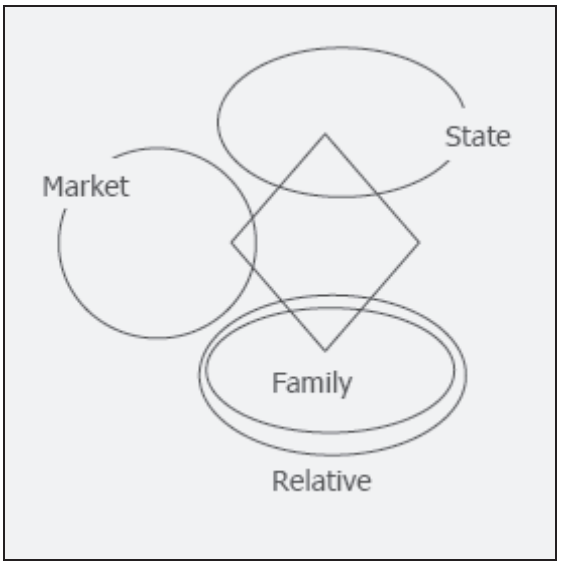
The reasons for this seemingly minor effect of the LTCI are as follows. First of all, the LTCI is not a new service but a replacement of social services and hospitalization. Even though care provision under the LTCI has increased, there are many reports that the total care provision by the state has actually decreased, especially for those with extensive care needs who received

[21] Plus meals and other expenses that are not covered by the LTCI.

[22] The average wage rate for part-time female workers in their 40s is 960–980 yen per hour. The average number of hours worked per day is five, and the average number of days worked per month is 18 (MLHW 2007c).

social services prior to the introduction of the LTCI. This is because (i) the LTCI places an upper limit on the amount of care that one can receive, and (ii) it imposes a co-payment of 10 per cent, pushing those with financial restrictions into "choosing" not to receive the care to which they are entitled. It should be noted that there is a great deal of difference in the utilization up to the upper limit allocated for each user (after an assessment of care needs by the municipality) depending on income.[23] The upper limit is determined solely on the basis of how much care is required by the person in question (ranging from seven categories of need to "not applicable").[24] But, even at 10 per cent, the user charge (co-payment) is still expensive for the elderly poor. Second, the LTCI rarely provides all-inclusive services. Caring for the elderly with extensive care needs requires exceedingly long hours, as seen from the empirical evidence by Shimizutani and Noguchi (2004). Thus, even though a family may use the 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 prohibitive for many households.

Figure 14: The care diamond for childcare in Japan



Another notable feature of the elderly care diamond is that there is an almost complete overlap between the state and market spheres. Indeed, the LTCI is a market solution with the financial backup of the state. Even though there are some private nursing homes that are not covered by the LTCI, and care services are fully paid by the client, almost all elderly care provision takes place through the LTCI. The coverage, the determination of care needs (care management)—and thereby the definition of the upper limit of how much care service one can receive—is carried out 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 did not have to be increased in order to meet the demand for care. The market mechanism was re-emphasized by including a co-payment portion into the system. A client can choose a service to purchase 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 per cent to 20 per cent, and now to 30 per cent), in order to

[23] There have been many newspaper and other reports that the elderly poor and their families, especially those with intensive care needs, have had to cut down the amount of service they received after the introduction of the LTCI. However, there are no government statistics to support this.

[24] The income of the person or the family is not considered.

reduce the "moral hazard" in health care demand. The same mechanism is being used to dampen demand for elderly care.

A further notable feature is that the relatives (that is, those who are not immediate family members[25]) and the community seem to play a very small role or no role at all. Almost all caregivers, besides professional care providers, are immediate family members. And even though many professional care service providers are non-profit organizations, they operate according to market mechanisms as private market suppliers.

The care diamond proposed by the author for Japanese elderly care is seen in Figure 13.

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 as to whether unpaid care work by a family member should be included in its framework. On the one hand, some (on the conservative side) argued that covering professional care services, while ignoring the same care work carried out by a family member, created a bias toward care provision outside the family and prevented the family's natural functioning as the primary care provider. They argued for including payment to family members when caring for an elderly person 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 unpaid care work done by a family member because this practice reinforced women's role as care providers and prevented them from being liberated from family responsibility. In the end, the payment for family care was included, but with very strict rules: for example, payment would only be made if there was no professional care service available in the region, and if the family caregiver possessed the same qualifications as professional caregivers.

