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# Current Situation and Problems of Legislation on Long-Term Care in Japan's Super-Aging Society

*Kimiyoshi Inamori*

*Kyoto University*

The long-term care insurance system, introduced in 2000, has promoted the socialization of long-term care and helped to reduce the burden on families with elderly relatives who need long-term care. But while the purpose of the long-term care insurance system is to provide a necessary and sufficient level of benefits for elderly persons in need of long-term care, the system alone does not necessarily meet all of their care needs. As a result, family care or services other than long-term care insurance are required to complement long-term care insurance services. The system of care leave based on the Child Care and Family Care Leave Act was established as a preparatory period with the aim of building a system for long-term care of family members in need of such care; income guarantees during the care leave period are provided in the form of care leave benefits from the employment insurance system. However, the rate of care leave actually taken remains at an extremely low level, despite progress by businesses in establishing related regulations. What is more important is to create schemes for working formats, such as short working hour systems or limits on overtime work, to assist workers in balancing everyday and continuous employment with family care.

## I. Introduction

What kind of long-term care has been sought by the Japanese legal system until now? Amid the ongoing trends toward birth rate decline and population aging, various initiatives are currently being promoted in the field of guaranteed elderly care, including promotion of the integrated community care system. These have their sights set on the year 2025, when the baby boom generation will pass the age of 75. This paper will examine developments to date in various legislation on long-term care for the elderly, and study existing problems. The principal focus will be on the Long-Term Care Insurance Act, which is mainly responsible for guaranteeing public care services for elderly persons in need of long-term care, the Child Care and Family Care Leave Act,<sup>1</sup> which helps workers who have elderly relatives in a care-requiring condition to balance their employment with family care, and the Employment Insurance Act, which is responsible for income guarantees during periods of care leave.

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<sup>1</sup> The full name of this law, at present, is the “Act on the Welfare of Workers Who Take Care of Children or Other Family Members Including Child Care and Family Care Leave.”

## II. The Basic Structure of Existing Legislation on Guaranteed Care

### 1. The System of Long-Term Care Insurance

Since the Long-Term Care Insurance Act came into effect in April 2000, long-term care insurance has been central to the system for guaranteeing public care services. Persons insured under long-term care insurance are those who are domiciled in the catchment area of a municipality and are 65 years of age or more (“primary insured persons”) and those insured by public medical insurance who are domiciled in a municipality and are between the ages of 40 and 64 (“secondary insured persons”). The system is mainly funded by contributions from insured persons and their employers. When an insured person enters a condition of need for long-term care, etc., is certified as such, and receives long-term care insurance services from a designated operator or similar, based on a service utilization agreement, 90% of the service cost is paid as insurance benefits.<sup>2</sup> The Long-Term Care Insurance Act states that necessary insurance benefits shall be provided for conditions of need for long-term care, etc., of the insured person (Article 2 para. 1 of the Act), and that “With regard to the contents and level of insurance benefits, consideration must be given so that the insured is able to live an independent daily life according to that person’s own abilities in his or her home as much as possible, even if said insured person enters a condition of need for long-term care” (Article 2 para. 4). In reality, however, for those living at home, a maximum payment commensurate with the need for long-term care has been set for non-residential in-home services and community-based services that are provided (in combination) based on an in-home service plan (“care plan”) (Article 43 para. 1).<sup>3</sup> This means that there is an upper limit to the volume of long-term care insurance services that can be received (though full services can be received by paying the whole amount in excess of the maximum limit (= “combined long-term care”). For those admitted to a facility, the minimum required care services are provided by the intensive care home for the elderly or other admitting facility by establishing remuneration for comprehensive long-term care, but many people are waiting to be admitted owing to a supply shortage. Thus, Japan’s long-term care insurance does not necessarily meet all the care needs of each person in need of such care.<sup>4</sup>

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<sup>2</sup> 80% in the case of higher earners. In reality, users pay their own contribution of 10% or 20% to the service provider, and the remaining 90% or 80% is paid by the insurer to the service provider as remuneration for long-term care. Meanwhile, the cost of creating care plans is covered 100% by benefits, so that the user pays nothing.

<sup>3</sup> Besides this, if a specific service is lacking, municipalities may stipulate a base amount of maximum payment for the categories of allowances at their own discretion, but there are few examples of this in practice.

<sup>4</sup> When calculating long-term care insurance premiums, the volume of long-term care insurance services needed in each three-year period (a fiscal unit) is estimated for each level of long-term care need, and insurance premiums are set by calculating back from the amount needed for the corresponding benefits. In that sense, compared to the German long-term care insurance system, where levels of insurance benefits are set within a range that can be covered by long-term care insurance finances, Japan’s long-term care insurance has been described as a “necessary and sufficient benefit

## 2. Care Service Guarantee Systems Other than Long-Term Care Insurance

There are various publicly funded systems guaranteeing care services other than long-term care insurance, which are used to complement the long-term care insurance system. Specifically, these are welfare safeguard measures under the Act on Social Welfare for the Elderly, independence support benefits based on the Act on Comprehensive Support for Persons with Disabilities (ACSPD),<sup>5</sup> and care assistance based on the Public Assistance Act.

