

## Chapter 2

# Health-Caregiving to the Elderly in Japan: Professionalized Labor, Community-Based Approaches, and International Migration

**Abstract** Health-caregiving is *the* core sector to study the impact of demographic change onto business and economics of a nation. On the one hand, the demand for health-caregivers, especially to the elderly, is on the rise as the old-age segment of a population increases. On the other hand, as the working population declines, it becomes increasingly difficult in professions of low pay, low prestige, and cumbersome working conditions to fill job vacancies. A demographically induced labor shortage is the result, and Japan is no exception to that. This chapter outlines the rising demand in health-caregiving in Japan, a trend which, beyond the numerical rise of the old-age population segment, is being intensified by an accompanying change of norms toward a professionalization and socialization of care. Individuals and families increasingly rely on the structures of outside health-caregiving, which are embedded in Japan's long-term care insurance. In addition, local governments mostly aim at mobilizing existing social networks, such as neighborhood associations, in order to increase the level of mental and physical activity among the old-age population. The recruitment of health-caregivers on the global labor market, however, does not (yet) seem to fit Japan's multi-perspective approach to managing elder-health care. This chapter addresses all of these policy responses and their societal dimensions.

**Keywords** Population aging • Health-caregiving • Labor shortage • Professionalization of care • Long-term care insurance • Neighborhood associations • Lifelong learning • International migration

## 2.1 Introduction

Population aging is among the most pressing challenges Japan currently faces. Other major challenges such as, most prominently, a sagging economic performance and a skyrocketing public debt, are nowadays understood to be among the accompanying effects of the nation's demographic change. Comparative research in post-growth societies like Japan tells us that, first, a decline in the population

segment in their early 20s—those who enter the workforce and leave their parents' homes to set up new households themselves—results in a declining consumption. Second, a relative decline of the younger generation toward the elderly in the workforce tends to result in a lack of innovative approaches in production and distribution (Klingholz and Vogt 2013: 12, 25).<sup>1</sup> The list of negative economic outcomes in “*a hyper-aged and depopulating society*” (Atoh 2008: 18), such as Japan, can be extended at will. Generally speaking, population aging and economic decline often go hand in hand.<sup>2</sup> Not even in Japan, with its relatively wealthy baby-boomer generation, those born between 1947 and 1949, was the so-called silver market, i.e., the newly emerging production sector directed at aging consumers able to fully compensate for a relative lack of young consumers.<sup>3</sup>

There is, however, one business sector, which stands at the forefront of growing demand—in both business and economics—in an aging society. Most naturally, that is the sector of health care to the elderly (Yashiro 2008: 33–34). Eldercare has increasingly become a cornerstone of Japan's life science's research efforts, the nation's industrial policy, its silver market production lines, and its export strategy alike (JETRO 2013). The Japan External Trade Organization's (JETRO, *Nihon bōeki shinkō kikō*) supportive stance for, for example, *Geriatric Care Asia* and for *Elder Care Asia*—an international exhibition and conference on health care and lifestyle for seniors, as the initiative describes itself—may serve as a case in point here. The Japan External Trade Organization aims at paving the way for “*Japanese silver industry companies to promote their products*” abroad, in this particular case in Taiwan, as one organization representative is quoted stating (ECA 2016).

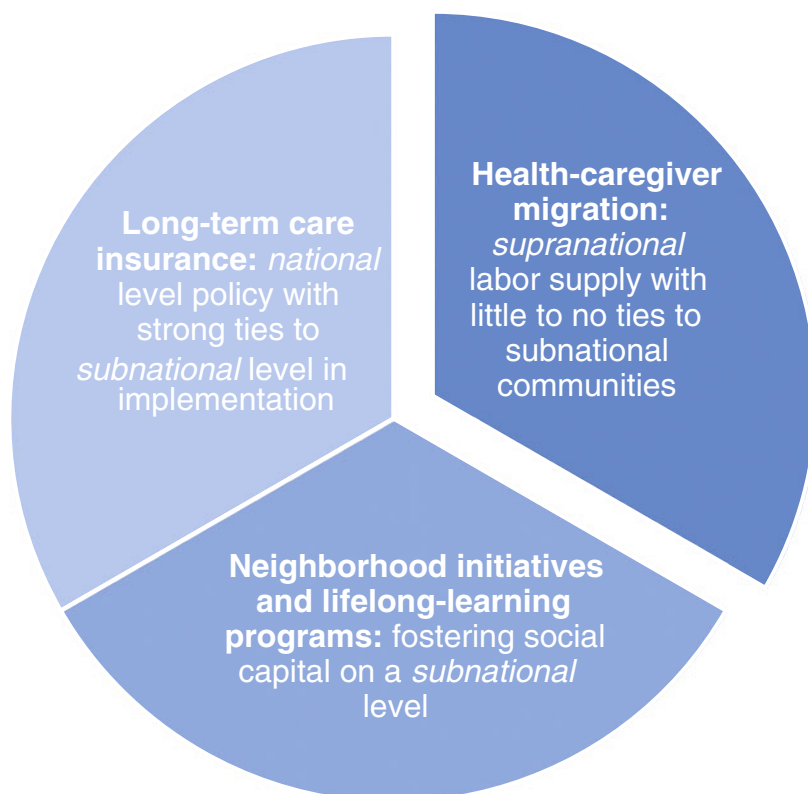
At the same time, eldercare is a crucial issue of Japan's political demography since the policy responses directed to the challenge of an accelerated need in health care to the elderly intersect at two issue areas equally important to aging societies. These are, first, questions of labor market structures, including the working conditions in the health care sector, and second, the changing role of families as the (former) primary caregivers in this setting. As bottom-line question emerges the following: *Who cares?* That is, who will serve as main caregiver to an increasing population of potential care-recipients, and to what degree can political actors shape the *policy outcome* in this realm?

