Abstract

This article looks at welfare state restructuring in Japan in the 1990s from the perspective of changes in gender relations and demography. Contrary to the retrenchment pressures exerted by economic and political globalization that figured predominantly in the 1980s, changes in gender relations and demographic patterns have been stimulating the Japanese welfare state in an expansionary direction, as witnessed by more active roles taken by the state in providing social care and promoting family–work reconciliation. Welfare state restructuring in Japan in the 1990s is interesting not only because of its juncture with a broader regime shift characterized by the collapse of the old-style conservative politics dominated by the Liberal Democratic Party (LDP) and the reconfiguration of Japan’s political economy but also because it underlines a new fluidity in bureaucratic policy-making processes as a result of an increasing politicization of social policy issues and the entry of new participants (such as women’s groups) in the policy debate. Moreover, it helps us bring into sharper focus the relationships between gender and welfare state restructuring and to address the question of how changes in gender relations are stimulating welfare state responses.
The 1990s was an important decade of social care expansion in Japan. Moving away from its earlier policies of welfare retrenchment, the Japanese welfare state introduced the compulsory public long-term care insurance scheme, expanded public child care, brought in new legislation on parental leave and family leaves, and put in place a host of other support services for workers with family responsibilities. The expansion of social care (or what Japanese call care no shakaika, literally translated as “the socialization of care”) in Japan offers an excellent opportunity to analyze welfare state restructuring. There are at least three reasons for this. First, many of these policies and reforms have been driven by gender and demographic imperatives. This allows us to look at the intersection between gender and welfare state restructuring and to address the question of how shifts in gender relations can stimulate welfare state responses. Second, many of the reforms have also brought the issue of social care to the forefront of policy debate. Unlike before, when child care and elder care were considered separate and relatively minor issues within social welfare, the notion of social care has now tied them together as congruent parts of a larger national agenda—that of social security and population concerns. Third, reforms to support women’s dual roles as mothers and workers, which many of the new policies are clearly attempting to do, also direct our attention to the ideological framework underpinning the contemporary Japanese welfare state. As a center-right rather than social democratic implementation, it raises the question of the meaning of the conservative welfare state restructuring of gender relations.

This article examines the nature of welfare state restructuring in Japan in the 1990s from the perspective of social care reforms. I will first define the concept of social care and justify its relevance as an analytical tool to examine welfare state restructuring. The second section will identify the generative factors that have contributed to the new understanding of policy issues and facilitated government policy responses. The Japanese government’s traditional reliance on the family in the face of changing social and economic conditions will be highlighted as contributing to the family care crisis of the 1980s. The third section will discuss the political economy of social care in Japan. Women’s social and political mobilization efforts and the issue of fertility decline will be examined in light of their impacts on social policy reforms. The success of women’s groups in exploiting changes in political structure in the early 1990s and their entering into the policy making process as new participants suggests a break in old-style conservative politics and openings for new interest groups to enter and participate in the policy arena. The impacts of the fertility decline, on the other hand, show how what appear to be apolitical...
and private decisions taken by women in the face of the new opportunity structure can become a powerful force to compel the state to reset its social policy agenda. The fourth section outlines the content of reforms, particularly in the areas of long-term care and family and work harmonization. Finally, the last section summarizes the developments in Japan and draws out the key lessons and questions for understanding the future of the Japanese as well as other welfare states.

The Concept of Social Care and Its Applicability to Welfare State Analysis

This article builds on Daly and Lewis's (2000) concept of social care. Daly and Lewis consider social care as lying at the intersection of public and private, formal and informal, paid and unpaid, and involving cash and service provisions required to meet the needs of the individual. They define social care as “the activities and relations involved in meeting the physical and emotional requirements of dependent adults and children, and the normative, economic and social frameworks within which these are assigned and carried out” (Daly and Lewis 2000, 285). Accordingly, social care is considered to embody at least three sets of analytical questions: (1) care as labor—which requires us to compare care with other forms of work and labor and the conditions under which it is carried out; (2) care as an obligation and responsibility—which forces us to examine the nature of social relations in which such activities take place and the roles of the state in structuring and mediating norms about care; and (3) care as activities with financial and emotional costs and benefits—which raises the question of how these costs are shared among individuals, families, and society, as well as how costs and benefits of caring for others may be evaluated. These analytical questions can further be approached from either macro or micro levels. At the macro level the division of care may be put to an empirical test through the analysis of care infrastructure and the distribution of care provision among different sectors, and a micro-level examination may determine the distribution of care among individuals within the family and community, and focus on who performs or receives care, the nature of care relationships, and the social conditions under which care is provided.

Social care is a particularly useful concept to analyze welfare state restructuring in Japan because of the extreme urgency to resolve the problem of care faced by that society. In Japan the rapid aging of the population and the steady rise in married women’s employment rates are forcing the government to solve the problem of a huge in-
crease in demand for care at the same time the volume of private unpaid care is shrinking. The question here is, given the situation, what are welfare state responses, and how are these responses mediated? In their comparative analysis, Daly and Lewis (2000) identify roughly three types of welfare state responses in Europe. The Scandinavian welfare states are identified as forming a “cluster of a kind” based on their tendencies to collectivize caring for both the elderly and children, whereas the countries in the middle and south of the European continent are grouped together as favoring privatization of care. The third group, which they call the Beveridgean welfare states, is identified by their tendency to draw a strong distinction between child and elder care and to prefer child care as a private rather than public responsibility.

Daly and Lewis’s social care typology serves as a valuable addition to the research on comparative social policy. As concerns about care has been a continuing preoccupation of policymakers (see for example, Jenson 1997; Koven and Michel 1993; Pedersen 1993), it makes sense that social care should be brought to the center of welfare state analysis. As their typology shows, welfare state responses to social care give a good indication of how care and gender intersect with social policy. However, Daly and Lewis’s analysis fails to take account of the causation of welfare state responses, nor does it tell us much about the political economy that shapes the observed outcomes. Accounting for the causes of welfare state responses is often a difficult task because it requires a careful examination of political dynamics surrounding the negotiation of the state, family, and market interests over the issue of care. In recent years a number of comparative studies of gender and social policy have attempted to explain the recent policy changes in the conservative or strong male breadwinner regimes by looking at the political dynamics of family and care policies (Gottfried and O’Reilly 2002; Gonzalez et al. 2000), and they have highlighted the difficulties faced by the conservative welfare regimes in negotiating policy changes. This article will go beyond Daly and Lewis’s analysis by extending the concept of social care to examine the Japanese welfare state and illustrating the policy dynamics of welfare state restructuring over the issue of social care.

Research on social care in Japan is still very new, and most studies have clearly separated the issue of elderly care from that of child care. In addition, even fewer have examined social care in relation to welfare state (Gottfried and O’Reilly 2002; Peng 2002, 2001a, 2001b). The dominant perspective on Japanese care policy has also emphasized the mainstream view of policy making and policy process in Japan—that of the power of the state bureaucracy in policy
making (see for example, Campbell 1992; Campbell and Ikegami 2000; and Masuda 1998, 2001). Although identifying an important aspect of policy making in Japan, their lack of gender insight and disregard of the role of civil society other than traditionally powerful interest groups, such as the Japan Medical Association and the Association of Large Employer’s (Keidanren), in policy-making processes have resulted in a simplistic and one-dimensional view. The need for a more in-depth understanding of the political economy is apparent in the case of social care in Japan. Moreover, the mainstream analysis has also argued, first, that long-term care insurance has been an unquestionable policy success story for the state bureaucracy, leaving little room for an assessment of the implications of the policy reforms on individuals and families. Second, these bureaucracy-centered analyses have also created a sort of à la carte vision of policy reforms, as each set of policy reforms is treated as a separate project because each involves a different cast of bureaucrats even within the same ministry. Hence, few linkages can be drawn between, for example, care for the elderly and care for families with dependent children.