Since the Long-Term Care Insurance Act came into effect, welfare safeguard measures under the Act on Social Welfare for the Elderly (ASWE) have mainly been applied when it is difficult to use long-term care insurance, such as in emergencies, or when an adult guardian needs to be secured in order to enter an agreement for the use of services (ASWE Articles 10–4, 11).

As independence support benefits based on the Act on Comprehensive Support for Persons with Disabilities, persons with disabilities may receive payments of care benefits for in-home care and other disabled welfare services (ACSPD Article 28 para. 1 onwards). Long-term care insurance takes precedence when those services are also being received (Article 7), meaning that independence support benefits serve to supplement or augment long-term care insurance.<sup>6</sup>

For welfare recipients, because those aged 65 and over contribute to long-term care insurance as primary insured persons, the precedence of long-term care insurance means that amounts equivalent to long-term care insurance premiums are paid as additional long-term care insurance premiums for livelihood assistance, and a user contribution is paid

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type” (Masanobu Masuda, “Nihon to doitsu no kaigo hoken-kan no soui [Differences between Japanese and German long-term care insurance],” *Shukan Shakai Hoshō*, no. 2798 (2014), p.32). Nevertheless, certification of the level of long-term care need is focused solely on the individual’s ability to perform daily living activity, irrespective of the care environment in which each person in a care-requiring condition is placed. As such, the required volume of long-term care is calculated from the hours of care, and therefore does not necessarily meet the actual care needs of each individual in a care-requiring condition. Unlike medical services, the volume of services required for long-term care is difficult to quantify objectively in the first place, and therefore, in the long-term care insurance system, combined long-term care is permitted as it takes the form of monetary benefits. In that sense, Japan’s long-term care insurance system is also “partial insurance” (Shuzo Tsutsumi, *Kaigo hoken no imiron: Seido no honshitsu kara kaigo hoken no korekara wo kangaeru* [Semantics of long-term care insurance: Considering the future of long-term care insurance based on the essence of the system], (Tokyo: Chuo Hoki Shuppan, 2010), p.48).

<sup>5</sup> The full name is “the Act to Comprehensively Support the Daily Life and Social Life of Persons with Disabilities.”

<sup>6</sup> “On the application relationship between independence support benefits based on the Act to Comprehensively Support the Daily Life and Social Life of Persons with Disabilities and the long-term care insurance system” (03/28/07 *Shōkihatsu* No. 0328002, *Shōshōhatsu* No. 0328002). However, long-term care insurance services are not uniformly given precedence, but rather an individual judgment is to be made as to whether long-term care insurance services corresponding to disabled welfare services are to be received (Shogaisha Fukushi Kenkyukai, ed., *Chikujo kaisetsu shogai-sha sogo shien ho* [Article-by-article commentary on the Act on Comprehensive Support for Persons with Disabilities], (Tokyo: Chuo Hoki, 2013), p.79).

when using long-term care insurance services (10% in principle) as care assistance, respectively. On the other hand, welfare recipients aged under 65 are exempt from the application of national health insurance, and therefore do not contribute to long-term care insurance. As a result, the necessary care services are provided as care assistance for welfare support.

As to welfare safeguard measures and the payment of care benefits, one may discern a degree of administrative discretion on decisions for or against, and on the details.

As shown above, the system of public guaranteed care services does not necessarily always meet the care needs of each individual in need of long-term care, etc.; in some cases, it needs to be supplemented by care provided by the family itself or by private care services other than long-term care insurance.

### 3. System Based on the Child Care and Family Care Leave Act

Changes in family composition, in the form of the progressive nuclearization of the family and women's advancement into the labor market, combined with other factors including the prolongation of care accompanying increased longevity due to advances in medicine, have had a major impact on the nature of family care. Elderly people living alone or in husband-and-wife households have increased, and a growing problem is to ascertain which family member should be responsible for long-term care. While people in employment are increasingly taking care of family members, the Child Care and Family Care Leave Act (CCFCLA) specifies several ways of facilitating a balance between employment and care.

Firstly, there is the system of taking family care leave to care for a subject family member in a care-requiring condition (CCFCLA Article 2 para. 2). Workers (except day laborers) may take care leave by submitting a request to their employer, specifying (1) that the subject family member pertaining to the care leave request is in a care-requiring condition, and (2) the first and last days of the care leave period (Article 11 paras. 1 and 3). However, employees on fixed-period contracts may only do so when they have been employed by the same employer continuously for at least one year at the time of the request, and when it is not certain that the labor contract will have expired within six months after the 93 days allocated for care leave. Workers with an employment period of less than one year, those whose employment relationship will end within 93 days, and those whose contractual working days are two or fewer days per week may be made ineligible by a labor-management agreement.

A "care-requiring condition" is defined as a condition requiring constant care for a period of two weeks or more due to injury, sickness, or physical or mental disability (Article 2 (iii), Enf. Regs. Article 1). The standards for judging "a condition requiring constant care" are set out in Ministry notices,<sup>7</sup> and there is no direct connection with situations requiring

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<sup>7</sup> "On the enforcement of the Act on the Welfare of Workers Who Take Care of Children or Other Family Members Including Child Care and Family Care Leave" (12/28/09 *Shokuhatsu* 1228 No. 4,

care under long-term care insurance. A “subject family member” is defined as a spouse (including *de facto* marital relationships), parent, child, or parent of a spouse, or a grandparent, sibling or grandchild who is cohabiting with and dependent on the worker (Article 2 (iv), Enf. Regs. Article 3).