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<sup>1</sup>Demographer Vegard Skirbekk and his colleagues suggest considering cognitive ability levels rather than biological age as an alternative method of measuring population aging and a possible decline in the innovative capacity of a nation (Skirbekk et al. 2013: 48–49).

<sup>2</sup>Reiner Klingholz, director of the Berlin Institute for Population and Development, in his recent monograph on the ongoing global demographic transition delivers a passionate call for a political, economic and societal acceptance of a demographically induced negative growth not only of population sizes but also of national economic outputs (Klingholz 2014). He specifically points to the example of Japan as a “*worst case example*”, where a lacking acceptance of the fact that Japan has entered an era of negative growth has been leading to dead-ended initiatives in numerous policy fields (Klingholz 2014: 193–216).

<sup>3</sup>Refer to economists Kohlbacher and Herstatt (2011) for a multifaceted study on the business opportunities inherent in what they call Japan's *silver market phenomenon*.



**Fig. 2.1** Multidimensional policy approaches to eldercare in Japan (design by author)

This chapter argues that the political demography of Japan's eldercare reflects a multi-issue and multilevel approach of managing the growing demand for eldercare in Japan. Against the backdrop of Japan's population aging and economic decline, this chapter aims at capturing these policy approaches by providing a multidimensional study of Japan's eldercare sector, as outlined in Fig. 2.1. The primary focus of the chapter lies with three policy responses directed at meeting the growing demand for eldercare.

These are, first, the introduction of a mandatory public long-term care insurance (LTCI, *kaigo hoken*) in 2000, which was aimed at advancing the socialization of eldercare in Japan. Second, the ongoing political fostering of lifelong learning programs—and civil society activism in general—is directed toward maintaining physical fitness and mental vitality among the elderly. The emergence of numerous so-called silver human resource centers (*shirubā jinzai sentā*), i.e., job agencies for retirees, to some degree follows the same logic. Both subnational-level institutions

strengthen the local and community-based character of managing eldercare in Japan. The same holds true for the long-term care insurance, which despite being a national-level policy, in terms of financing and implementation of the system is strongly connected to political and civic actors on a subnational level.

Third, the introduction of an avenue for international health-caregiver migration from Indonesia and the Philippines to Japan in 2008, respectively, 2009, as well as later on, i.e., in 2014, from Vietnam, symbolizes Japan's tentative attempts to participate in the globalization of health care work.<sup>4</sup> The health care migrants, however, are confined to working in institutionalized health care—oftentimes in large-scale institutions, and thus are structurally excluded from being engaged in the vivid landscape of local health-caregiving in Japan. While both, the long-term care insurance and the subnational-level initiatives have strong ties into the local communities, where they are being carried out, the scheme of international health-caregiver migration comes into this landscape as a literally *foreign* concept to many Japanese communities.

This chapter on Japan's eldercare exemplifies an ongoing change in the understanding of what individuals are supposed to contribute to the well-being of their family members, and what citizens are supposed to contribute to their nation. The progress of this change of attitude, however, is vastly different in the three fields sketched out above. This is on the grounds that, what prevails to this day is a vivid and widespread informal political participation of Japan's citizens, which in fact stands in sharp contrast not only to the low degree of politicization of the Japanese public when it comes to aspects of formal political participation, but also the low degree of participation in government campaigns, openly implemented in an exclusively *top-down* manner.<sup>5</sup>

## 2.2 Research Design

This chapter argues that the political demography of Japan's eldercare reflects a multi-issue and multilevel approach of managing the growing demand for eldercare in Japan, and in particular for eldercare that is performed outside the realm of families. In Japan, currently, a national-level socialization of care is pursued

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<sup>4</sup>Under its contentiously debated scheme of recruiting international trainees (cf. Chap. 4), Japan, from 1965 on, and until the mid-1970s, had already hired a small number of health care workers, predominantly from South Korea (Chiavacci 2011: 80–81).

<sup>5</sup>It should be noted, however, that some analysts of Japanese society point out that local civil society is most active and most successful in those regions of the nation that are particularly conservative. Historical sociologist Eiji Oguma in this context pointed to the case of Okinawa, where tightly knit traditional societal structures translate into an immensely active culture of social protest and informal political participation (Oguma 2016/04/01). This is to say that informal political participation is neither a new phenomenon nor necessarily a phenomenon of the liberal left political spectrum.

alongside with a local-level strengthening of caregiving and a—still reluctant and hesitant—participation in the global care-chain.<sup>6</sup>

This study applies a political science perspective, and asks why some of the measures of managing eldercare in Japan have been more successful than others. The degree of success here will be measured in two ways: First, in terms of the vitality of different approaches to caregiving as business-related and/or community-based initiatives, i.e., mainly the accessibility of supporting institutions. And secondly, in terms of acceptance of a specific supportive care institution by care-recipients and caregivers alike, which is measured through quantitative and qualitative approaches such as numbers of users, size of allotted budget and persistent, respectively, changing norms toward caregiving outside of the realm of families.

It will be argued that the successful measures, the national- and subnational-level measures, skillfully make use of the existing potential as well as the willingness to engage in community-based political participation among citizens. The relatively unsuccessful measure on an international, respectively, transnational level, however, turns out to be too detached from the local communities, and too confined in its tight systemic structures to gain the trust of the relevant actors involved, such as patients, their families, heads of personnel at caregiving institutions, the Japanese staff in employment in these institutions as well as potential health-caregiver migrants.