Applying the concept of social care from a gender perspective, this article hopes to overcome the limitations of the mainstream approach. Social care will be used as a tool to analyze the Japanese welfare state and its transformation over the last couple of decades. I examine how the boundaries of care labor, care obligation and responsibility, and costs are being redrawn between family, market, state, and community in Japan, and how social, political, and economic factors have helped bring about such an exigency. Through an examination of welfare state restructuring I will highlight: (1) the importance of civil society, particularly the role of women’s groups in affecting social policy changes during the 1990s; (2) the linkages between elder care and child care within the overall context of social care; and (3) the centrality of social care as a concept for understanding contemporary welfare states under transformation.

The Japanese Welfare State: The Generative Factors behind the Care Crisis

Despite a considerable expansion in the 1970s, the Japanese welfare state is still one of the leanest in the Organisation for Economic Co-operation and Development (OECD) countries, ranking closely below the United States in terms of total expenditure as a share of gross domestic product (GDP). Japan’s low social security expenditure is largely a function of the lack of public assistance and personal social services. Of the total social security expenditure, pension and
health care insurance take up the lion's share: in 1990 their proportional weight was approximately 90 percent (NIPSSR 2000).

Throughout the 1980s, the tight fiscal control imposed under the state’s new conservative (Japanese-style welfare society) regime managed to substantially curb the rate of the rise of social security expenditure. For example, social security expenditures rose by about 1 percentage point between 1980 and 1990 (from 12.4 percent to 13.6 percent of the national income). This modest increase, despite tremendous expansionary pressures from pension and health care, was achieved by keeping down the cost of social welfare and by shifting public care and personal service responsibilities back to the family. Notwithstanding the fact that the family had always taken on a significant burden of social welfare, the welfare state restructuring of the 1980s reemphasized the family’s social welfare responsibilities and rolled back many of the policy reforms initiated in the 1970s. The free medical care services for the elderly introduced in 1973, for example, were abolished and replaced by user fees in 1982. The income assistance program (seikatsu hogo), which saw a modest expansion during the 1970s was rationalized in the early 1980s by means of a tighter means test. The child allowance program introduced in 1971 was also gradually retrenched by tougher means tests. The special child-rearing allowance and other financial assistance programs to single-mother families also faced similar cutbacks throughout the decade.

The Japanese welfare state’s reliance on the family is most evident in (1) a high level of coresidency and care dependency among elderly people and their children; (2) a lack of public and market care provisions; and (3) a high rate of dependency among unmarried adult children.

In 1980, nearly 70 percent of the elderly were living with their adult children. To encourage and maintain a high level of coresidency, the government introduced a number of policies to support three-generation households and family-based care, such as tax credits for three-generation households and care allowances for family members caring for their elderly relatives. Although the coresidency rate has been declining since the 1980s, more than half of the elderly still live with their children today (Ministry of Health and Welfare 2000). In 1997, 58.9 percent of people over the age of sixty in Japan were living with either their married or unmarried children, as compared to 12.9 percent in Germany and 16.1 percent in the United States (Prime Minister’s Office 1997). On the other hand, the proportion of elderly living or being cared for in institutions in Japan was 3.6 percent in 1998, even though an estimated 13 percent of all the elderly were considered in need of such care. Along with the high
coresidency rate the level of familial care in Japan is also very high. The National Basic Survey in 1995 found 86.5 percent of bed-ridden elderly were being looked after by their coresiding family members, and another 6.3 percent were being looked after by their families who were not living with them. Only 7.2 percent of all bed-ridden elderly were being looked after by people who were not their families (Ministry of Labour 1998). A recent study based on the national household survey also shows an inverse relationship between the level of postretirement income and the coresidency rate, and a positive relationship between the level of disability and the coresidency rate, highlighting the elderly people’s economic and care needs as two important variables in postretirement coresidency decision making in Japan (Funaoka and Ayusawa 2000). These data suggest that not only is a large proportion of elderly in Japan being cared for by their families but that this is partly preconditioned by the lack of public and institutional support.

The public provisions for child care services appear to be a little better. In Japan about 22 percent of all preschool-aged children are cared for in public child care centers. This figure is further broken down to 4.7 percent for zero- to two-year-olds, 17.1 percent for two-year-olds, 31.8 percent for three-year-olds, and 26.7 percent for four- to six-year-olds (Ministry of Health and Welfare 1998). Although an international comparison of child care is difficult due to irregularities in cross-national data, the Japanese figures appear comparatively higher than that of the United States (1 percent of children zero to two years and 14 percent of three to school-age are in publicly funded child care), where the employment rate of married mothers with small children is higher than Japan. On the other hand, the tendency toward family-based care for smaller children, particularly those under the age of two, which is apparent in Japan, is quite similar to many of the continental and Mediterranean European welfare states, such as the Netherlands, Germany, and Italy (where 2, 2, and 5 percent of children zero to two years, and 53 percent, 78 percent, and 88 percent of children three to school age, respectively, are in public child care). The Japanese figures for public child care are much lower than those of the Scandinavian welfare states like Denmark and Sweden (48 percent and 32 percent of children aged zero to two, and 85 percent and 79 percent of children aged three to school age, respectively, are in public child care) (Meyers et al. 1999). There are also a number of problems associated with public child care in Japan that merit attention.

First, the current child care spaces are still far short of meeting the needs. The number of children on the official waiting lists has risen from 26,114 in 1994 to 40,523 in 1997 as more mothers enter the
labor market (Ministry of Health and Welfare 1998). Second, public child care also largely serves older preschool-aged children, partly because of economic expediency and partly due to institutional legacy. Child care for children under age two is comparatively more expensive than for older children because of greater care needs, a higher worker-to-child ratio, and special care and dietary requirements. Many child care centers therefore either do not provide services for children under two years of age or, if they do, offer only limited spaces. Because most working women can take only up to a year of child care leave, anyone hoping to continue working would be seriously affected by the lack of public child care. Private-sector child care services, although beginning to develop, are still inadequate in Japan. Moreover, they tend to be unlicensed, uncertified, expensive, and generally considered unsafe (Japan Times 2001). In lieu of public child care most working mothers thus rely on their families, particularly grandparents, to care for their children. The employment rate of mothers living in three-generation households with youngest child aged between zero and three is 41.4 percent as compared to 25.2 percent for those mothers living in two-generation households, suggesting the availability of familial care as an important factor in married mothers’ employment (Ministry of Labour 1998).

Finally, notwithstanding the high level of coresidency between the elderly and their adult children, the coresidency rate of young unmarried adult children and their parents is also very high and has been steadily rising in the recent years. In 1996, approximately 80 percent of unmarried working adults in their twenties were reported coresiding with their parents (as compared to 70 percent in 1975), whereas the proportion for those between the ages of thirty and thirty-four was about 70 percent (up from 50 percent in 1975). Nearly half (48.6 percent) of unmarried adults who were living with their parents were also reported receiving financial assistance from their parents, and the majority also enjoyed personal services, such as cooking, cleaning, and laundry provided by their mothers (Ministry of Health and Welfare 1998). Studies show that cohabitation between adult children and their parents (or young adults’ inability to achieve economic self-sufficiency) can be explained by (1) the widening income disparity between young and older workers (Seiyama 2001); (2) the high housing cost; and (3) the lack of adequate public support for young people, such as income support and housing subsidies (Iwakami 2000; Miyamoto 2000).