Up to now, care leave may be taken in a single block for a total of up to 93 days per subject family member in a care-requiring condition, but a 2016 amendment of the Act made it possible to take leave in three segments from January 2017. When measures to reduce working hours or similar are taken, the period in question shall total no more than 93 days.

Employers who have received a request for care leave may not refuse that request (Article 12 para. 1). However, when the scheduled start date of the requested care leave is less than two weeks after the date of the request, employers may designate any day after said scheduled start date within that two week period as the scheduled start date (Article 12 para. 3).

Secondly, there are measures to reduce working hours. Employers are under obligation to take such measures for workers in their employ (except day laborers) who take care of subject family members in care-requiring condition, for a period exceeding 93 consecutive days (a minimum of 93 days combined with the days of care leave) based on a request from the worker, for each subject family member and for each care-requiring condition. Specifically, employers must use one of the measures of (1) a system of shortened contractual working hours, (2) a flextime system (Article 32–3 of the Labor Standards Act), (3) advancing or delaying the time of starting or finishing work, and (4) a system of subsidizing the cost of care services used by workers, or some other system equivalent to these (CCFCLA Article 23 para. 3). However, workers with less than one year of employment and those with two or fewer contractual working days per week are ineligible for these measures when a labor-management agreement has specified them as exempt from measures to reduce contractual working hours or similar. These measures have been created for workers who, for one reason or other, do not take care leave for the requisite period.<sup>8</sup>

Thirdly, there is the system of taking time off for care. Workers (except day laborers) who are taking care of subject family members in a care-requiring condition, or otherwise providing care as stipulated in ordinances of the Ministry of Health, Labour and Welfare, may be granted time off to give said care (time off for care) upon request to their employers, within a limit of five days per fiscal year in the case of one subject family member in a care-requiring condition, or ten days per fiscal year in the case of two or more subject family members (Article 16–5 para. 1). However, this shall not include workers with an employment period of less than six months, or, of those with two or fewer contractual working days per week, those made ineligible by a labor-management agreement. From January

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*Kojihatsu* 1228 No. 2).

<sup>8</sup> Romu Gyosei, ed., *Kaitei-ban shosetsu ikuji kaigo kyugyoho* [Detailed Commentary on the Child Care and Family Care Leave Act], revised edition (Tokyo: Romu Gyosei, 2005), p.441.

2017, it will be possible to take time off in units of less than one day.

When requesting time off for care, (1) the fact that the subject family member pertaining to the request is in a care-requiring condition, and (2) the date on which time off for care will be taken must be specified. Employers who have received a request may not refuse it.

Fourthly, there is the limitation on overtime work. When workers who take care of subject family members in a care-requiring condition request such a limitation in order to take care of said subject family member, employers may not extend working hours beyond a limit on overtime work (24 hours per month, 150 hours per year) except when it would impede normal business operations (Article 18, Enf. Regs. Article 31–3). However, this does not apply to day laborers, workers employed for less than one year, or those with two or fewer contractual working days per week. The period subject to such limitation must be at least one month but not more than one year, and must be requested no less than one month prior to the start date (“limitation period scheduled start date”). There is no restriction on the number of times this may be requested.

Fifthly, there is the limitation on late-night work. When workers who take care of subject family members in a care-requiring condition request such a limitation in order to take care of said family member, employers may not make them work in the hours between 10 p.m. and 5 a.m. (“late-night”) except when it would impede normal business operations. However, this shall not apply to day laborers, workers employed for less than one year, workers who have a family member living in the same household who can take care of the subject family member during late-night (i.e. a family member who is aged 16 or over, who does not work during late-night (including those who work during late-night on a maximum of three days per month), who is not in a situation of difficulty in taking care of the subject family member due to injury, sickness, or physical or mental disability, and who is not due to give birth within six weeks or has given birth within the last eight weeks), those with two or fewer contractual working days per week, or those whose contractual working hours are all during late-night (Article 20, Enf. Regs. Articles 31–11, 31–12). The period subject to such limitation must be at least one month but not more than six months, and shall be requested no less than one month prior to the start date (the limitation period scheduled start date). There is no restriction on the number of times this may be requested.

Sixthly, there is the limitation on non-contractual working hours. When workers who take care of subject family members in a care-requiring condition request such a limitation in order to take care of said family member, employers may not make them work beyond contractual working hours during the limitation period (at least one month but not more than one year) except when it would impede normal business operations (Article 16–9).

Employers are prohibited from dismissing or otherwise treating workers disadvantageously by reason of said workers requesting or taking the leave, time off, or measures outlined above, or on other similar grounds (Article 23–2).

Besides this, employers must, when making changes to the assignment of workers

that result in a change in the place of employment, give consideration to said workers' situation with regard to family care, when such a change in the place of employment would make it difficult for the worker to take care of family members while continuing to work (Article 26). When a worker has quit by reason of family care, the employer must endeavor, whenever necessary, to implement special measures for re-employment or other measures equivalent to the same (Article 27).

#### 4. Care Leave Benefits from the Employment Insurance System

During a period of care leave, employers are not obliged to pay wages, as no labor is provided. Instead, when care leave is taken, care leave benefits are paid from the employment insurance system as an employment continuation benefit. Care leave benefits were established under the 1998 amendment to the Employment Insurance Act, and the benefit rate was raised in the 2000 amendment.