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

The childcare diamond in contrast to the elderly care diamond

While elderly care (kaigo) and childcare (hoiku) policies share many commonalities—especially as a care burden on women—both, and consequently the care diamonds, are constructed quite differently. This is because the policy objectives of elderly care and childcare are quite different. For elderly care, the ostensible objective of the recent enactment of the LTCI is to "socialize the burden of care among the entire society", yet the hidden motive of the government is to cut down the fiscal outlay for elderly care. The Japanese government was faced with a dilemma. On the one hand, as an industrialized welfare state, it was expected to deal with the elderly care problem; not to do so would be considered a failure of the government. 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 died. On the other hand, it was becoming increasingly clear that this practice would require an increased financial commitment from the government. In other words, the government had to act wisely so that (i) it would not look as if the Japanese welfare state was retrenching, while at the same time (ii) it would reduce government expenditure. The LTCI was perceived as a way to achieve both (even though the intended cost containment did not succeed, as seen in the previous section).

In contrast, the policy objective for childcare has been "to balance work and family (work-life balance)". This, in reality, can be interpreted as having two objectives. One is to increase the

[25] In Japan, the direct-line family members (father, mother, son, daughter, grandfather, grandmother, grandson, granddaughter, spouses and children's spouses) are considered to be immediate family, and other relations are called relatives.

fertility rate, and thereby reverse the trend of population ageing, and the other is to reverse the decrease in labour force participation rates of women, which still retain the dip during child-rearing years. However, the government's effort in pursuing these objectives has been half-hearted throughout the 1990s and 2000s. Cash benefits, tax concessions and other financial assistance to households with children were expanded in the 2000s, yet they are still modest compared to other industrialized countries. While public childcare provision has also increased, it is still far from meeting the demand. Furthermore, there has been no serious effort by the government to encourage more childcare provision by the private sector.

These differences in elderly care and childcare policies have resulted in two different care diamonds. The first difference is that while the LTCI clearly tried to emphasize the home solution, that is, the elderly being cared for at home with some assistance from professional care service providers,[26] the childcare policy clearly placed its emphasis on the institutional solution, that is, children being taken care of in institutions. There are very few public services or support for those who choose to take care of their children at home (such as tax credit for home childcare, financial compensation for mothers who stay at home,[27] or regulations to promote the baby-sitting and nanny service industry). This is because the childcare policy's objective was ambiguous about whether it should help to lessen some of the childcare pressure on women who were 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 society and are given sole responsibility to raise their children (without the father's help), only a few programmes (such as child-rearing centres, mentioned in footnote 2) have been put in place to support them. In order to place children in a public daycare centre, a mother has to be in the work force, and entry into the labour market is the only way to delegate some of her childcare responsibilities (unless the household can afford to pay for a kindergarten).

Another notable difference between elderly and childcare policies is the utilization of market mechanisms. The elderly care provision, especially home services, is mostly met through the LTCI. Thus, in financing and regulating, the market works through the state. Even though the actual delivery of services might be carried out by the private sector (and non-profit organizations, welfare societies, cooperatives and so on), the state has a presence in every step of the process from the assessment of needs and care management, to the allocation of a service amount. Even though there are some differences in quality, especially among private care providers, the service provided is more or less the same. In contrast, the childcare market is clearly divided into public (licensed daycare centres) and private spheres (non-licensed daycare centres). The licensed daycare centres, even though some of them are run by private entities, are strictly under the government's control, where the admission, placement and pricing are all decided by the government. At the same time, non-licensed daycare centres are completely market-driven, and prices, quality and quantity of services vary dramatically. Thus, unlike the care diamond for the elderly, the care diamond for children shows that both the state sphere and the market sphere are independent of each other.

The third difference between the care diamonds of the elderly and children is the size of the "relatives" sphere. Elderly care is almost entirely carried out by spouses and children, while childcare is very often supplemented by grandparents (mostly grandmothers). Nearly 10 per cent of children under six are being taken care of by their grandparents (table 19). In many instances, grandparents take care of children even if they do not reside in the same household.

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

[27] There is a scheme for maternity leave by which mothers (or fathers) can interrupt their work for up to a year after a child is born and are paid 40 per cent of their salary. However, this covers only full-time permanent workers, and the take-up rate of maternity leave is for women who work as full-time and permanent workers was 72.3 per cent in 2005 (MHLW 2005).