Paying tribute to the effective and successful subnational dimension of managing eldercare, the focus of this chapter lies with the intersection of the political economy of eldercare and the fostering of social capital in the local communities of Japan's aging society.

### 2.2.1 *Perspectives of the Chapter*

This section on the research design of the chapter will introduce both theory-driven perspectives onto the management of Japan's eldercare. These are political demography (Sect. 2.2.2) and social capital (Sect. 2.2.3) in health-caregiving.

The following Sect. 2.3 will lay out the structure of demand and supply in the health-caregiving labor market in Japan. The demand (Sect. 2.3.1) will be sketched out through a close-up look at the basic demographic data of Japan's population aging. The supply side (Sect. 2.3.2) will be introduced through data from the health-caregiving segment of Japan's labor market. The focus of this section then lies with a study of Japan's system of long-term care insurance (Sect. 2.3.2) and its effects on the demand/supply-balance in health-caregiving. The emerging

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<sup>6</sup>For an introduction to the concept of the global care-chain, and its social implications, also for the sending countries of migration, refer to Hochschild (2000). For an introduction to the global dimension of health-caregiver migration, in particular from an economic point of view, refer to Kingma (2006).

hypothesis—i.e., that the introduction of the insurance scheme generated a higher demand than the current supply can meet—will be supported in Sect. 2.3.3 on the emotional acceptance of health-caregiving outside the family. It will be argued that the numerical shift in the demand/supply-balance is pushed to further extreme through a simultaneously occurring shift in norms toward defamiliarized health-caregiving, i.e., an increasing acceptance of health-caregiving outside the realm of the family and, sometimes, outside the privacy of one's home.

While Sect. 2.4 then focuses on professionalized labor as a response to the question of *Who cares?* the subsequent Sect. 2.5 puts particular emphasis on community-based approaches to solving Japan's rising demand of health-caregivers. At the center of interest of the sections presented here is the leading question of how, why, and by whom social capital is being activated and fostered in order to serve as a basis of community lead health-caregiving. A case in point, which will be introduced, are lifelong learning initiatives in local neighborhoods. It will be argued that policy actors increasingly rely on a volunteer-based self-sufficiency of communal actors—many of them civil society actors—when *managing* caregiving. A cooperative relationship between civil society actors and state actors is in fact a well-known phenomenon of Japan's world of politics. In many of the existing cooperation structures, however, state actors seem to move from cooperation to gradually coopting partners from civil society (Ogawa 2014). This is most prevalent in Japan's health-caregiving to the elderly. In an era of Japan as an increasingly neoliberal and retrenching welfare state, the management of caregiving seems to be less and less of a state-run task.

With Sect. 2.6, Japan's state-run system of health-caregiver migration will be introduced into this framework of exploring the *Who cares?* dimension of managing eldercare in Japan. It will be argued that, while the system itself surely is unattractive in many ways, it also does not fit into the overall approach of community-centered health-caregiving to the elderly in Japan, and thus stands little chance to turn out a successful addition to the landscape of eldercare in Japan. The migration scheme itself will be introduced in detail in Chap. 3 of this book.

Section 2.7 discusses the insights that emerged in this chapter and presents its main concluding thoughts.

### 2.2.2 *Political Demography and Health-Caregiving*

The research of demographers is crucial to identifying the factors that produce various kinds of population change—from voluntary changes in behavior to pre-conditioning patterns such as nutrition, climate, and/or diseases—and to estimating how the current and future size and distribution of various populations and groups is likely to vary depending on those factors. Yet, demographers usually cannot tell us how people and social institutions will react to those changes. That is the task of political demography (Goldstone 2012: 13).

Political scientist Jack A. Goldstone defines political demography as the discipline that picks up the data demographers gather and asks the question how population transitions of any kind impact the people who experience these transitions and the social institutions that govern and manage these transitions. In other words, political demographers watch out for the big question of “what does this mean?” with *this* referring to the manifold changes in a population composition that follow significant shifts in one or more demographic variables, namely fertility, mobility, and mortality. Furthermore, following Goldstone’s definition of political demography, it becomes clear that political demography is not a single discipline in itself, but requires a highly interdisciplinary set of approaches to coherently address this big question.

While demographic research delivers the data, approaches from, most prominently, political science and sociology, as well as, in addition, economics, law, and the life sciences provide the concepts that help framing the research questions of political demographers and social demographers (Hank and Kreyenfeld 2015: 2–3). The disciplinary perspectives between demography and various social sciences indeed merge to a degree that often makes it difficult “*to draw a precise line between demographers conducting population studies research and disciplinary researchers who happen to use demographic data*” (Hirschman and Tolnay 2005: 421). The field of health care serves as a case in point when identifying the close interconnectedness between demographic research and social science research.

Health care as a subject area to be studied through the lens of political demography requires an interdisciplinary approach. Economist William A. Jackson points out the manifold disciplines engaged in studying the relation between health care and aging, which, of course, has a “*biological core*” (Jackson 1998: 148), but becomes predominantly an issue of economics when focusing on how health care “*expenditure will depend on the future health and longevity of old people*” (Jackson 1998: 148). When stressing the “*institutional relation between age and retirement*” (Jackson 1998: 148) one will find it useful to apply the research tools provided by political science. When studying the effectiveness of health care, for example, by asking how living standards and health care measures “*can reduce the needs of old people for medical treatment*” (Jackson 1998: 148), one finds oneself at the intersection of sociology and gerontology. The interconnectedness of political and social demography and health care as scholarly disciplines is indeed multifaceted, and highly complex.