These patterns of familial dependency show not only the extent of the family’s financial and care responsibility in Japan but also that the care burden may have increased rather than decreased over time.
Moreover, as in the case of many European countries, the increasing demand for personal care in the face of the lack of public provisions is not substituted by the market. In Japan women’s family care obligations continue to be reinforced by social policies and employment practices that encourage married women’s economic dependence on men and discourage adult women’s economic independence and also marital dissolution. The married women’s tax exemption law, allowing housewives to earn up to ¥1.3 million (approximately 20 percent of the average male annual wage) without tax and social insurance liabilities, is a strong incentive structuring married women’s part-time employment, and the tax credit for three-generation households has served to reinforce elderly coresidency and married women’s care responsibilities at home. On the other hand, the lack of income assistance for divorced and unmarried single mothers and punitive measures, such as disqualifying divorced lone mothers from income support for the first half year after divorce, have discouraged women from divorcing their husbands, particularly when their children are young. Also opportunities for women to achieve economic independence are limited by the lack of social support and of effective equal employment legislation.10

Throughout the 1950s and 1960s such a familialistic welfare regime posed little problem because the economic growth was rapid and the population was still relatively young. However, in the 1970s a number of the economic and demographic problems began to converge, setting in motion a series of changes. In 1971 Japan officially became an aging society as the proportion of the elderly reached 7 percent of the total population. In 1974–75 the country faced its first economic crisis since the end of World War II. The economy registered a negative growth in 1975, and thereafter recovered positive growth but at a much lower level. The government responded to the decline in economic growth by cutting back on social welfare. As the real value of male wages began to decline, the married women’s employment rate began to rise. By the beginning of the 1980s Japan was a textbook case of the family care crisis: the number of elderly in need of care was rising as more married women went out of their home to work; the limited institutional and public care services were retrenched by welfare cutbacks; and market provisions for elder care did not exist. The care needs of the elderly and children were expanding just as the postwar welfare regime, which was structured to accommodate such needs by enabling the women to care for their family members at home, began to crumble.

This sets the context for the political and economic dynamics that would lead to a new settlement in the social care arrangement between the state, family, and market to follow.
The Imperatives for Change

The shift in gender relations was most apparent in the erosion of the male breadwinner/female housewife family form. As noted, the steady decline in married women’s employment since 1955 began to reverse after 1975, and by 1986 more than half of married women were reported working.\(^{11}\) The family’s need for a second wage earner was, however, contradicted by the increased policy expectation on the family to care for the young and the old. The state’s assumptions about the family and its neglect of the family’s care burden was reflected by the Second Provisional Commission on Administrative Reform (Second Rincho) in 1981, which sought to achieve fiscal restructuring through social welfare cuts. This was met by two distinctively different responses. One came from housewives, most of whom were middle-class women in their fifties who were faced with an increased burden of having to manage work while caring for their aged parents and/or parents-in-law and often still dependent children. These women responded to the welfare retrenchment by directly challenging the government’s family policy. The other reaction came from their younger cohort. They reacted to the neoconservative politics of the 1980s by not only dissociating themselves from political activities but also consciously or unconsciously shifting their marriage and fertility patterns in such a way that would later contribute to the fertility crisis.

Women’s Social Mobilization

The political challenges of working housewives came shortly after the state began implementing the Japanese-style welfare society policies in 1981. Fearing that the new welfare reforms would push the family’s care burden to the limit, women’s groups began to mobilize at the grassroots level to protest against the government’s top-down policy-making process.\(^{12}\) Speaking to the problem of women’s double burden, groups such as the Women’s Committee for the Betterment of the Ageing Society (WCBAS) (Korei shakai wo Yokusuru Josei no Kai) began mobilizing around the issues of the aging society and the family’s care burden in 1983 (Higuchi 1997). The public support proved surprisingly strong. WCBAS, which started as a gathering of 298 women in 1983, doubled its membership to 600 within a year; by 1989 it had become a nationwide network with regular appearances on the national media. WCBAS undertook its own research, collected data, and disseminated information on the family’s care burden. Data highlighted the contradictions between the state’s family policies and the reality of the family. The evidence also underscored the gender aspects of family care. For example, it was revealed
that although women made up an overwhelming majority of carers (85 percent), they were also more likely to be institutionalized when it came to their turn to be cared for, as evidenced by their high representation (80 percent) in public institutions (Higuchi, 1997). The lack of political representation for women was also pointed out (Koreika Shakai wo Yokusuru Josei no Kai 1998). In response the group brought together not only housewives but also academics, social activists, and volunteers and social workers on a common platform of care. Different local chapters formed study groups, tours, and symposiums to learn about long-term care policies and conditions of elderly people in other countries (Koreika Shakai wo Yokusuru Josei no Kai 1998). They also actively recruited and trained women to enter politics. In this process, WCBAS and other women’s groups pushed to redefine the policy issues and women’s interests in relation to the state’s welfare policies. The social and political impacts of women’s groups were considerable. They helped change public debate on social welfare policy. Not since the 1960s had women’s groups been so politically active in policy issues. The rise in public and media interest in the issue of social care for the elderly also helped the group gain credibility as a public advocate on behalf of women and the family. As women’s mobilization gathered momentum, more academics, the media, and politicians joined in lobbying for the extension of social care.

Women’s political mobilization joined with other policy streams in the 1980s and 1990s to push social care policies forward. One stream came from the government, not directly because of its interest in social care but rather because of its attempt to introduce a new tax. As noted earlier, in 1982 the government enacted the Health Care for the Aged Law which, among other things, replaced free medical care for those over the age of seventy with a copayment system and introduced a cross-subsidization scheme among the three public health insurance systems to cover the cost of medical care for the elderly and to reduce the government’s fiscal burden of having to subsidize the expensive National Health Care Insurance scheme from its general tax revenue. Despite these efforts, however, health care costs continued to rise. In 1989, the government introduced a 3 percent consumption tax on the ground that this was necessary for an aging society. As the LDP was already under severe criticism from women’s groups over its family policy, the introduction of the consumption tax under the climate of welfare retrenchment invited an even larger and broader political backlash. The voter revolt was expressed in the Upper House election in the same year. The LDP suffered a humiliating loss, which culminated in the party losing the control of the Upper House, and a huge gain for the opposition Ja-
The political fragmentation within the LDP in the early 1990s, resulting in the departure of LDP members and the formation of splinter groups, including the Democratic Party of Japan, was another policy opportunity for women’s groups and other interest groups to enter public debate and push for social care (Eto 2000). Among the economic transformation following the collapse of the bubble economy and a string of corruption scandals, the LDP split in 1993 and gave way to a series of coalition governments (Pempel 1998). The first such coalition government, headed by the reformist Prime Minister Hosokawa Morihiro of the Japan New Party (Shin Shin To), opened the policy window for the idea of long-term care insurance that had been circulating among bureaucrats within the Ministry of Health and Welfare and among the community groups. In fact, the ministry had already formed a policy study group to work on the idea of long-term care insurance since the mid-1980s. The bureaucratic interest in a long-term care insurance scheme came partly as a result of long-term fiscal concerns about health care, particularly in relation to the problem of social hospitalization, and partly as a result of pressures from the Federation of National Health Insurance Associations and major business organizations like Keidanren. These groups had been demanding that the government ease the financial burden imposed on them as a result of the cross-subsidization scheme introduced under the Health Care for the Aged Law in 1982. The Ministry of Health and Welfare was also keen to push for a new social insurance because unlike taxes social insurance

