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Introduction

Many problems with nursing care have arisen with the extension of the life expectancy, which is common in developed countries. Each country has taken different approaches to solve these problems; Japan was the third country in the world, after Holland (1962) and Germany (1995) to introduce an insurance-style system of long-term care services: The public LTCI (LTCI) system, codified by law in the year of 1997 and implemented in 2000.

As we mentioned in RR1, after the mid 1980s the aging policies gained speed; there was certainly a clearly defined retrenchment in pensions and other related income protection, but, on the other hand, there was an enhancement of policies tending to invest public funds and develop new policies related to the long-term care services.

The background of the enactment of the LTCI Act was defined by, among others, the increment of elderly households, the prolongation of care services, which caused elderly care by elderly (care given to elderly by other old-aged family members), the serious "elderly mal-treatment" problem and the rise of support for the "socialization" of long-term care. During that time newspapers, magazines and TV programs the care problem was treated widely, contributing to the formation of a public opinion favouring the enhancement of care services.

Further, the need to solve the so called "*social hospitalization*" (hospitalization not due to medical treatment but to nursing care need) was a unique primary factor for the enactment of the LTCI Act. In brief, there was a tendency among the Japanese citizens to prefer hospitals to the (at that time) stigmatized welfare facilities, which accelerated the rise of medical costs. This, in turn, tormented the Ministry of Health, Labour and Welfare.

Looking back in time, there were some epoch making events: first, the elaboration of the "*Gold Plan*" in 1989 ("*New Gold Plan*" from 1994, "*Gold Plan 21*": from 1999 to 2004) and second, the announcement in 1994 of the "*21st century welfare vision –facing an aging society with declining fertility rates*".

Due to the Gold Plan, the amount of home- and facility-based services increased. This contributed largely to the smooth implementation of the LTCI Act. The "*21st century welfare vision*" suggested a change of the formula 5:4:1 of the interrelation between the government expenditure in pensions, medical treatment and welfare, changing it to 5:3:2, which was greatly appreciated as a message showing the enrichment of care services for the citizens.

The LTCI Act was enforced from April 2000 onwards and started with success. In the beginning, in some regions (rural areas) services were slow to follow insurance coverage. However, since the "Gold Plan" had already increased the supply of care services since 1989, the problem was not so serious.

However, it was not entirely true that there were no problems. First, a trend of long-term care service usage constraint and suppression could be observed due to the 10 percent of co-payment (not covered by the insurance) for low-income people. Second, the number of low care level users exceeded the prospects and forecasts, putting pressure on the public budget. Third, while the long-term care service system aimed at the enrichment and perfection of home-services, in fact, it increased the demand for facility-based service. The reason for this is as follows: especially family members who take care of frail elderly people prefer in-

facility service on the ground that home-based service would not alleviate their care burden to the same extent as facility-based service. As a result, a new preventative long-term care service was introduced in 2005, aimed at limiting the number of the recipients. It also introduced charges for food and residence at long-term care facilities (commonly referred to as "hotel cost") in order to dampen the demand for facility-based service.

Besides all of the above, the following problems remain unsolved: (1) the lack of sufficient human resources (=workers' shortage) due to the low wages and difficult working conditions and the diminution of the remuneration unit of care services which is set by the regulation and applied to all services covered by the Long Term Insurance Act), (2) lack of public funding. Hereafter, we would like to discuss the first point, by examining composition and attributes of the care workers, salaries, working hours and other working conditions, as well as how the workers themselves value their working environment.

The structure of this report is as follows:
The first section focuses on elderly care. Using available statistical data, we will tease out the types of elderly care services and elderly care workers (home-visit long-term care worker, long-term care workers, nursing staff, long-term care manager, etc.). We disclose data about gender and age composition as well as care workers' qualifications. We will then zoom in on the working conditions (employment type, salary, working hours, and social insurance coverage) of long-term care workers. By using recent survey data on the care workers' opinion about working conditions, we will try to assess whether they value working in this field, their degree of job satisfaction, and appraisal of their working hours. In the following, we will present the results of a series of in-depth interviews with five long-term care facility workers and five home-visit long-term care workers (home helpers) carried out between December 2008 and January 2009.