This interconnectedness of political demography and health care forms the central research perspective of this chapter. Bearing in mind the main line of argumentation of this chapter—namely that a political and societal management of eldercare can effectively and successfully commence only once the subnational level is profoundly involved in the various stages of formulating and implementing these initiatives—this chapter adds the concept of social capital as an analytical component that speaks to the importance of a vibrating subnational level.

### 2.2.3 Social Capital and Health-Caregiving

As political scientist James S. Coleman points out, social capital generally is “*defined by its function*” (Coleman 1988: 98). Social capital is said to be “*productive, making possible the achievement of certain ends that in its absence would not be possible*” (Coleman 1988: 98). These achievements are twofold: First, social capital generates networks among individuals and/or organizations. Second, it also creates the essence of these networks in terms of the norms and values, such as social trust, which they stand for. Political scientist Robert D. Putnam thus defined social capital as “*networks, norms, and social trust that facilitate coordination and cooperation for mutual benefit*” (Putnam 1995: 67).

Put differently, social capital in its capacity as creating networks and fostering the emergence of norms and values stands at the core of healthy societies. Also, the individual members of communities with vibrant social capital are generally in better health, physically and mentally, than those who do not benefit from social capital. This observation holds true for all known cross-country comparisons (Pekkanen and Tsujinaka 2008: 714). As Putnam put it: “*social networks help you stay healthy*” (Putnam 2000: 331).

Moreover, members of communities with vibrant social capital are more likely to be engaged in politics (Aldrich 2008). This applies not only to formal, but in particular also to informal political participation. In fact, this insight stems from Daniel Aldrich’s work on social movements, and in particular his case studies on how local communities manage to block unpopular government policies. Those communities with a higher degree of social capital turn out to be more effective and more likely to be successful with their activities.

Social movement research in general is a valuable source for understanding the patterns of mobilizing citizens—be it to political or nonpolitical activism. For the case of Japan, political scientist Robert J. Pekkanen (2006) has previously identified a dual structure within Japan’s civil society. While only few organizations are large-scale, highly professionalized and aim at political advocacy, a myriad of small, solely volunteer-based organizations dedicate their engagement to hands-on activism in their local neighborhoods. In other words, on the one hand, the potential for networks of contentious policy action to emerge are slim in Japan. Yet, on the other hand, the participation rate in all kinds of community-oriented activism is outstandingly high in Japan.

The so-called neighborhood associations, approximately 300,000 of which are dispersed over the Japanese archipelago and by formal membership “*encompass a large majority of Japanese*” (Pekkanen and Tsujinaka 2008: 707), are central to the creation of social capital among citizens. Their central role for lifelong learning initiatives in local neighborhoods will be deliberated upon in Sect. 2.5. On the spectrum of more formally organized groups, it is Japan’s numerous nonprofit organizations that have mushroomed in particular in the field of health care. They, too, “*function as outlets of social participation of the elderly*” (Potter 2008: 704).



Moreover, they answer “*a public need not fulfilled by public social welfare policies*” (Potter 2008: 704).

A close-up look at civil society, social capital and health-caregiving thus allows us to understand the importance of local citizens’ organizations as (1) entities of practical preemptive health care, i.e., as outlets of physical and mental activation of citizens, and (2) as bridging elements between local citizens and state-run initiatives, such as the long-term care insurance, which are best addressed through the lens of political demography.

## **2.3 Demand and Supply: Health Care to the Elderly in Japan**

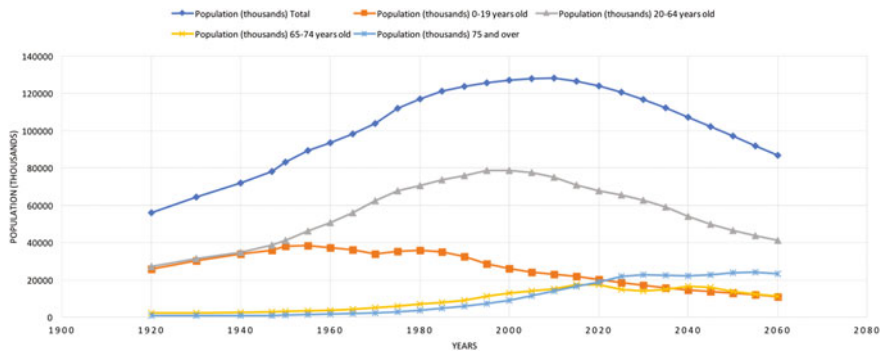
Before embarking onto the study of explicitly community-based eldercare in Sect. 2.5, and the growing of a health care market in Sect. 2.4, Sect. 2.3 will focus on professionalized labor in the health care sector.

First, the rising demand in eldercare will be clarified by looking at the bare numbers of population aging alongside a study of changing norms toward a socialization of eldercare. The rising demand currently, however, is not matched by a sufficient supply of health-caregivers. This mismatch creates space for alternative actors, stemming, for example, from within civil society, in order to fill the emerging gaps. It also triggers policy actors to push these alternative actors into engagement in this policy field, rather than other, possibly more contentious ones, by creating corresponding structural incentives (Pekkanen 2006; Potter 2008).

Second, this section will argue that, while not explicitly community based, the professionalized labor in health care, too, is implicitly tied to the local communities, in particular so when it comes to the implementation of caregiving. This is shown by addressing Japan’s system of long-term care insurance, a state-run system, which all the while, is hugely dependent on how it is being put into practice on a communal level.