Under the existing system, (1) when "generally insured persons" under employment insurance submit a request to their employers and actually take leave in order to care for a specified family member (the generally insured person's spouse, parent, child, or spouse's parent), (2) and when there are at least 12 months in which the basic daily wage is paid for at least 11 days within the two-year period preceding the day on which care leave was started, (3) care leave benefits are paid after the end of care leave subject to an application by the generally insured person (Article 61–6 of the Employment Insurance Act). Care leave benefits are paid as a lump sum by dividing the care leave period into monthly segments, starting from the date of care leave commencement, then calculating and totaling the payment amounts for each monthly segment. The amount paid in each payment unit segment is 40% of the daily wage at the start of the leave multiplied by the number of days of payment, but in the 2016 amendment, this percentage was raised to 67% from August 2016 onwards, as a temporary measure (Supp. Prov. Article 12–2). Since the maximum care leave is 93 days, the maximum period subject to payment of care leave benefits is also three payment unit segments. Moreover, when wages are paid by the employer and the total of wages plus care leave benefits exceeds 80% of the wage before taking leave, care leave benefits are reduced according to the value of the excess.

### III. Development of Systems of Guaranteed Care Services

#### 1. The Era of Welfare Measures

In the past, family care was basically regarded as a matter belonging to the private domain, and was undertaken as part of private support. At the same time, public guaranteed care services were extended to those faced with long-term care needs who cannot rely on private support. Before the advent of long-term care insurance, elderly care needs were handled by an elderly welfare system based on the Act on Social Welfare for the Elderly.

Under that system, the necessary services were provided to elderly persons with

long-term care needs in the form of welfare measures (including the dispatch of home helpers to those living at home and admission to Intensive Care Homes for the Elderly, among others). Of course, these services were funded from tax revenues, and owing to fiscal constraints in that regard, together with constraints on the supply of services due to insufficient quality and quantity in the provision of services, the system could not necessarily meet all of the long-term care needs faced by each individual elderly person in a care-requiring condition. The government was deemed to have broad-ranging discretion on whether or not to apply measures, and their content, and the limited services available were allocated in order of priority. If admission to a facility was an option, the minimum necessary services were provided within the facility, but as well as the burden of costs on an ability-to-pay basis, the number of facilities was small compared to the numbers seeking admission, giving rise to long waiting lists.<sup>9</sup>

## 2. Enactment and Implementation of the Long-Term Care Insurance Act

The Long-Term Care Insurance Act, approved by the Diet in 1997 following many years of deliberation, was implemented from April 2000 after a two-year preparatory period. At first there were concerns over whether use of the system would take off, owing to a traditionally deep-rooted awareness of long-term care based around the family, among other issues. In fact, however, not only was there a dramatic increase in the volume of service provision mainly involving in-home services and residential services, but the Act also opened up a vast array of care needs that had previously been under the radar, and the socialization of long-term care progressed. The volume of service provision increased partly because the door to care service provision had been opened to private business entities other than social welfare corporations (e.g. NPO corporations, health care corporations, agricultural organizations, limited companies and joint stock companies), mainly in the field of in-home services.

Subsequent developments in the long-term care insurance system mainly concerned the increased use of long-term care insurance services and the response to this. The question of how to address users' needs and ever-growing burdens, intertwined with the concepts of emphasis on in-home care and user orientation raised in the Long-Term Care Insurance Act, would define the way in which the system would develop in future.

## 3. The Rising Burden of Costs

The increased use of services has also brought a rise in costs, in turn causing long-term care insurance premiums to increase as well. The primary insurance premium paid by primary insured persons was 2,911 yen (national average) in Phase 1 (FY2000–2002), but continued to rise to 3,293 yen in Phase 2 (FY2003–2005), 4,090 yen in Phase 3

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<sup>9</sup> While the elderly health care system acted as a receptacle for the deficiencies of the elderly welfare system, it gave rise to the problem of “social hospitalization” (keeping patients hospitalized due to inadequate infrastructure).



(FY2006–2008), 4,160 yen in Phase 4 (FY2009–2011), 4,972 yen in Phase 5 (FY2012–2014), and 5,514 yen in Phase 6 (FY2015–2017).<sup>10</sup>

This is the consequence of introducing a system in which the benefits and burdens of social insurance are linked. The basic rule of social insurance is that if the benefits rise, then so too do the premiums.