<table>
<thead>
<tr>
<th>LDP</th>
<th>JSP/SDP/SDP</th>
<th>DSP</th>
<th>Komeito</th>
<th>JCP</th>
<th>Others</th>
<th>Total no. seats</th>
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<tr>
<td>6 July 1986</td>
<td>72</td>
<td>20</td>
<td>5</td>
<td>10</td>
<td>9</td>
<td>10</td>
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<tr>
<td>23 July 1989</td>
<td>36</td>
<td>46</td>
<td>3</td>
<td>10</td>
<td>5</td>
<td>26</td>
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<tr>
<td>26 July 1992</td>
<td>68</td>
<td>22</td>
<td>4</td>
<td>14</td>
<td>6</td>
<td>13</td>
</tr>
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Source: Otake (2000).
funds would go directly into its own coffers rather than to the Ministry of Finance (Campbell 1992).

Throughout this time, women’s groups were also continuing to call for the right to social care and proposed a social insurance scheme as a way to ensure this (Eto 2001). Hence, when the Hosokawa government expressed its interest in the idea of a long-term care insurance scheme in 1994, the Ministry of Health and Welfare immediately set up a committee to work on legislative reform (Masuda 2001), opening an important window for women’s groups to enter into the policy debate. Women’s groups spearheaded by WCBAS quickly linked their campaign for social care with the new policy proposal. The policy-making process for the long-term care insurance became even more permeable when the head of WCBAS, Higuchi Keiko, was invited to join the Ministry of Health and Welfare’s Research Committee on Care and Independence Support for the Elderly (Koreishakaigo Jiritsu Shien Shisutemu Kenkyukai), a special advisory council responsible for approving the ministry’s policy draft proposals on health and welfare issues for elderly people before they are submitted to Parliament.

The policy process involving the setting up of a special advisory council, as described, is not new. Japanese policy bureaucrats have been remarkably successful in co-opting different and powerful interest groups in their policy making process by using a variety of councils or Shingikai (sometimes called research committees, or Kenkyukai) to reach consensus. In the past, only those who the bureaucrats deemed important or legitimate to the policy making were invited to the councils. These included academics, members of the business community and professional associations, and other economic and industrial leaders. Women, particularly those representing women’s groups or common community groups were rarely recognized as legitimate participants of such councils. Hence, the fact that the head of the WCBAS was invited to join the council indicated the legitimacy that the group had gained in the eyes of the bureaucrats and their greater sensitivity to public participation and opinion. This established a channel for women’s groups to voice their opinions on social care policy, although it also leaves WCBAS open to cooptation in such bureaucrat dominated policy discussion. On the other hand, the bureaucracy also stood to benefit from the public support of women’s groups as their interests in long-term care insurance intersected with those of women’s groups.

The cooperation between the bureaucrats and women’s groups soon became evident. In 1995 the idea of long-term care insurance met an unexpected opposition from conservative elements within the LDP when a new coalition government replaced the Hosokawa coali-
tion government in 1995. Realizing that the draft proposal was going nowhere, WCBAS launched a political campaign called the Ten Thousand Citizens’ Committee to Realize Social Care (Kaigo no Shakaika wo Motomeru Ichiman’nin Shimin Iinkai, henceforth the Committee), to galvanize public support. Receiving little support from the ruling LDP, the Committee formed an alliance with the newly formed Democratic Party of Japan (DPJ) and other opposition parties to push for its proposed version of the long-term care insurance scheme. While WCBAS rallied the public and politicians, the ministry bureaucrats worked on forging consensus among the members of the council. A year later, when the governing LDP coalition government realized that it needed DPJ support to pass the health care insurance reform bill, it consented to accept the passage of the long-term care insurance bill as an exchange. The political accommodation did not satisfy all the demands of the Committee, but it did help push the process forward and allow the group to shape the content of this crucial piece of legislation and in the process significantly altered the course of welfare state reform in Japan.

The Fertility Decline

While the housewives took on the state in their fight for social care, their younger cohorts took the route of political disengagement. The political participation rate of men and women under the age of forty dropped steadily throughout the 1980s. Rather than challenge the structural blocks through social and political mobilization younger Japanese women focused on fulfilling their personal and career aspirations by refusing to subscribe to the traditional life course (for useful data and analysis on women’s life course fertility patterns, see Atoh 1990 and Retherford et al. 1999). The opportunity structure for young Japanese women in the 1980s was also qualitatively different from their older cohort. The social expectations for women to get married and to assume the role of full time housewives were much weaker than those of a couple of decades earlier. The equal employment opportunity law of 1986, though it did not guarantee women labor market equality, nevertheless accorded them more employment opportunities and greater possibility of career jobs than before. Yet although new legislation allowed more employment opportunities for women, the labor market structure remained hostile to career women with family and care obligations. The parental leave and care leave legislation were not introduced until the 1990s.

On the other hand, for many women who wanted to get married, the lack of an ideal partner left them with few opportunities to do so. The public opinion surveys show that for both unmarried men and women between the ages of twenty-five and thirty-four, the most
The same survey also shows that men and women are seeking different things from their marriage partners. Women were looking for men who would be willing to share household and child care duties; men preferred women who would value and accept his (traditional) work responsibilities (Ministry of Health and Welfare 1998). Given such an opportunity structure and mismatch in gender expectations, women who wanted a career chose to postpone and even avoid marriage and/or childbirth, whereas those who wanted to get married also saw their marriage opportunities significantly diminished. The nonmarriage rate for women between the ages of twenty-five and twenty-nine rose from 20 percent to 50 percent between 1975 and 1995, and the average length of steady employment for women increased from 6.1 years in 1980 to 8.2 years in 1996 (Ministry of Labour 1998).

The aggregate effect of individual decisions to postpone and/or forgo marriage was significant. In 1989 the total national fertility rate dropped to 1.57, a critical psychological point for the Japanese (Ministry of Health and Welfare 1998). This so-called 1.57 shock set a flurry of policy activities within the government as policy makers rushed to find solutions to the “quiet crisis.” Government bureaucrats urged researchers and academics to identify the cause of the fertility decline and to come up with solutions to reverse or at least halt the drop in the fertility rate. The research findings pointed to the shift in women’s marriage and career decisions and to the existing gender relations as the causes of fertility decline (Nakano and Watanabe 1994; Atoh et al. 1994). In particular, studies focused on two main causal factors: the high opportunity cost associated with having a child and the lack of harmonization between work and family responsibilities. Not only are the costs of raising a child huge but the lost income resulting from mothers withdrawing from full-time employment was identified as a significant factor in fertility decisions (Maruyama 1999). In other words, the existing gender relations were forcing young women to choose either marriage or career, and many young women were deferring the choice or choosing the latter.