While this report focuses mainly on elderly care workers, the second section will briefly describe the attributes and working conditions of childcare workers, including child care centre workers (under the jurisdiction of the Ministry of Health, Labour and Welfare) as well as kindergarten teachers (under the jurisdiction of the Ministry of Education, Culture, Sports, Science and Technology). It also includes qualitative evidence from interviews with five childcare workers.

Elderly Care Workers

1. A General Description of Elderly Care Workers

In recent years, the prolongation of the life expectancy in Japan has meant that the elderly population has increased significantly, raising the need for nursing care. The number of elderly people over 65 years of age is 25,670,000 (male 10,870,000 and female 14,800,000), representing 20.1% of the whole population (according to the 2005 national population census). Out of this elderly population, 4,250,000 (or 16%) required support or primary nursing care approved by the LTCI System by the end of the 2006 fiscal year (Ministry of Health, Labour and Welfare, 2008).

The LTCI System was implemented in 2000 and ever since the "socialization of care" has been pursued. Given that the number of elderly households composed by either elderly "single" or elderly "husband-and-wife only" has increased, the provision of welfare services has become more and more pressing.

The introduction of the LTCI, the details of which are described in Research Report 3, has huge impacts to the care labour market both in terms of labour demand and supply as shown below.

1. The LTCI system itself does not provide care services directly to the frail elderly but it finances care services. The frail elderly, who applies for using services and is approved by the insurance agency, can use the services with 10 per cent co-payment. The number of the elderly who were approved and really used the services has increased enormously since the introduction of the insurance scheme (1.84 million people in the year of 2000, 2.54 million in 2002, 3.17million in 2004 and 3.54 in 2006).

2. The local agencies set up by the municipality (city, town and village) evaluate the application by the frail elderly and judge the seriousness or the degree of frailness of the applicant, which ranges from the first (slight) level to the fifth (serious) level. The ceiling of the budget varies with the degree of the frailness (166 thousand Yen per month for the first level, 195 thousand Yen for the second level, 268 thousand Yen for the third level, 306 thousand Yen for the fourth level and 358 thousand Yen for the fifth level[1]),meaning that the more serious frail elderly can make use of more intense services.

3. The total benefits obtained by recipients increased from 3.8 trillion Yen in 2001 to 7.4 trillion Yen in 2008, meaning that the market for care services grew rapidly. In accordance, many private profit-seeking corporations embarked in the care business, especially in home-based services representing more than 50 % of the total number of corporations under the LTCI in 2006. In the case of facility-based services, private profit-seeking corporations prohibited by the regulation, so care services are exclusively provided by public or non-profit organizations (Shakai-fukushi-hojin).

4. The expansion of the care services market and the participation of private corporations meant that the care labour market expanded rapidly. Indeed, the number of long-term care workers more than doubled from around 550,000 (in 2000) to 1,200,000 (in 2006)

The situation of service usage within the LTCI System is depicted in Table 1.

Home Services in Table 1 consist of “In-home (home-based) Services” and “Regional Special Services”. Facility Services are services which are provided to the recipients who are in welfare facilities, both of which are explained in detail in Table 2.

73% of LTCI users utilize home services. We can observe that when the care level is lower (less serious) there is more home service usage, 93.4% for the care level 1 and 86.2% for the care level 2. On the other hand, the proportion of facility service usage rises with the care level (i.e. the degree of frailty): It is 49.3% for care level 4 and 60.4% for care level 5.