Of course, there is strong resistance to any increase in burdens, but in the case of long-term care insurance, the balance between benefits and burdens needs to be considered even more than in the case of health insurance. This is partly due to inherent differences between the risk of a care-requiring condition and the risk of disease, but also due to a difference in the fiscal structure of the two systems. The difference lies in consideration for the ability of the person insured to personally bear the cost. While funding for long-term care insurance is in principle provided half-and-half by insurance premiums and the public purse, persons aged 65 and over, as primary insured persons, must pay the primary insurance premium as a fixed-amount premium based on income levels. When receiving more than a certain level of public pension income, the premiums are specially levied from pension benefits. As the nuclearization of the family progresses and more elderly people live alone or in husband-and-wife households, this special levy of social insurance premiums represents a very visible reduction in pension income for households that only have pension income as their personal income. Since public finances for care insurance work in three-year cycles, long-term care insurance premiums are stipulated by municipal ordinance for the coming three years every three years, and in the sense of gaining acceptance of burdens, there are also strong political constraints on any increase.<sup>11</sup>

By contrast, insurance premiums of secondary insured persons, as the actively working generation, are fixed-rate insurance premiums deducted from wages, and the resistance to burdens is thought to be lower than with primary insurance premiums. Nevertheless, these too cannot be raised limitlessly. This is because, when considering levels of burden, not only do long-term care insurance premiums have to be considered in combination with the health insurance premiums that are levied at the same time, but also, in the case of secondary insured persons, the existing long-term care insurance system only provides limited response to the risk of a care-requiring condition on the part of the secondary insured person. That is, for secondary insured persons themselves to receive benefits from long-term care insurance, their care-requiring condition would have to be caused by a so-called “specified disease.” As such, burdens of long-term care insurance premiums for secondary insured persons, though not entirely lacking an aspect of being for the sake of their own long-term

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<sup>10</sup> The more modest rise in Phase 4 resulted from fiscal and other measures using subsidies to improve employment terms for care workers, with a view to avoiding an increase in premiums.

<sup>11</sup> Moreover, the contribution ratio between primary and secondary insurance premiums has to be periodically revised in line with the proportions of persons insured, and given an increase in primary insured with progressive population aging, the contribution ratio of primary insurance premiums is continuing to rise gradually.

care, could be said to have a strong significance of social assistance or social support for the older generation by actively working generations.<sup>12</sup> It is difficult to gain acceptance of increases in burdens that are not directly linked to a person's own (potential) benefits.

If we assume there to be a limit to increases in insurance premiums, the remaining response in terms of burdens would be to raise the contribution from the public purse. In fact, the Long-Term Care Insurance Subcommittee of the Social Security Council did previously discuss a proposal to raise the public burden ratio from the current 50% to 60%, among others, but in the end the matter was shelved.

#### 4. Revision of Benefits

When there is limited scope for increasing burdens, the way to maintain the system is to make revisions on the benefits side (optimization or reduction of benefits).

In the 2005 amendment, undertaken as a revision five years after enforcement, a major system change was introduced to cope with a sudden increase in the use of long-term care insurance services by persons with only a minor care need. Specifically, categories of support need were revised and preventive care benefits were introduced. Meanwhile, on the regulatory (designatory or supervisory) authority of businesses and others, a new service type consisting of community-based services, regulated by municipalities as insurers, was created as separate from the in-home and institutional services overseen by the prefectures. The intention was to establish a system of small-scale service provision in the sphere of everyday life. Besides this, community general support centers were also introduced, and amendments that pioneered today's integrated community care system were made.

The introduction of community-based services was praiseworthy in itself, in that persons in need of long-term care could live normal lives while receiving care services in a form in which they were not uprooted from their existing living environment as far as possible. However, because existing benefit types remained intact when the new benefit type was introduced, this led to a complication of benefit types and made the system harder to understand. While diversification of the benefits menu could be seen as a system response to new needs (or needs not met by existing benefit types), it does also reflect the fact that the various benefit frameworks (e.g. operating criteria, structure for calculating long-term care compensation) are too rigid. On that point, it could also be symptomatic of the fact that Japan's long-term care insurance is heavily based on legislation and official notices, for better or worse, and that there is little room for discretion by insurers (municipalities). The complexity of benefits was further intensified by the 2011 amendment, which added two new types to community-based services.

This trend toward diversification (ballooning?) of benefit menus came to an important turning point in the 2014 amendment. Home-visit care and outpatient care aimed at people in need of support were moved away from preventive benefits as statutory benefits and into

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<sup>12</sup> Tsutsumi, *ibid.* Note 3) p.104.

Integrated Long-Term Care Prevention and Daily Life Support Programs (New Integrated Programs) as community support programs (though deferred until March 2018), and the range of insurance benefits shrank for the first time. Of course, the fiscal effect of this is not necessarily clear. Municipalities are obliged to implement New Integrated Programs, and insurance premiums are used as the funding source.

For users with incomes above a certain level, on the other hand, the user burden was raised from 10% to 20%. In other words, the benefit rate was reduced from 90% to 80%. Meanwhile, means testing was added to the conditions for supplementary benefits paid to reduce burdens of food and housing costs for residents of long-term care insurance facilities who belong to households that are exempted from paying resident tax. After the amendment, the supplementary benefit will no longer be paid if there are savings above a certain figure.

Finally, anticipating a further increase in cases of severe need, new admissions to Intensive Care Homes for the Elderly were in principle limited to those with medium or high levels of care need (level 3 or higher). Those with level 1 and 2 care needs could only be admitted in exceptional cases, based on the judgment of the municipality, when as a result of unavoidable circumstances they were deemed to have conspicuous difficulty in living anywhere other than in Intensive Care Homes for the Elderly.