### **2.3.1 Population Aging**

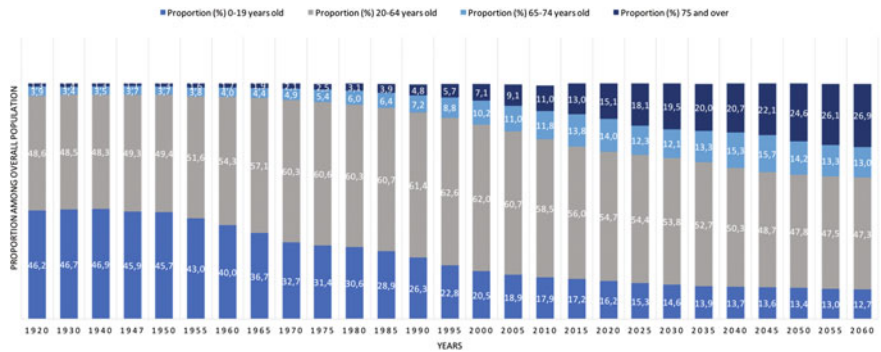
Japan’s only age-group to currently experience numerical growth is the old-age population (65 years of age and over). In 2010, this age group stood at 29.48 million. It is predicted to have risen beyond the benchmark of 30 million in 2012, when the first baby boomers (born between 1947 and 1949) entered this group. By 2020, the size of the group will have increased to 36.12 million. Its increase will level, and proceed more modestly for some time, reaching 37.01 million in 2033, before peaking at 38.78 million in 2042, when the second baby boomers (born in the early 1970s) enter this group. A steady decrease is predicted for the years to



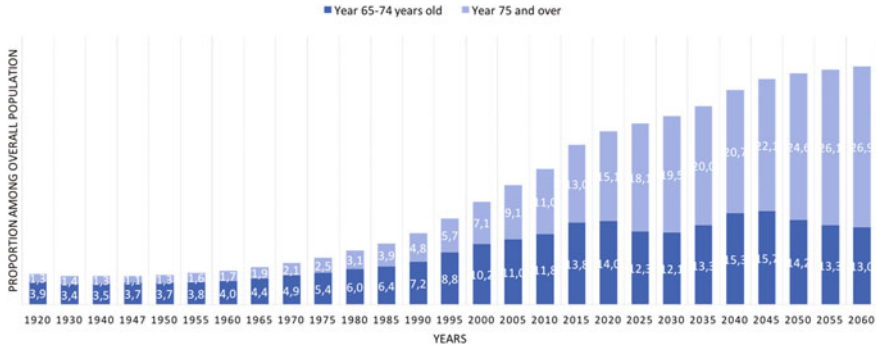
**Fig. 2.2** Actual and projected population in Japan (in absolute numbers) according to age-groups (NIPSSR 2012a, b)

follow, with the size of the population dropping to 34.64 million by 2060 (NIPSSR 2012a, b). Figure 2.2 visualizes this development.

Based on the 2010 population projections by Japan’s National Institute of Population and Social Security Research (NIPSSR, *Kokuritsu shakai hoshō jinkō mondai kenkyūjo*), the proportion of elderly out of the entire population increases from 23.0% in 2010, to 25.2% in 2013, and to 33.4% by 2035. That is, while in 2013, one in four people in Japan was elderly, 22 years from now it will be one in three. In 2060, 39.9% of Japan’s population will be elderly. This is one in 2.5 people (NIPSSR 2012a: 3). Since the number of the child population (14 years and younger) and the number of the working-age population (between 15 and 64 years of age) decreases much faster than the equally decreasing old-age segment, the share of the old-age population in the overall population will continue to grow even beyond its numerical population peak in 2042, as is depicted in Fig. 2.3 (NIPSSR 2012a: 4).



**Fig. 2.3** Actual and projected population in Japan (in percent) according to age-groups (NIPSSR 2012a, b)



**Fig. 2.4** Actual and projected population in Japan (in percent): “young-old” (65–74 years old) and “old-old” (75 years and over) population distribution (NIPSSR 2012a, b)

Before elaborating on the consequences of the dynamics sketched out above for Japan’s economics in general, and the labor market in particular, a close-up look at the old-age segment reveals more of the problematic dimension of Japan’s population aging. In fact, it is necessary to point to the pronounced trend of aging *within* the bracket of the old-age population, as is highlighted in Fig. 2.4. While in 2010, the number of the population of 65–74-year-olds stood at 15,173 persons, and thus slightly outnumbered the population of those aged 75 years and older (14,072 persons), by 2060 the population of 75 years and older will stand at 23,362 persons, more than twice that of the “young-old population” (11,279 persons). In other words, it is the “old-old population” that sees a particularly sharp increase in the overall population. It is predicted to rise from 11.0% in 2010 to 26.9% by 2060. Over the same course of time, the proportion of the population aged 65–74 years will change from 11.8 to 13.0%. It will have reached its climax in 2045, with a 15.7% share in the overall population (NIPSSR 2012b).

Indeed, Japan is on its way to turn into a society with the “*largest proportion of old people in the world*” as health-service researcher Nanako Tamiya and her colleagues (2011: 1183) have pointed out. It is in particular the aged dependency ratio<sup>7</sup> or elder care cost that rises and puts numerous strains onto the national economy in terms of upholding welfare services. Demographic expert Toshihiko Hara highlights the fact that while from the late nineteenth century to around 1930 —i.e., during the Meiji and Taishō periods, and into the early Shōwa period<sup>8</sup>—the child dependency ratio or child care cost was high, the page now, i.e., from around 2000 on, has been turned dramatically to a society of low child dependency ratio

<sup>7</sup>The aged dependency ratio or elder care cost is calculated by dividing the number of people aged 65 and over with the number of people aged 15–64.