Conclusion

In the words of Goodman and Peng (1997), the development of Japanese social welfare can best be described as "peripatetic adaptive learning", adapting social schemes from other industrialized countries to meet the current needs of the country. The development of elderly and childcare policies fits this description well. Both policies were formulated and changed to meet the immediate demands and issues of society, and the government sought a solution by selectively learning from Western nations, rather than being led by principles and theories. For elderly care, the introduction of the LTCI in 2000 was such a case. As was described in previous sections, the LTCI, modelled after Germany, was adapted to meet immediate needs to cut the rising cost of elderly welfare. For childcare, the immediate need was to reverse the trend of the 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 can be balanced, and it has expanded some schemes to do so (for example, increasing public childcare facilities). On the other hand, the state is still strongly biased towards "male breadwinner, female housewife" households and 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,[28] and this is also the case for elderly and childcare policies. What is conspicuously missing in the development of both policies are the voices of caregivers—notably women—and those receiving care themselves. For elderly care, the government has been expanding public provision in response to demographic pressure, the change in family structures and the increase in women's labour force participation. However, although the LTCI expanded the total amount of service provision, it did little to lessen the burden on those women who shoulder the heaviest responsibility for elderly care (that is, those who spend long hours on elderly care at home). If the objectives of introducing the LTCI had incorporated the voices of these women, it would have expanded the public provision of institutional care as well. However, the number of public institutions, including hospitals and nursing homes, has been reduced in order to restrain social expenditure as 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 childcare, the absence of women's voices in policy making has resulted in a childcare policy that has many discrepancies. For working mothers, the greatest need is for high-quality public daycare centres. Yet, the services offered by these daycare centres are often inadequate to meet their needs both in quantity and in quality (for example, opening hours). Moreover, in 2006, the central government stopped subsidizing local governments for the operation of public daycare services. Without the central government subsidy, many local governments are now cutting back their daycare provisions. For non-working mothers, the government has put in place many preferential schemes for the male-breadwinner, female-housewife families, but has done little to mitigate the burden of childcare on mothers who stay at home. Without their husband's support, many women are left on their own to carry out childcare duties.

Why does Japan's policy continue to be bureaucracy-driven in the area of care policy? This is a question that many political scientists and others are trying to answer. Some point out the abysmally low representation of women in the political arena. The percentage of women representatives in the Lower House in Japan is 11.3 per cent, ranking 99th among 147 nations (as of December 2009, Inter-Parliamentary Union 2009). Still others point to the extremely low number of civil society movements in Japan (Yuasa 2008). Some blame the academia and so-called experts who are represented in *shingikai* (deliberative councils). They point to the fact that policy evaluation is rarely conducted in academia and thus, even when academicians are represented in councils, they usually just approve the policies prepared by the bureaucrats. A

[28] Kamimura 1999; Tominaga 2001; Miyamoto 2003.

fairly large number of scholars and journalists blame neoliberal economists and big enterprise interest groups that have been quite vocal, monopolizing key positions in the government for the past two decades (until the 2008–2009 economic crisis). For example, the Keizai Zaisei Shimon Kaigi (Economic Financial Advisory Group, set up in 2001 and headed by the Prime Minister)—which, until 2009 September, when the Democratic Party won the election, had been the strongest policy-making institution—did not include any representatives from labour unions, feminist or disabled persons' groups. There is a Gender Equality Bureau in the Prime Minister's Office which is supposed to oversee gender equality in all policies, and is represented mostly by women, but the power of the Gender Equality Bureau is nothing compared to that of the Keizai Zaisei Shimon Kaigi.

However, the most convincing answer to the question was given by a scholar of the historical development of social policy, Hisao Namekata, who said that Japan has never really been a welfare state,[29] meaning that Japanese people have never experienced a real welfare state and thus have low expectations of what the state can offer to its people. The result of a survey that I conducted in 2008 offers evidence for this statement. The following question was asked of 1,800 randomly sampled adults all over Japan:

For every child in Japan, do you think (an item) is (please choose):

a) a necessity that every child in Japan should have,

b) desirable, but if he/she cannot obtain it because he/she is poor, then *shikataganai* (too bad, but has to accept it),

c) not a necessity,

d) don't know.

For sports equipment (soccer balls, baseball mitts, etc.) and toys (dolls, blocks, etc.), the percentage of those who selected the first option was only 12 per cent (Abe 2008). A similar survey conducted in 1999 in the United Kingdom showed that percentage of respondents who answered "toys (dolls, blocks, etc.)" is "a necessity that every child should have and not go without" was 84 per cent (Gordon et al. 2000).

It seems *shikataganai* is the Japanese people's state of mind.

[29] Personal communication with Hisao Nametaka, 1 May 2009.