By this time, bureaucrats had learned sufficiently from the European experience and had accepted the utility of family-work harmonization policies. The Child and Family Bureau of the Ministry of Health and Welfare, which had been trying to raise the profile of the child welfare issue, particularly in relation to child protection, saw one of its objectives coinciding in a timely way with the demographic interests of the Population Problems Bureau of the Ministry in the
early 1990s, paving the way to interbureau policy consensus. The European experience had shown that throughout the 1980s women-friendly welfare states like Sweden were successful in raising or keeping a high fertility rate, whereas familialistic welfare states like Italy were experiencing rapid fertility decline. The policy implications were obvious: contrary to the situation in the 1960s, child rearing and women’s paid work in the 1990s were complementary rather than alternative (OECD 1999), and it was the countries that supported work and family harmonization that had a better potential to prevent fertility decline.

The bureaucratic position favoring more women-friendly/family-friendly social policies received a further boost by a political environment that happened to be more sensitive to gender issues at the time. Since 1993, the LDP coalition government went through a series of transitions as they changed partners, making policy trajectories also somewhat irregular. However, with successive change in the political regime the politicians also saw a greater value in courting women’s votes. The Council for Gender Equality was established during the brief premiership of Hata Tsutomu in 1994, for example, when the LDP formed a coalition with the Sakigake Party (SP) and the Social Democratic Party of Japan (SDPJ). Less than a year after the inauguration of the Hata coalition government, the new coalition (led by SDPJ leader Murayama Tomiichi) made a further push on the gender equality issue, placing it at the top of the government’s political agenda. Two years later when Hashimoto Ryutaro’s coalition government replaced the Murayama cabinet, it quickly introduced the Gender Equal Society Plan (Danjo Byodo Shakai Sankaku) to consolidate the targets for gender equality. For the bureaucrats in the Ministry of Health and Welfare, the political climate was highly favorable for pushing a framework for family-work harmonization policies. With the Gold Plan of 1989 setting precedence for social care expansion, the Angel Plan (the Emergency Ten Year Plan in Response to Declining Fertility supported by five different Ministries) passed in 1994 with minimum difficulty. As if to complement the Gold Plan, the Angel Plan aimed to expand child care services and to introduce supportive employment legislation to help women harmonize work and family responsibilities with a set of fairly ambitious numerical targets. Thus in a completely different way young women had forced the state to reset its social policy agenda in the 1990s. In this case the changes in individual behavior in response to the new opportunity structure, culminating in the drop in fertility, had become a powerful political stimulus forcing the government to take action.
The New Political Discourse

The combination of women’s political mobilization and the fertility crisis had significantly reshaped the political discourses and reconfigured the political and institutional interests in Japan in the 1990s. Whereas before 1990, the problems of Japan’s aging society were largely debated in terms of how to strengthen the family’s traditional roles, after 1990 the debate shifted to one of how to save the family (i.e., women) from collapse and to provide incentives for young people to get married and have more children. By the beginning of the 1990s, even the most conservative of the LDP politicians were shying away from advocating the Japanese-style welfare society. The government had also abandoned its attempt to promote three-generation household arrangements and, instead, had begun to consider married women’s employment as a norm rather than an anomaly.

The fertility decline also redefined the issue of the aging society in terms of the long-term economic and social implications for Japan. It is important to emphasize here the issues that are being discussed in relation to the low fertility and rapid aging of Japanese society. Current demographic projections estimate the proportion of people over age sixty-five will double from the current figure of 15.6 percent to 32.3 percent by 2050. At this rate of aging, even taking into consideration the increase in the employment rates of women and of the elderly people, Japan will face serious labor shortages after 2005. A sharp rise in the dependency ratio is also expected to push up the individual social security burden.26 The current government projection estimates the total social security burden to reach between 29.5 to 35.5 percent of the national income, as compared to 18.9 percent in 1998 (Ministry of Health and Welfare 1998; NIPSSR 2000). In terms of individual taxes, the social insurance burden is estimated to go over 50 percent of the national income.

The impacts of these demographic changes are broad. The decline in labor productivity and the steady erosion in the total capital asset from people retiring will gradually undermine economic growth.27 The problem of labor shortages is already forcing the government to rethink its immigration policies. The decline in the total fertility rate will also lead to more families with only one child and a sharp increase in households made up of elderly couples or elderly people living alone, which will undermine the state’s long held ideal of the traditional role of the family to care for its members. Already in many rural areas the migration of young people to cities has resulted in an increased care burden for the family and the local govern-
ments. Finally, given the current fertility rate the total population of Japan will reach a peak around 2007 and thereafter will decline steadily. By the end of the twenty-first century the Japanese population is estimated to drop to about half the current level (Ministry of Health and Welfare 1998). In summary, the demographic shifts will have serious social and economic as well as cultural and psychological impacts on Japan.

The shifts in gender relations and demographic patterns have thus forced the Japanese state to redefine its interests in relation to social welfare and to alter the direction of welfare state restructuring in the 1990s. As the social politics of the 1980s and 1990s have made clear, it is not only futile to force the family to take on more welfare burdens, but also that the new political economy of gender and demographic structures demands new gender policies and that the issue of social care is at the center of the policy debate. Thus in a remarkable turnaround from the earlier policy of welfare retrenchment, the 1990s marked the beginning of social care expansion in Japan.

Social Policy Reforms since 1990

The social policy reforms of the 1990s have resulted in two important changes. First, they led to a noticeable redistribution of responsibilities for personal care between the state, the market, and the family, with the state taking on a larger share than before. Second, the role of the market and the community (volunteer sector) in social care provision has also become more important. This section will examine the two major social policy reforms of the 1990s—the long-term care and the family-work harmonization policies (or kazoku to shigoto no ryoritsu)—to illustrate how the boundaries of care labor, care obligation and responsibility, and costs are being redrawn between family, market, state, and community.

Long-Term Care Insurance and Social Care for the Elderly

Table 2 outlines the content and target figures set by the Gold Plan of 1989 and the New Gold Plan introduced in 1994. Despite the expansion, however, the two Gold Plans have proved inadequate. This has called attention to the serious lack of public provisions and led to much public criticism about the adequacy of public care support. The criticisms were directed first to the fact that in anticipation of a huge demand for care services after the introduction of the Gold Plan, local governments tightened the means test to limit the demands. This excluded most of the elderly from the public care system. Second, not only were there not enough services for all those in need, the services were further restricted to those who were deemed
### Table 2. Summary of the Gold and the New Gold Plan targets and actual figures