<sup>8</sup>In Japan, the period names correspond with the reigning of Emperors: Meiji period (1868–1912); Taishō period (1912–1926); Shōwa period (1926–1989); Heisei period (1989 to present).

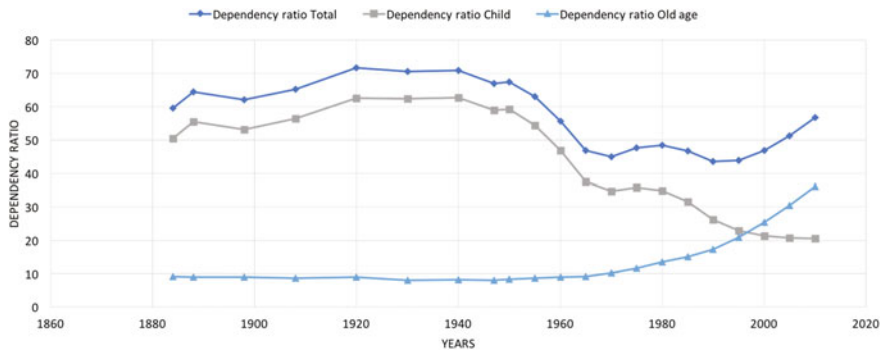


Fig. 2.5 Dependency ratios in Japan over time (NIPSSR 2012a, b)

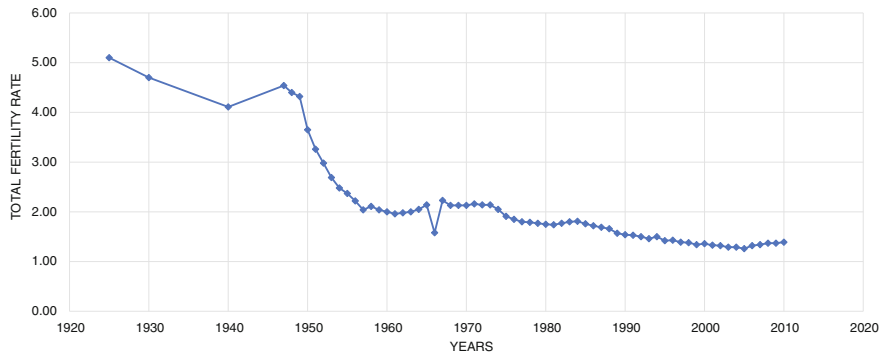


Fig. 2.6 Total fertility rate in Japan over time (NIPSSR 2012a, b)

and high aged dependency ratio,<sup>9</sup> respectively, high elder care cost (Hara 2015: 16). This numerical development is pictured in Fig. 2.5.

Rarely do the larger and smaller turns in these dependency ratios occur without a reason. They oftentimes were and are closely connected to historic events such as wars or natural disasters, or simply reflect policy choices. In order to characterize the impact of politics on the development of the total fertility rate (TFR) in Japan (Fig. 2.6), political scientist Leonard Schoppa uses the catchy picture of how politicians view newborn babies. A baby’s *value* switched dramatically since the early twentieth century, when babies were seen as “*tomorrow’s soldiers and factory workers*” (Schoppa 2008: 639), to the post-war years, when babies were seen as “*tomorrow’s poor and needy welfare cases*” (Schoppa 2008: 639), and again to today when babies are seen as “*tomorrow’s taxpayers, and there aren’t enough of*

<sup>9</sup>The child dependency ratio or child care cost is calculated by dividing the number of people aged 14 and below with the number of people aged 15–64.

*them to pay for the health and pension benefits retiring baby boomers are counting on*” (Schoppa 2008: 639). In other words, states have always had, and to this day have a clear political and economic interest in influencing a nation’s TFR, be it to boost it or to reduce it.

However, it has become difficult for Japan to engage in pro-natal policies ever since World War II, when Japan pursued a policy of aggressively boosting the TFR with its slogan of *umeyo fuyaseyo* (give birth and multiply), thus linking demographic politics to national security and state ideology. Germany shares a similar history, and to this day, in both countries any pro-natal policies that go beyond measures such as increasing the number of day-care centers for babies and toddlers, are pretty much unthinkable. Too persistent are the political and societal taboos connected with pro-natal policies. Moreover, in both countries the reluctant pro-natal policies already in place lack their wished-for results, with the TFR in Japan and Germany currently standing at 1.4 babies per woman (BIB 2016; NIPSSR 2012b)—both well below the so-called replacement level.<sup>10</sup>

In 1990, the TFR in Japan had fallen to 1.57 babies per woman. This figure was as low as it had previously only been in 1966, the zodiac year of the fire horse when many parents-to-be put off their plans for pregnancy due to an old superstition of girls being born in such a year being bound to bring harm to their later husbands. The leveling of the 1990 TFR with that of 1966, in Japan was soon coined 1.57 shock. The shock over the low TFR quickly was met with policy reforms to enhance fertility. The reform plans have become known as so-called Angel Plans directed at alleviating the emotional stress of full-time mothers, at creating more day-care centers in order to support working mothers, etc. (Coleman 2008; Roberts 2002). The plans, however, have largely lacked success, in particular because they refuse to effectively tackle Japan’s labor market structures and culture of work that does not allow for enough space of flexible working styles and work biographies. In fact, many parents-to-be still wish for two or three children; however, they do not seem to be able to put their life plans into reality (NIPSSR 2016; Tanaka 2008). Moreover, the degree of parental well-being in Japan is comparatively low (Holthus et al. 2015).