Bibliography

Abe, Aya. 2008. *Kodomo no Hinkon* (Child Poverty). Iwanami Shoten, Tokyo.

———. 2006. "Hinkon no genjo to sono youin" (The state of poverty and its causes). In T. Oshio, E.Tajika and T. Fukawa (eds.), *Nihon no Shotoku Bunpai* (Income Distribution in Japan). Tokyo University Press, Tokyo.

Abe, Aya and Akiko Oishi. 2005. "Boshi setai no keizai jokyo to shakai hosho" (Economic well-being of single-mother households and social security system). In NIPSSR (ed.), *Kosodate Setai no Shakai Hosho* (Social Security for the Households with Children). Tokyo University Press, Tokyo.

Cabinet Office. 2006. *Kokumin Seikatsu Hakusho* (White Paper on People's Living). Cabinet Office, Tokyo.

Chitose, Y. 2003. "Child care system in Japan." In National Institute of Population and Social Security Research (ed.), *Child-Related Policies in Japan*. NIPSSR, Tokyo.

Fraser, N. 2000. "After the family wage: Gender equity and welfare state." In B. Hobson (ed.), *Gender and Citizenship in Transition*. Macmillan, Basingstoke.

Fukuda, Motoo. 2000. "Study of childcare supply—A perspective of cost." *Kikan Shakai Hosho Kenkyu (*Quarterly Journal of Social Security Research), Vol. 36, No. 1, pp. 90–101.

Goodman, R. and I. Peng. 1997. "The East Asian welfare states: Peripatetic learning, adaptive change, and nation-building." In G. Esping-Andersen (ed.), *Welfare States in Transition: National Adaptations in Global Economies*. SAGE Publications, London.

Gordon, D., L. Adelman, K. Ashworth, J. Bradshaw, R. Levitas, S. Middleton, C. Pantazis, D. Patsios, S. Payne, P. Townsend and J. Williams. 2000. *Poverty and Social Exclusion in Britain*. Joseph Rowntree Foundation, York.

Ikami, H. 2003. "Fukushi kokka dotairon heno tenkai: Gender no shiten kara" (Development of the dynamic welfare state theory: From the perspective of gender). In T. Uzuhashi (ed.), *Hikaku no Naka no Fukushi Kokka* (Welfare States in Comparison). Minerva Shobo, Kyoto.

Inter-Parliamentary Union. 2009. *Women in National Parliaments*, www.ipu.org/wmn-e/world.htm, accessed on 2 Februrary 2010.

Iwata, M. 2007. *Gendai no Hinkon* (Contemporary Poverty). Chikuma Shobo, Tokyo.

JILPT (Japan Institute of Labour Policy and Training). 2003. *Ikuji Kyugo Seido ni Kansuru Chosa* (Survey on Parental Leave). JILPT, Tokyo.

Kamimura, T. 1999. "Fukushi kokka keisei riron no Asia NIES heno kakucho" (Expansion of welfare state development theory to Asian NIES), *Sociologos*, No. 23.

Kenko Hoken Kumiai Rengokai. 2006. *Shakai Hosho Nenkan 2006*. Toyo Keizai Shinpo Sha, Tokyo.

———. 2002. *Shakai Hosho Nenkan 2002–9* (Social Security Yearbook). Toyo Keizai Shinpo Sha, Tokyo.

Kose Tokei Kyokai. 2004. *Kokumin no Fukushi no Doko* (Statistics on Welfare). Kosei Tokei Kyokai, Tokyo.

Lewis, J. 1992. "Gender and the development of welfare regimes." *Journal of European Social Policy*, Vol. 2, No. 3, pp. 150–173.

MHLW (Ministry of Health, Labour and Welfare). 2008a. *Nippon Jin no Heikin Yomyo* (Average Life Expectancy of Japanese People). www.mhlw.go.jp/toukei/saikin/hw/life/life06/index.html, accessed on 11 January 2009.

———. 2008b. *Heisei 19 Nendo Koyou Kintou Kihon Chosa Kekka no Gaiyou* (Results of Equal Employment Survey 2007). MHLW, Tokyo. www.mhlw.go.jp/houdou/2008/08/h0808-1.html, accessed on 22 February 2009.

———. 2007a. *Kokumin Seikatsu Kiso Chosa Heisei 18 Nen* (Basic Living Conditions Survey 2006). MHLW, Tokyo.

———. 2007b. *Shakai Fukushi Shisetsu Chosa* (Social Welfare Institutions Survey). MHLW, Tokyo. www.mhlw.go.jp, accessed on 2 February 2010.