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<tbody>
<tr>
<td>No. home helpers</td>
<td>31,405</td>
<td>100,000</td>
<td>170,000</td>
<td>176,000</td>
</tr>
<tr>
<td>No. spaces for day services</td>
<td>4,274</td>
<td>10,000</td>
<td>17,000</td>
<td>13,350</td>
</tr>
<tr>
<td>No. beds in short-stay centers</td>
<td>1,080</td>
<td>50,000</td>
<td>60,000</td>
<td>57,000</td>
</tr>
<tr>
<td>No. community care support centers</td>
<td>NA</td>
<td>10,000</td>
<td>10,000</td>
<td>N/A</td>
</tr>
<tr>
<td>No. visiting nurse stations</td>
<td>NA</td>
<td>NA</td>
<td>5,000</td>
<td>4,470</td>
</tr>
<tr>
<td>No. spaces in special chronic care homes</td>
<td>162,019</td>
<td>240,000</td>
<td>290,000</td>
<td>297,000</td>
</tr>
<tr>
<td>No. elderly health care institutions</td>
<td>27,811</td>
<td>280,000</td>
<td>280,000</td>
<td>230,000</td>
</tr>
<tr>
<td>No. spaces in care houses</td>
<td>200</td>
<td>100,000</td>
<td>100,000</td>
<td>44,176</td>
</tr>
<tr>
<td>No. elderly welfare centers</td>
<td>NA</td>
<td>400</td>
<td>400</td>
<td>266</td>
</tr>
<tr>
<td>No. new community care workers</td>
<td>NA</td>
<td>NA</td>
<td>200,000</td>
<td>N/A</td>
</tr>
<tr>
<td>No. new nurse and nursing care workers</td>
<td>NA</td>
<td>NA</td>
<td>100,000</td>
<td>N/A</td>
</tr>
<tr>
<td>No. new OTs, PTs</td>
<td>NA</td>
<td>NA</td>
<td>150,000</td>
<td>N/A</td>
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</table>

most needy—that is, low-income elderly living alone or without family support. As a result, despite the expansion most elderly continued to be excluded from the Gold Plans and were expected to be cared for by their families. It was found that in 1995, approximately ninety thousand women left the workforce to care of their elderly relatives, and many others were attempting to manage the care for their aging parents and elderly relatives while continuing to work (Statistics Bureau, Management and Coordination Agency 1997). Other surveys also found that despite the Gold Plans, 85 percent of the elderly people were still being cared for by their female relatives at home in 1996 (Ministry of Health and Welfare 1998).

These problems were the reason why women’s groups pushed for the introduction of the long-term care insurance scheme. For many feminists, the Gold Plans proved too inadequate and underscored the desirability of a social insurance scheme as a way to ensure individual rights to social care. The Long-Term Care Insurance (introduced in 1997 and implemented in 2000) did transform the concept of social care for the elderly from a needs based care provision to a rights based universal social insurance scheme. As a universal social insurance scheme, it covers care services for people over the age of sixty-five who are deemed to require care and those between the ages of forty and sixty-four who need care as a result of disabilities resulting from aging, such as Alzheimer’s disease. Insurance contributions are compulsory for people over the age of forty. The insurance covers a wide range of community-based and institutional care services with the amount of coverage based on the level of disability. With the introduction of long-term care insurance most of the services covered by the Gold Plans were transferred to the insurance program, and the means-tested care services are being left for low income elderly receiving social welfare (seikatsu hogo) and for the disabled, who are not covered under the insurance scheme. In principle, the introduction of the insurance has meant that all elderly requiring care now have the right to receive care, regardless of income or family situation.

The Family-Work Harmonization Policy

The Angel Plan, introduced in 1994, was also revised in 1999 (see Table 3). In addition to the expansion of child care services, the child allowance has been broadened, and a number of new labor laws have been introduced in the 1990s to help working women and mothers better harmonize work and family responsibilities. Paid parental leave legislation was introduced in 1994 to allow parents to take up to one year of unpaid child care leave. In 1998, an income replacement equivalent to 25 percent of the salary and the cost of
Table 3. The Angel Plans targets and actual figures

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<tr>
<td>No. child care spaces for 0–2 year old</td>
<td>470,000</td>
<td>580,000</td>
<td>680,000</td>
<td>584,000</td>
</tr>
<tr>
<td>No. extended hour child care centers</td>
<td>2,530</td>
<td>7,000</td>
<td>10,000</td>
<td>7,000</td>
</tr>
<tr>
<td>No. child care centers operating during weekends and holidays</td>
<td>NA</td>
<td>100</td>
<td>300</td>
<td>N/A</td>
</tr>
<tr>
<td>No. temporary child care centers</td>
<td>NA</td>
<td>In 450 local communities</td>
<td>In 500 local communities</td>
<td>1,500</td>
</tr>
<tr>
<td>Multifunctional child care centers</td>
<td>200</td>
<td>1,600</td>
<td>2,000</td>
<td>365</td>
</tr>
<tr>
<td>Child care support centers for stay-at-home mothers</td>
<td>354</td>
<td>1,500</td>
<td>3,000</td>
<td>1,500</td>
</tr>
<tr>
<td>Temporary child care support for stay-at-home mothers</td>
<td>600</td>
<td>1,500</td>
<td>3,000</td>
<td>N/A</td>
</tr>
<tr>
<td>After-school programs for elementary school-age children</td>
<td>5,220</td>
<td>9,000</td>
<td>11,500</td>
<td>9,000</td>
</tr>
<tr>
<td>Treatment and counseling centers for infertile couples</td>
<td>NA</td>
<td>24</td>
<td>47</td>
<td>N/A</td>
</tr>
</tbody>
</table>

social insurance were added to this legislation to encourage take-up; in the spring of 2000, the income replacement was raised to 40 percent. A family care leave was also introduced in 1996, allowing workers to take up to three months of unpaid care leave, and in 2000 an income replacement of 25 percent of the salary was added onto this legislation.

Like the Gold Plans and the long-term care insurance scheme, reforms under the Angel Plans reveal a significant extension in social care provision and support for families with small children and an attempt to support women’s labor market participation. These reforms also show public recognition of the problems associated with the existing gender relations that put an enormous burden of care onto women and an attempt to ease the women’s care burden while facilitating their employment through provision of care services and protective employment legislation. In terms of the cost, the total expenditure for social welfare, including the Gold and Angel Plans, increased by nearly twofold, from ¥4,799 billion to ¥8,323 billion (approximately US$40 billion to US$69.4 billion) between 1990 and 1998, as compared to ¥3,999 billion to ¥4,799 billion (approximately US$33.3 billion to US$40 billion) between 1981 and 1990 (NIPPSR 2000).30

**Enhanced Role of the Market and Community through Devolution and Deregulation**

The extension of social care has also been carried out in concert with the devolution of the state’s social welfare responsibilities and the deregulation of the care services throughout the 1990s. The administrative responsibilities for the Gold Plans, the Long-Term Care Insurance Scheme, and the Angel Plans have been gradually downloaded to the local governments.31 This has theoretically given local governments greater autonomy to respond to local social welfare needs but also created a tremendous fiscal pressure, particularly in rural areas. Because local governments in Japan cannot raise their own taxes without central government approval, the expansion of social care responsibilities without the means to raise their own revenues has pushed many local governments near bankruptcy.32 For local governments in rural areas where economic growth is negative and demographic aging is much faster than in urban centers, devolution has had severe consequences.

Deregulation of welfare services has also created pressure on the public-sector service providers as well. In child care services, the mandatory placement system (sochi seido), which gave the state total control over the placement of children in public child care centers, has been replaced by an individual contract system through the child
welfare reform in 1996. This has allowed parents to choose child care centers and services and at the same time forced public child care centers and their services to face market competition. The deregulation of the public child care services has led to entry of private, for-profit service providers into the child care market and an increased competition for service contracts from local governments. The outcomes have been mixed. Studies show that although more child care centers are providing longer hours of service (which may benefit parents who work long hours), many state-run child care centers have been forced to close and many other public child care centers have been compelled to use part-time and contract workers as a way to cut personnel costs (Peng 2000). Furthermore, the new policy measures to increase the target number for child care spaces has led politicians to call for lowering the regulatory standards applied to public child care centers so as to enable more private child care centers to be certified. This has raised serious concerns about the quality of care.