## 5. From Insurance to Safeguard Measures?

Something that demands particular caution as a trend seen in the 2014 amendment is the fact that, while the sustainability of the long-term care insurance system is in doubt, the social insurance nature of long-term care insurance when it was first introduced seems to have been gradually diluted (in other words, it is veering away from the path of social insurance). Instead, elements of the previous safeguard-based system seem to be creeping back in, little by little. This is plainly seen in the changes mentioned above, namely (1) the shift of home-visit care and outpatient care for those in need of support to New Integrated Programs, (2) the differentiation of some burden ratios based on levels of income, (3) the addition of means testing for supplementary benefits, and (4) the admission of persons with level 1 and 2 care need to Intensive Care Homes for the Elderly in exceptional cases.

The basic rule of social insurance is that contributions, in the form of insurance premiums, are paid with attention to flow income, and when an insurance event occurs, fixed benefits are paid irrespective of assets or income. Of course, actual systems of social insurance take a variety of forms. In the Medical Care System for Older Senior Citizens, some burden ratios are already being differentiated in line with the size of income, while the ceiling on the patient's own contribution under the high-cost medical expense system is also stratified into three tiers depending on income levels. Of the above, (2) will make long-term care insurance the same as the Medical Care System for Older Senior Citizens. On the other hand, (3) will take account of stock as well as flow when deciding benefits, and thus could be said to be more advanced than it was before. Although supplementary benefits may be regarded as benefits with a welfare-like character, the question should then arise as to why

benefits with a welfare-like character are funded from insurance premiums. Meanwhile, (1) and (4) permit discretion by municipalities, meaning that the concepts of user-orientation and user self-determination attached to long-term care insurance will also recede to that extent.

If the long-term care insurance system reinforces these characteristics of a safeguard-based system in future, the very need to maintain long-term care insurance as social insurance (the *raison d'être* of long-term care insurance) would also come into question. In any case, the long-term care insurance system (particularly for those with a minor care need) is expected to further reinforce its nature as a partial guarantee in future. When it does, the void thus created will probably be filled by payable or free corporate services other than long-term care insurance, together with long-term care by family members and others.

#### **IV. Development of Systems Related to Family Carers**

##### **1. Creation of Care Leave Systems**

With the rapid advance of aging since the end of the 1980s, a dramatic increase in elderly persons requiring long-term care (particularly those suffering from dementia or bed-ridden) and a prolongation of care periods were anticipated. Meanwhile, the family environment surrounding elderly persons was changing considerably with the advance of the nuclear family (i.e. an increase in elderly people living alone or in husband-and-wife households) and the rise of dual earner households, among others. There were also concerns over an increasingly serious shortage of long-term care workers due to the progressive birth rate decline.

A 1994 report by the "Elderly Social Welfare Vision Round Table Conference," set up as a private advisory group of the Minister of Health and Welfare in 1993, pointed out the importance of developing infrastructure for care services by drawing up a New Gold Plan ("Five-Year Plan to Promote Health Care and Welfare for the Elderly") as a reinforcement of the previous one ("Ten-Year Strategy to Promote Health Care and Welfare for the Elderly"), and of systems of care leave. Though actively promoting social infrastructure development for care services under the New Gold Plan, the aim was not to meet all long-term care needs, but the report also stressed the importance of diffusing the care leave system to that end, on the premise that long-term care by families would be even more necessary.

Systems of leave on grounds of long-term care of family members or others were already being operated by some companies as in-house welfare systems. The Ministry of Labour also made efforts to spread and promote these, based on a report by a study group consisting of labor and management representatives and experts, such as by drawing up "Guidelines on care leave systems, etc." (July 1992).

The Women's Working Group of the Women's and Young Workers' Problems Council, acting on a request to review effective diffusion measures including legislation on care leave systems, deliberated the issue while referring to the results of study by an expert

group on care leave systems. The Working Group then compiled a report, with opinion divided on whether such systems should be made subject to law, and the Council's Generally Assembly submitted a proposal entitled "On Legal Arrangements for a Care Leave System, etc." to the Minister of Labour. Based on these discussions, the Child Care Leave Act was amended in 1995 with the addition of family care leave and other changes, and the name of the law was also changed to the Child Care and Family Care Leave Act.

Although the Child Care and Family Care Leave Act made it compulsory for businesses to implement a care leave system, this was not to be enforced until April 1, 1999, after a fixed preparatory period. Care leave systems were initially aimed at workers other than day laborers and fixed-term employees, were limited to three consecutive months, and could only be taken once per subject family member.

## 2. Development of the Family Care Leave System

After this, in the 2004 amendment, (1) the limit on the number of times care leave could be taken was eased, and leave could be taken once per care-requiring condition per subject family member (up to a total of 93 days), while (2) fixed-term employees could also take care leave if they had been employed for at least one year and were expected to still be employed beyond 93 days after the scheduled start date of care leave. Besides this, the system of time off for care was created in the 2009 amendment.

Compared to the childcare leave system, for which revisions were actively promoted from the angle of measures to address the declining birth rate, the development of the family care leave system was more gradual. However, this does not mean that there were no problems with the existing care leave system. For example, let us examine the implementation status of the system.<sup>13</sup> If we compare figures for FY1999, when the system was made compulsory, and the most recent figures from FY2014, the state of provisions on the care leave system rose from 40.2% to 66.7% in businesses with five or more employees and from 96.8% to 99.2% in those with 500 or more employees. However, the development of provisions was not necessarily reflected in the actual state of take-up. The ratio of care leave takers to all full-time employees was unchanged from 0.06% in FY1999 to 0.06% in FY2015. By gender, the ratio was 0.03% for men and 0.11% for women in FY2015, and 74% of care leave takers were women, showing a conspicuous gender bias. By contrast, the ratio of job quitters on grounds of long-term care to all full-time employees had risen to 0.12% (men 0.04%, women 0.23%) in FY2013, double the ratio of care leave takers. Thus, although the development of the care leave system has progressed, it would appear that it is not necessarily easy to use.