The unborn babies of today, however, will not only be missed as “*tomorrow’s taxpayers*” (Schoppa 2008: 639), but also, more generally, as future members of the workforce. Both of the trends sketched out above, i.e., the numerical rise in the old-age population, which is accompanied by a numerical decline in the child population, lead to Japan’s pronounced population aging. They also clearly intersect in the labor market.

Nowhere does this intersection become more obvious than in the sector of health-caregiving to the elderly: While the number of those potentially in need of

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<sup>10</sup>The economic impacts of a below replacement level TFR in Japan and Germany are subject to numerous in-depth studies. Refer, for example, to the early works by Naohiro Yashiro (1999) for the case of Japan, and to Franz-Xaver Kaufmann and Walter Krämer’s coedited volume on the demographic time-bomb for the case of Germany (Kaufmann and Krämer 2015), in particular to the chapter by Hans Werner Sinn (2015).

health care is on the rise, the number of those entering the profession is on the decline. Also, the turnover rate in the profession is extremely high, which points to the dimension of choice as an additional factor to keep in mind when studying the health-caregiving profession in Japan. Not only is the number of youngsters in the workforce in decline, but in times of a demographically induced labor shortage in many sectors, it becomes relatively easier to switch jobs or professions all together. Professions that offer low wages, low prestige, and tough working conditions, thus have a hard time recruiting new personnel.

### 2.3.2 Long-Term Care Insurance

Japanese and international scholars have come to classify Japan's welfare state as "*not much different from the large welfare states of the continental European countries*" (Estévez-Abe 2008: 19). It is in particular with regard to the old-age welfare services—among them public pensions, medical care, and long-term care—that the comprehensive character of Japan's welfare system becomes apparent. Political scientist John C. Campbell characterizes Japan's old-age welfare services as follows: "*By the turn of the millennium Japan's pension and health-care programs for older people had reached the standard of rich nations. In the field of long-term care, it had become a world leader*" (Campbell 2008: 653).

At first glance, this might seem surprising, since one would expect, for example, Germany, a country in Bismarck's tradition,<sup>11</sup> to feature generous welfare provisions. Yet, why does Japan—with its roots also in Confucian family values that stress filial piety—feature a generous net of welfare provisions to the elderly? The answer to that question, of course, lies in politics. The post-war history of Japan's creation of a welfare state has been one of multiple phases of expansion and retrenchment of services, each of which can be connected to party politics, electoral campaigning, and the state of national economic growth or crisis (Campbell 2008: 653–665).

Japan's long-term care insurance exemplifies this development. Just before the first oil crisis, when Japan's economy was still booming, Prime Minister (1972–1974) Kakuei Tanaka named the year 1973 the "first year of the welfare era" (*fukushi gannen*). The minimum public pension was more than doubled and the co-payment for medical bills was discarded for those over the age of 70 years and below a certain level of income. During the 1970s, despite strained economic circumstances, Japan's welfare state did not retrench extensively. This is due to a period of relative success of Japan's largest opposition party, the Social Democratic

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<sup>11</sup>Otto von Bismarck (1815–1898), a conservative German politician, initiated and saw through three major welfare laws, which earned him the honorary title of *father of the German welfare state*. These were the health insurance bill of 1883, the accident insurance bill of 1884, and the old age and disability insurance bill of 1889. Refer to Kasza (2006) for an introduction to welfare states in comparative perspective.

Party (SDP, *Shakai Minshu-tō*), in local-level elections, which the ruling Liberal Democratic Party (LDP, *Jiyū Minshu-tō*) counteracted by remaining steadfast to Japan's relatively generous welfare system (Campbell 2008: 654–659).

At the end of a decade of again accelerated economic growth, in 1989, the Japanese cabinet agreed on its famous “Gold Plan,” a ten-year strategy to foster health and welfare of Japan's elderly (*Kōreisha hoken fukushi suishin jūkanen senryaku*): The number of beds in nursing homes were to rise from 200,000 to 500,000; the number of adult day-care centers from 1000 to 10,000; and the number of home-helpers from 30,000 to 100,000. In 1994, these target numbers were once again raised (Campbell 2008: 659–660). Soon, however, numerous problems of the “Gold Plan” became apparent. Among those were soaring costs of the program and administrative difficulties, such as “*definitions of eligibility, the types and amounts of services provided*” (Tamiya et al. 2011: 1184). In the early 1990s, the Ministry of Health and Welfare<sup>12</sup> started drafting an insurance based system to provide long-term care.

As a direct result, Japan's public mandatory long-term care insurance was enacted in 1997, and implemented in 2000 (Tamiya et al. 2011: 1184). As Tamiya et al. (2011: 1185) point out, the long-term care insurance's goal is the “*socialization of care, meaning that the government provides care as an entitlement to all, irrespective of their income level or the availability of informal care.*” Everyone aged 40 years and above is obliged to pay premiums (about 1% of income); everyone aged 65 years and above<sup>13</sup> is entitled to support via this insurance system (MHLW 2012: 230; Tamiya et al. 2011: 1185). 50% of Japan's long-term care insurance is financed by premiums, the other half by public expenditures (MHLW 2012: 229).<sup>14</sup> The eligibility is assessed via a questionnaire, a home visit and the deliberations of an expert committee. Clients are classified into eight different categories according to their needs, with benefits ranging from \$400 to \$2900 per month. Clients need to shoulder a 10% co-payment for all services ordered (MHLW 2012: 234; Tamiya et al. 2011: 1185).