In the case of long-term care insurance, although local governments are responsible for administering the insurance, the care services have been privatized. However, not only is market competition not working but the elderly and their families are also not necessarily receiving more or better care as compared to before. The computerized evaluation method used to measure individual disability level has been criticized for being inaccurate and screening out many people who are in need of care; the huge regional variation in services has been criticized for contradicting the principle of universal right to care under the social insurance system; and the 10 percent surcharge levied on all the services has been blamed for “care-shy” behavior among the users. There is also a serious flaw with the valuation of care services in the Long-Term Care Insurance scheme. Moreover, as a result of deregulation and changes in the government role, most of the local government care workers have been laid off and forced to seek work in the private sector, often for lower pay. Even more in than the case of child care, the expansion of social care for the elderly has resulted in a significant deregulation of services with some serious consequences.

In summary, the welfare state restructuring of the 1990s has resulted in important changes in the mixed economy of social care. The huge expansion of social care for children and the elderly has gone hand in hand with the decentralization of the state’s welfare responsibilities to local governments and greater marketization of social care services. As it stands now, social care reforms have made care services more flexible and responsive to the needs of people in the community, but the introduction of market competition has also
raised concerns about the quality of care. The expansion of social care underscores its timeliness as well as the earlier lack of public provisions. The decentralization and deregulation of social care offer possibilities for a greater mix of provisions to meet individual needs and more efficient provisions of services, but at the same time, brings into sharper focus the issues of the local governments’ capacity to provide care. The boundaries of care labor, care obligation and responsibility, and the costs are clearly being redrawn.

Conclusion: Lessons from the Japanese Experience

The Japanese welfare state restructuring of the 1990s offers some important lessons for Japan and other welfare states. First, the Japanese experience makes it clear that gender relations and demographic changes are crucial factors shaping social policy today. Though coming from different directions, the eventual interlocking of these two factors and their compounding effects have been the key to the policy reforms. The 1990s saw a significant change in the Japanese government’s way of thinking, as evidenced by the fact of its admission that existing gender relations were problematic (see Ministry of Health and Welfare 1999 for a discussion of the problems related to the current family-work organization and gender relations). This is important because it suggests a qualitative shift in the state’s policy position vis-à-vis women and the family.

However, having said that the Japanese welfare state has gone through a transformational shift in the 1990s, it begs the question at the heart of the concern about the ideological framework: what is the meaning of right-center implementation of gender restructuring policies? It is evident that changes in political, economic, and demographic conditions in Japan have created opportunities for women to affect welfare state reforms. Also evident is that the cleavages in political structure, particularly with the breakup of the LDP-dominated politics and the emergence of the center-right/center-left coalition—even though for a very brief period of time—have created policy openings for women and bureaucrats to pursue a more women-friendly/family-friendly policy mix.

Second, and more immediately, the political and demographic imperatives faced by the Japanese welfare state in the 1990s should serve as a good illustration of what happens when the family becomes overburdened by traditional care and welfare responsibilities. In Japan, the institutional assumptions about the family’s caring roles and the state’s overreliance on the family helped foster political reactions and demographic changes that ultimately forced the gov-
ernment to change its policy trajectory. The reciprocal influences be-
tween institutions and politics—the institutional structure compelling individual responses; and the individual responses compelling institutions to respond in return—suggest a dynamic relationship be-
tween the individual and the state, and call attention to the impor-
tance of a political economic perspective to understanding the pro-
cess of policy change.

Such political economy may not be limited to Japan. Similar shifts in gender relations and demographic patterns can also be witnessed in other welfare states in the East and West. As the postindustrial economy draws more women into paid employment, the state will have to pay more attention to the tensions between changes in gender relations and the existing institutional arrangements that continue to assume the postwar male breadwinner/female housewife family model. Such tensions are perhaps particularly visible in Japan. However, other familialistic welfare states in Europe and East Asia (like Italy, Spain, Portugal, Korea, and Singapore) may share similar concerns as well. Certainly, the fact that the fertility rates in these countries are among the lowest in the industrialized countries does seem to suggest that young people in these countries may also be realizing that they are not able to afford to have children. Throughout its development history, the Japanese welfare state has been learning and adopting ideas from western welfare states. In this context Japan has the unenviable position of leading the way into the uncharted waters of population aging and decline.

Finally, the Japanese welfare state’s policy responses to gender and demographic pressures, though clearly significant, have yet to show signs of success—that of reversing or even slowing the decline of the fertility. It seems that the policy reforms have been largely focused on relieving women of undue care burdens by putting most of the effort on expanding social care. The evidence suggest that this may not be enough to affect gender relations in a significant way, and because the basic structure of gender relations remains unchanged women have not changed their fertility decisions. There may be also a fundamental weakness in the state’s perception of the problem, because it continues to define the problem of gender relations in terms of their adverse effects on fertility and the aging of the society—not that gender inequality is a problem in itself. The extension of social care therefore has been a policy response to relieve the care burden placed on women under the existing system of gender relations, not a policy to facilitate changes in gender relations. More positive steps facilitating gender equality may be in order.
NOTES

The author would like to thank Matsushita International Foundation for financial support and Heidi Godfried and the reviewers for thoughtful comments.

1. Interestingly, Daly and Lewis’s (2000) typological sketch seems to overlap closely with the three models of welfare regimes identified by Esping-Andersen (1990). What this suggests is the utility of examining welfare states by using different parameters and, as well, a possible synthesis of the mainstream and feminist comparative welfare state analyses as we develop the comparative framework.


3. Between 1970 and 1980, social security expenditure rose about sevenfold, from ¥3,524 billion to ¥24,763 billion, or from 5.7 percent to 12.4 percent of the national income. The current social security expenditure is at 18.88 percent of the national income or 14.02 percent of GDP. In 1996 Japan’s total social security expenditure was 13.11 percent of GDP, as compared to 15.10 percent for the United States, 28.21 percent for Germany, and 33.11 percent for Sweden (NIPPSR 2000).

4. The conservative welfare regime of the 1980s is often referred to as the Japanese-style welfare society regime (Nihongata Fukushi Shakai Regime). The term was first coined by the ruling conservative Liberal Democratic Party (LDP) in 1979 in its policy paper calling for the review of welfare policy. The Japanese-style welfare society became the platform for the LDP to advance its political agenda to steer the Japanese welfare state toward retrenchment and to attack the (Western-style) welfare state expansion of the 1970s. Redefining Japan as a welfare society, not a welfare state, the policy called for the end of welfare state expansion and for the establishment of a new regime based on "individual self-help and mutual aid between families, neighbors, and the local community, and on the selective provision of public welfare by an efficient state as accorded by the principle of the liberal economic society" (Economic Planning Agency 1979, 10).

5. The pressure on pension and health care spending came from the maturing of the pension schemes and the aging of population. The proportion of people over the age of sixty-five rose from 9.1 percent in 1980 to 12.1 percent in 1990 (Ministry of Health and Welfare 1998).

6. Campbell and Ikegami (2000) argue that if we account for the rate of "social hospitalization" the level of institutionalization for elderly would come closer to 6 percent. This, however, only underscores the fact that there are very few options for institutional care for the elderly. Because the public institutional care is scarce and means tested, and the private institutional care facilities are also lacking and expensive, the elderly in Japan have to rely on their families much more than in other countries. Social hospitalization is therefore a logical option for middle-class elderly who cannot rely on their families for adequate care. Other data also support this. According to
the Association of Women and Youth’s survey, the majority of people claimed that they have hospitalized their family members at some point to meet their care needs. The national survey also found that about 41 percent of people have used private hospitals and 37 percent of people used public hospitals to have their family’s care needs met; only about 11 percent of people used home helpers and 3.6 percent used public institutions for the aged (Ministry of Labour 1998).