In the 2016 amendment, therefore, amendments designed to prevent job-quitting for long-term care consisted of (1) the option to split care leave into segments, (2) the creation

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<sup>13</sup> The figures below are taken from the MHLW FY1999 Basic Survey of Employment Management of Women and the FY2013, 2014 and 2015 Basic Survey of Gender Equality in Employment.

of a system of exemption from overtime work, (3) the option to take time off for care in half-day units, and (4) an increased rate of care leave benefits. Of these, (4) was implemented from August 1st, 2016, and (1) to (3) will take effect from January 1, 2017.

The care leave system has the character of a preparatory period while a system of continuous long-term care is being created,<sup>14</sup> and from the angle of workers achieving a continuous balance between family care and work, various systems related to workers' employment formats (such as measures to reduce contractual working hours) would be more appropriate. This is because, unlike childcare, it is often impossible to predict for how long family care will be required. In that sense, a praiseworthy aspect of the 2016 amendment is that the minimum period during which employers are obliged to reduce contractual working hours has been increased from 93 consecutive days to three years.

### 3. Guaranteeing Incomes during Care Leave

While the takeup rate of care leave is at an extremely low level, one factor that prevents workers from taking care leave is thought to be the problem of income guarantees during the care leave period. During this period, employers are under no obligation to pay wages,<sup>15</sup> meaning that care leave takers have greater difficulty in maintaining a living during that time. As stated above, under the existing system, care leave benefits paid from the employment insurance system as a kind of employment continuation benefit effectively bear the function of income guarantees during the care leave period. Care leave benefits were created under the 1998 amendment of the Employment Insurance Act, together with the implementation of the care leave system in 1999, and initially involved payment of 25% of the pre-leave wage after the end of the care leave<sup>16</sup> (the same level as child-care leave benefits at the time). Later, the benefit level was raised to 40% of the pre-leave wage in the 2000 amendment, in tandem with child-care leave benefits.

Subsequent trends were in contrast to those of child-care leave benefit, which underwent positive developments concerning the method and levels of payment, in connection with measures to address the declining birth rate.<sup>17</sup> Nevertheless, as the problem of job

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<sup>14</sup> A commentary on the Employment Insurance Act also states that care leave is generally "taken as a 'wait-and-see' period until long-term care aims are decided, such as the use of external care services" (*The Employment Insurance Act, New Edition* (Institute of Labour Administration, 2004) p.165). However, because the care leave period is limited to 93 days per subject family member, care leave cannot be taken if the number of days has reached the limit, even when the care-requiring condition of said subject family member changes.

<sup>15</sup> Although the employer may pay a wage, in that case, when the total of wages plus care leave benefits exceeds 80% of the wage before taking leave, the difference between the amount equivalent to 80% and the paid wage is paid as care leave benefits.

<sup>16</sup> It has been pointed out that the large gender disparity in take-up rates is due to the fact that the pre-leave wage is used as the basis for calculating benefit amounts.

<sup>17</sup> For child-care leave benefit, in the 2009 amendment, the previous child-care leave basic benefit (30% of the pre-leave wage paid during child-care leave) and child-care leave workplace return benefit (20% of the pre-leave wage paid six months after returning to work) were integrated into a single

quitting for long-term care came under closer scrutiny, care leave benefit was at last raised to 67% as a provisional measure in the 2016 amendment.

Although care leave benefits have been positioned in the employment insurance system as a measure to prevent unemployment caused by long-term care and to assist and encourage continued employment, job-quitting for long-term care is by no means rare. For this reason, doubts remain as to whether the current level of care leave benefits fulfils the intended function. As well as the appropriateness of the benefit level, the very nature of the system needs to be reconsidered, including a reappraisal of whether it is appropriate for the employment insurance system to carry the function of guaranteeing income during care leave in the first place.

#### 4. Amendment of the System of Benefits for Commuting Injuries

In connection with family care by workers, it might be apt to mention the amendment of the benefit system for commuting injuries. When a worker is not living together with a family member who needs long-term care, the situation could occur whereby the worker calls in at the home of the family member to give care while on the way to work. In the conditions for a commuting injury to be handled under the Industrial Accident Compensation Insurance Act (IACIA), if a worker deviates from or interrupts a “reasonable route” while commuting, any movement after that is in principle not recognized as commuting. However, in cases where such deviation or interruption is the minimum required for carrying out an act necessary in daily life as specified by an MHLW ordinance due to unavoidable circumstances, the journey after returning to the commuting route is once again to be treated as commuting (IACIA Article 7 para. 3). Regarding these exceptional circumstances, a court judgment on a case whereby a worker who, after giving care at his father-in-law’s house on his way home from work, had an accident after returning to his commuting route<sup>18</sup> provided the impetus for an amendment of the Enforcement Regulations in 2008. With this, “long-term care of a spouse, child, parent, spouse’s parent or cohabiting and dependent grandchild, grandparent or sibling in need of long-term care (limited to journeys made continuously or repeatedly)” was added to the acts specified by MHLW ordinance (Enf. Regs.