———. 2007c. *Chingin Kozo Kihon Chosa* (Wage Structure Survey). MHLW, Tokyo.

———. 2006a. *Kaigo Service Shisetsu Jigyousha Chosa* (Care Service Provider Survey). MHLW, Tokyo. www.mhlw.go.jp, accessed on 2 February 2010.

———. 2006b. *Kokumin Seikatsu Kiso Chosa Heisei 16 Nen* (Basic Living Conditions Survey 2004). MHLW, Tokyo.

———. 2006c. *Kose Hakusho 2006* (The 2006 White Paper on Health and Welfare). MHLW, Tokyo.

———. 2005. *Josei Koyo Kanri Kihon Chosa* (Survey of Management of Women Labor). MHLW, Tokyo.

———. 2000a. *Kokumin Seikatsu Kiso Chosa 2000 Nen* (Basic Living Conditions Survey 2000). MHLW, Tokyo.

———. 2000b. *Kosei Hakusho 2000* (The 2000 White Paper on Health and Welfare). MHLW, Tokyo.

———. 1981–1999. *Income Distribution Survey* 1981, 1984, 1987, 1990, 1993, 1996, 1999. MHLW, Tokyo.

Miyamoto, T. 2003. "Fukushi regime ron no tenkai to kadai" (Development and issues of welfare regime theory). In T. Uzuhashi (ed.), *Hikaku no Naka no Fukushi Kokka* (Welfare States in Comparison). Minerva Shobo, Kyoto.

Murakami, T. 1984. *Shin Chukan Taishu no Jidai* (The Era of the New Middle-Class Public). Chuo Koron shinsha, Tokyo.

Nihon Hoiku Kyokai (Japan Child Care Association). 2009. Chosa Kenkyu, www.nippo.or.jp/research/, accessed on 2 February 2010.

NIPSSR (National Institute of Population and Social Security Research). 2009. *Jinko Tokei Shiryoshu* (Population Statistics Handbook). www.ipss.go.jp/syoushika/tohkei/Popular/Popular2009.asp?chap=0, accessed on 2 February 2010.

———. 2008. *The Cost of Social Security in Japan: Fiscal Year 2005 (April 2005–March 2006)*. IPSS Statistical Report No. 18. www.ipss.go.jp/ss-cost/e/cost05/data/cost2005.pdf, accessed in April 2010.

———. 2002. *Shusei Doko Kihon Chosa 2002*. NIPSSR, Tokyo.

Nishimura, S. (ed.). 1998. *Iryo Hakusho 1998*. Nihon Iryo Kikaku, Tokyo.

OECD (Organisation for Economic Co-operation and Development). 2008. *Growing Unequal?* OECD, Paris.

———. 2007. *Education at a Glance 2007: OECD Indicators*. OECD, Paris.

Oishi, A. 2003. "Hahaoya no Shugyo no Oyobosu Hoiku Hiyo no Eikyo" (The effect of childcare cost on mother's labor force participation), *Kikan Shakai Hosho Kenkyu*, Vol. 39, No. 1, pp. 55–69.

———. 2002. "The effect of childcare cost on mother's labor force participation." *Journal of Population and Social Security*, Vol. 1, pp. 50–65.

Ohtake, Fumio. 2005. *Nihon no Fubyoudo* (Inequality in Japan). Nihon Keizai Shimbun Sha, Tokyo.

Razavi, Shahra. 2007. *The Political and Social Economy of Care in a Development Context: Conceptual Issues, Research Questions and Policy Options*. Programme on Gender and Development, Paper No. 3. UNRISD, Geneva.

Sainsbury, D. 1996. *Gender, Equality and Welfare States*. Cambridge University Press, Cambridge.

Shimizutani, S. and H. Noguchi. 2004. *Kaigo Hoiku Service Shijo no Keizai Bunseki* (The Economic Analysis of Elderly and Childcare Service Market). Toyo Keizai Shinpo Sha, Tokyo.

Tamiya, Y. and M. Shikata. 2009. *Research Report 2 Japan: Analysis of Time Use Surveys on Work and Care*. Programme on Gender and Development. UNRISD, Geneva.

Tominaga, K. 2001. *Shakai Hendo no Nakano Fukushi Kokka* (Welfare States in Changing Societies). Chuo Koron shinsha, Tokyo.

Yuasa, M. 2008. *Han Hinkon* (Anti-Poverty). Iwanami Shoten, Tokyo.

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