[1] 100 Japanese Yen = 1 US Dollar

Table □ State of long-term care service use by nursing care level (Number of recipients in thousands, 2007)

	Total Number	Support Required, etc	Care Level □	Care Level □	Care Level □	Care Level □	Care Level □
Total Number □□□	2,870.2 (100)	681.7 (100)	740.8 (100)	654.7 (100)	577.4 (100)	492.1 (100)	405.2 (100)
Home Services □□□	2,101.8 (73.2)	670.9 (98.4)	691.6 (93.4)	564.2 (86.2)	415.1 (71.9)	263.2 (53.5)	167.7 (41.4)
Facility Services □□□	820.5 (28.6)	□ □	51.7 (7.0)	101.8 (15.5)	179.7 (31.1)	242.6 (49.3)	244.7 (60.4)

Notes□ 1□Since many people use both "Home Services" and "Facility Services", the "Total Number" does not necessarily match, 2□Includes people from 0 to 64 years-old (127,000 people).
Data source: Ministry of Health, Labour and Welfare (2007) *Care Benefits Survey Monthly Report*□March 2007 Report□

The general state of the services rendered by the LTCI system is shown in **Table 2**. Here, A. In-home services refer to services the recipients use while living at home, including:

1) Home-visiting services such as home-visit long-term care by so-called " home helper" , bathing services at the tub-equipped lorry and nursing services

2) Day-care facility services of two kinds: mostly entertainment-related "day services" (to chat and/or play with other elderly people, watch movies, sing or dance at the facility) and health-related "day care rehabilitation" including health-keeping and outpatient medical services.

3) "Others" consist of various kinds of services, including "short stays" of up to one week, during which recipients get facility-based services staying at institution.

From 2000 to 2006, the number of service providers of in-home services increased markedly, especially in the home-visit long term care and day services categories (9,833 to 20,948 and 8,037 to 19,409 respectively). Over the same period, the number of group homes for the elderly with dementia multiplied by 12.4 times (675 to 8,350). Compared to that, the number of the service providers seems to be stagnant (10,992 in the year of 2000 to 12,036 in the year of 2006), the reason of which is that private profit-seeking corporation are prohibited to embark in this field. The total number of workers engaged in long-term care-related jobs almost doubled from around 550,000 in 2000 to 1,196,412 in 2006.
B. Community-based service are provided at small scale group homes (less than ten residents) for elderly with dementia which is the intermediate form of home and institution. C. Services rendered at facilities are institution-based services at a larger scale (usually more than fifty residents).

Table □ Number of service providers and people working in each field

	2000	2003	2006		
	Number of service providers and/or facilities	**Number of service providers and/or facilities**	**Number of service providers and/or facilities**	**Number of Users and/or residents**	**Number of workers**
A. In-home services (Home-visiting related□					
Home-visit long term care	9,833	15,701	20,948	1,042,347	176,527
Home-visit bathing	2,269	2,474	2,245	62,412	9,580
Home-visit nursing care	4,730	5,091	5,470	291,907	27,015
(Day care facilities□					
Day service	8,037	12,498	19,409	1,105,211	177,094
Day care rehabilitation	4,911	5,732	6,278	466,745	57,513
1. Long-term care health facilities for the elderly	2,638	2,960	3,288	273,523	31,689
2. Medical facilities	2,273	2,772	2,990	193,222	25,824
(Others□					
Short-stay care service	4,515	5,439	6,664	227,990	97,550
Short-stay nursing care	4,651	5,758	5,437	59,028	□
1. Long-term care health facilities for the elderly	2,616	2,980	3,340	53,592	□
2. Medical Facilities	2,035	2,778	2,097	5,436	□
Daily life long-term care admitted to a specified facility	…	…	1,941	73,313	41,422
Rental services of welfare equipments	2,685	5,016	6,051	726,948	□
B. Community-based service					
Group home for the elderly with dementia	675	3,665	8,350	116,749	101,917
C. Services rendered at facilities					
Long-term care welfare facilities for the elderly	4,463	5,084	5,716	392,547	240,683
Long-term care health facilities	2,667	3,013	3,391	280,589	176,170