7. It is however important to point out that unlike the US the market provision of child care service does not exist in Japan. Hence there is no substitution for public child care other than the family.

8. Unofficially there are about one hundred fifty thousand children waiting for child care space (Prime Minister Jun’ichiro Koizumi’s campaign speech, July 14, 2001, announced in the NHK news)

9. Data also show that mothers who live in three-generation households are more likely to have full-time jobs than those living in two-generation households.

10. The Equal Employment Opportunity Law was introduced in 1987; however, it lacks effective enforcement measures, relying largely on self-compliance efforts by employers. As a result, women are still found largely in lower-wage, insecure positions.

11. Before the mid-1950s, the employment rate of married women in Japan was very high. Most of them worked in the farm or in the family business. For example, the female employment rate in 1955 was about 57 percent with 71 percent of them working as self-employed or in family business. By 1975, the total female employment rate had dropped to 45.7 percent. However, it is also important to point out that throughout the high economic growth era, there were also many married women who had to work for a living. Lone mothers, women in low-income households, and women with family businesses continued to work, and poor women bore a heavy burden of lack of welfare provisions, even though the popular image of married women was that of full-time housewives.

12. Interviews with Takenaka Emiko and Yamada Keiko, president and vice president of the Koreishakai wo Yokusuru Josei no Kai, Osaka-chapter, 11 November 2001. Much of the data on women’s social mobilization and social policy-making process in the 1990s used in this article were gathered from literature review and in-depth interviews with key stakeholders. The interviews were conducted between June 2001 and March 2002. I interviewed a total of twelve individuals who were members of the women’s movement, Association of Large Businesses (Keidanren), LDP, Ministry of Health and Welfare, and Japan Medical Association, on their perception and analysis of the long-term care insurance and long-term care policy in Japan. Except for two cases where the interviewee did not consent to being taped, all the interviews were taped, transcribed, and analyzed. The interviews ranged from one to two hours in length, and in some cases also involved follow-up communications to clarify finer points.

13. It is worth emphasizing here that the main reasons for this is that men are either not willing (because of the strong assumptions about the
separate gender roles) or unable to do their share of family care because of their work commitment or work conditions that leave them little time for the family.

14. For example, in the Osaka chapter of WCBAS, nearly 20 percent of its members are politicians (interview with Takenaka and Yamada), and it has also become a recruiting ground for new women political candidates for local government (interview with Yodoshi Chizuko, counselor, Tondabayashi city council, 16 November 2001).

15. Interview with Yodoshi Chizuko, and personal communication with Hotta Tsutomu, president of Sawayaka Welfare Foundation (6 October 2001).

16. Public health care insurance in Japan is organized into three main programs: (1) the employee health insurance for workers in large, medium, and small firms and their dependent family members; (2) the health insurance scheme organized by mutual aid societies for employees in the public-service sector, private schools, seamen, and their dependent family members; and (3) national health care insurance for the self-employed, retired, and those who do not fall into either of the categories of health care insurance. Not surprisingly, because most of the retired workers are no longer covered by the employee health insurance, they have to switch to the national health care insurance on retirement. This had resulted in a significant skewing of the demographic composition of the insured in favor of the employee insurance schemes. Although the government subsidizes about half of the cost of the national health care insurance from the general tax revenue, the high proportion of elderly people in this insurance scheme has led to a serious financial crisis.

17. Campbell (1992), for example, argues that it was politically crucial for the government to speedily introduce a welfare reform policy for the aging society to gain voters’ support of any new tax measure.

18. This party later merged with other splinter groups including that headed by Kan Naoto to form the Democratic Party of Japan, or DPJ.


21. Interview with Masuda Masanobu.

22. Masuda points out that unlike other councils before, the council members were much more fractious this time because of more transparency and access to information, and each participating interest group began to feel that it needed to represent the interests of their constituencies first (interview with Masuda Masanobu).

23. For more detailed discussion on the role of the community and women’s groups in the passage of long-term care insurance bill, see Eto 2001 and Ushiyama 1999. For discussion of the policy process from the bureaucratic perspective, see Masuda 1998, 2001.

24. The figure of 1.57 is critical because it marks the historical low. Previously, the fertility rate had dipped sharply and temporarily to 1.58 in 1968 because that year, symbolized by the fire-breathing horse according to the Chinese astrological calendar, was considered a particularly ominous year for childbirth.
25. Interview with Yodoshi Chizuko.

26. It is estimated that the ratio will increase to 1 elderly to 1.7 workers by 2050, from the current ratio of about 1 to 4.4 (Ministry of Health and Welfare 1998).

27. Economic forecasts estimate average economic growth rates to drop to about 1.8 percent in 2010 and 0.8 percent by 2025 (Ministry of Health and Welfare 1998).

28. It is estimated that by 2025, nearly 60 percent of the communities in Japan will have more than a third of their total population over the age of sixty-five, as compared to the current figure of 10 percent (Ministry of Health and Welfare 1998).

29. The child allowance program was originally introduced in 1971 as an income supplement to low-income families with under-school-age children. However, throughout the 1980s the program was cut back and the eligibility age for children was reduced to three from six. In the 1999 revision, the age restriction was lifted from three to six years, and the income cut-off for the family was raised. Under the previous child allowance, only about 60 percent of all low-income families with children under the age of three were qualified to receive the allowance. With the reform, an estimated 80 percent of families with children under six will now qualify for the allowance.

30. This is only the social welfare portion of the total social security expenditure. Although social welfare made up only 11.5 percent of the total social security expenditure in 1998—the other 88.5 percent being taken up by pension and health care insurance—its expenditure has risen at a rate much faster than pension or health care. All the exchange figures for U.S. dollar is set at the rate of: US$1 = ¥120.

31. Currently the cost burden ratio between the central and local governments for most social care services is fifty-fifty.

32. In 1999 the total local government debt was estimated at ¥176 trillion (US$1.5 trillion) or 35.4 percent of the GDP. There has been a mounting social movement calling for greater local autonomy led by social policy experts, economists, and community activists over the 1990s.

33. The long-term care insurance allows individuals to “purchase” a designated amount of care services each month, depending on the level of disability. The cost of each service is preset by the insurance (government). However, when purchasing the services the users are charged 10 percent of the total cost of the service, the logic is that it will make the service more transparent to the users. In other words, the long-term care insurance will pay 90 percent of the total cost of the care services allowed to the user. The 10 percent surcharge or user charge has forced people with low income to limit the use of care services under the long-term insurance scheme. The government’s own survey has shown that the actual demand for care service was much lower than it had initially expected, as people shied away from using care services that were entitled to them because of the financial burden.

34. Because the costs of all the services provided by long-term care insurance are preset by the government, all the care providers set their service rates accordingly. However, because the cost of home help service (which
includes cleaning, cooking, shopping, laundry and other support services that do not deal directly with the physical handling of the clients) has been preset at a rate about half that of the physical care services, this has convinced users to use home helpers to provide physical care at the same time they clean the house.

35. Prior to the introduction of the long-term care insurance, most of the care workers in Japan had been employed by local governments. Interviews with local governments and social welfare associations in Iwate and Hyogo Prefectures and Yokohama city and with care workers in Yokohama chapter of local government employees union (May–December 2000).

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