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child-care leave benefit (50% of the pre-leave wage paid during child-care leave). In the 2014 amendment, the benefit rate was raised to 67% of the pre-leave wage for 180 days after the start of the leave. Of course, the current nature of child-care leave benefit may also be seen as having diverged from its original purpose as an employment continuation benefit.

<sup>18</sup> This is the Osaka High Court judgment 04/18/2007 *Rōdō Hanrei* No. 937 p.14 (Labour Standards Inspection Office Director Habikino Case), which recognized the long-term care of the father-in-law as falling under “Purchase of daily necessities and acts equivalent to this” (Enf. Regs. Article 8 (i)). This judgment has been subject to various assessments, but despite being a remedial case that compensates for a deficiency in the legal system (Atsuko Kajikawa, “Tsukin saigai no nintei [Certification of commuting injuries].” In *Shakai hoshō hanrei hyakusen* [100 selected Social Security Precedents. 4<sup>th</sup> edition], ed. Kenichiro Nishimura and Masahiko Iwamura (Tokyo: Yuhikaku, 2008), p.121.), it led to the long-term care of close relatives being expressly stated in ordinances through the amendment.

Article 8 (v)).

## V. Treatment of Care Workers

Given that long-term care insurance publicly “guarantees” care services (whether “completely” or “partly”), the care services provided or secured within that framework are expected to be at least of a certain standard in both quality and quantity. A problem in that sense is how to secure quality care workers in the numbers required, amid a decline in general manpower numbers due to the falling birth rate, as well as the rigors of care work.

Although emphasis was placed on securing numbers of care workers when the system was first launched, as the system spread, the focus shifted to one of securing quality. Among other measures, third-party evaluation was made compulsory and the qualification system was improved. Since then, however, there has been a progressive drift of workers away from care work. One major cause of this is poor treatment, i.e. the heavy physical and mental burden of care work, and the fact that wage levels are not commensurate with the burden of work.

Of course, there is no golden bullet to solve this problem. This is because, although it is theoretically possible to make arrangements on the treatment of care workers in entrustment contracts in the case of the safeguard system, in the case of long-term care insurance, the payroll costs of care workers are included in the care remunerations established for each long-term care insurance service; actual decisions on wage structures and wage amounts by individual employers are based on the business judgment of each employer. Amid a general downward pressure on care remunerations, parts of income from care remunerations that are earmarked for improving the treatment of care workers will surely also be subject to constraints. And although the Ministry of Health, Labour and Welfare is currently studying comprehensive measures revolving around the core tenets of encouraging participation, improving the working environment and treatment, and improving quality as measures aimed at securing the care workers needed in future, the means available to the administration are only indirect ones.

The drift away from the industry by care workers could lead to a decline in the quality of long-term care in general. As long as a system of long-term care insurance is regarded as a prerequisite, raising actual care remunerations is the true path to addressing this issue, and there will be no improvement in the treatment of care workers if this is shied away from. Although attempts have been made, such as inducement by adding amounts for improving the treatment of care workers, excessive use of monetary increases or decreases will only serve to make a complicated system even more complicated. Moreover, it should be borne in mind that the injection of public funds, like the grants for improved treatment of care workers undertaken in Phase 4, will have a future impact on funding for long-term care in-



urance.<sup>19</sup>

## VI. Conclusion

In reality, the long-term care insurance system does not necessarily always provide “complete” guaranteed care; particularly when it comes to those requiring in-home long-term care, it has a strong character of “partial” guaranteed care. As such, a certain degree of family care (or similar) is actually also necessary. That is to say, Japan’s guaranteed elderly care system, while based on a public guaranteed care service supported by long-term care insurance, has a structure that complements family care, services outside long-term care insurance, and others. In this sense, public long-term care and private long-term care should work together.

Points considered important from the viewpoint of balancing employment with family care are (1) how do workers divide their 24 hours and 365 days (work-life balance in terms of time), and (2) financial guarantees for time allocated to family care. The former is a question concerning worker’s employment formats, while the latter brings into question the ideal nature of an income guarantee system.

Rather than a system designed to help workers give family care on a continuous basis, the care leave system represents a preparatory period for building a system of long-term care if there is any change in the care-requiring condition of a family member. In the sense of continuously balancing employment with family care, a scheme of measures including the reduction of working hours and restrictions on overtime work would be more important. Measures made compulsory by law are the minimum requirement, and further development of systems by individual businesses is to be desired.

The problem of income guarantees during care leave may also be understood more broadly as a problem of income guarantees when engaged in family care. In this case, the appropriateness of family care benefits in long-term care insurance also becomes a point of contention. Against this, however, there will also be the counter-argument that long-term care insurance services should be enhanced and further efforts made to socialize long-term care.<sup>20</sup>

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<sup>19</sup> In the 2012 revision of care remunerations, additional funding for improved treatment of care workers was originally set up as an exceptional and transitional measure in Phase 5 only, in order to achieve a smooth transition of a significant part of the grants for improved treatment of care workers to care remuneration.

<sup>20</sup> Tsutsumi, *ibid.* Note 3) p.44.