Japan's long-term care insurance differs from others, such as the German one, in one crucial point: It “*provides only services rather than cash for care*” (Tamiya et al. 2011: 1184). This is due to some substantial lobbying efforts by Japan's feminist groups. One of their spokespersons, Keiko Higuchi, has stressed the need to de facto outsource health care work from the families, in order to end the exploitation of daughters and daughters-in-law in whose responsibility the health care work to the elderly has traditionally fallen. As Peng (2001: 191) pointed out, the ruling Liberal Democratic Party in fact welcomed the large number of unpaid caregivers as “*hidden welfare capital*” (*fukushi no fukumi zaisan*), whereas many of

<sup>12</sup>In 2001, the Ministry of Health and Welfare (*Kōsei-shō*) and the Ministry of Labour (*Rōdō-shō*) were amalgamated to form the Ministry of Health, Labour and Welfare (*Kōsei-rōdō-shō*).

<sup>13</sup>In case of need due to age-related diseases, persons aged 40–64 years, too, are eligible to receive benefits (MHLW 2012: 230; Tamiya et al. 2011: 1185).

<sup>14</sup>The responsibility for half of the public expenditures lies with the national level, and a quarter each with prefectures and municipalities (MHLW 2012: 229).

those active as caregivers referred to the hardships of their day-to-day experiences as “*caring hell*” (*kaigo jigoku*). Eventually, it was the feminist groups who won this political battle against the ruling party, and managed to establish the thought that financial benefits to clients potentially would not have a similar effect of an equally encompassing defamiliarization of health care work. Thus, a service-only approach was to be implemented (Klingholz and Vogt 2013: 15–16).<sup>15</sup>

Most popular among the clients of Japan’s long-term care insurance—amounting to 47.8% of the expenses of all services—are in-home services. These comprise any form of home-visit services, such as nursing care and rehabilitation, as well as daily life care or short-term institutionalization. An additional 4.9% of expenses are used for in-home care support services, which cater to those in lower categories of need. 37.4% of the expenses are used to cover the fees of long-term health facilities or sanatoriums, and 9.9% of expenses are used for community-based services, such as community-based facilities to prevent the further erosion of an elderly’s health condition (MHLW 2012: 235).

Alongside the growing demand for services under the system of long-term care insurance, costs, too, are predicted to rise steeply; they are in fact expected to double over the relatively short time span from 2012 to 2025 (MHLW 2013). It should not go unnoted that already back in the early years of Japan’s long-term care insurance the system underwent some significant reforms regarding, among others, the certification of beneficiaries. These reforms were mainly motivated by cutting the ever-rising insurance costs (Tsutsui and Muramatsu 2005, 2007); in fact, reforms to enhance the efficiency and effectiveness of the system continue to this day, and it is fair to say that Japan’s long-term care insurance ever since its start has been subject to dynamic changes (Morikawa 2014).

Today, some two thirds of the expenses used in Japan’s long-term care insurance cover services based either at home or in the local communities of the elderly’s home. In fact, many of the elderly in need for long-term health care still live in their own homes, respectively, cohabitate with their children. While the “service only” policy to some degree liberated the mostly female health-caregivers in the families, many of them still struggle with “*expectations embodied in traditional family values*” (Tamiya et al. 2011: 1188). Yet, based on evidence drawn from government surveys, we may be able to conclude that the long-term care insurance in fact “*brings about new attitudes*” (Tamiya et al. 2011: 1188).

### 2.3.3 Health-Caregiving Outside the Family

A longitudinal survey conducted by the Cabinet Office of Japan (CAO, *Naikakufu*) shows a shift in attitudes toward professional health care, and health care conducted

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<sup>15</sup>In fact, activities of women’s groups “to lobby the Japanese government and politicians to provide more social support for the elderly and for families taking care of their elderly relatives” (Peng 2008: 1038) date back to the 1980s.



within the family. It is important to note that this shift is prevalent in the care-receiving generation as well as in the caregiving generation. In 1995, 57.3% of elderly agreed with the statement that “*it is just natural when children provide care to their own parents*” (*Kodomo ga oya no kaigo o suru koto wa atarimae no koto da.*). This figure has dropped to 48.6% in 2003—a mere 3 years after the implementation of the long-term care insurance. Equally, the figure of potential caregivers who agreed with the statement that “*just because I am their child does not mean I will need to provide care for my parents*” (*Kodomo dakara to itte, kanarazushimo mizukara oya no kaigo o suru hitsuyō wa nai.*) rose from 28.7% in 1995 to 36.1% in 2003 (CAO 2004). While these shifts are not dramatic, they indicate that a value change is taking place. The socialization of care, which was jump-started by the implementation of the long-term care insurance in 2000, has taken root.

This has been confirmed by another survey, which was conducted by Unicharm, one of the world-leading manufacturers of baby and adult diapers, and other sanitary products. The Unicharm survey revealed a substantial disparity among the sexes when asked, “[w]ho would you prefer to help you with your intimate care should you no longer be able to perform it yourself” (*Moshi jibun ni haisetsu kea ga hitsuyō ni nattara?*) (Unicharm 2008). While 66.7% of the men surveyed responded they would prefer their spouse to perform their intimate care, only 20.7% of the women opted for the response ‘spouse’. Of the women 25.1% opted for their daughter as preferred caregiver (3.7% of men), 14.2% for a home-helper (8.2% of men), and almost a third of surveyed women, i.e., 32.7% preferred a personal caregiver to perform their intimate care (17.6% of men). In other words, 46.9%, i.e., close to half of all women, plan on using professional health-care takers in case they need assistance with their intimate care, and 25.8% of men, or about a quarter, would prefer to choose this option (Unicharm 2008).

Yet, the research by Tsukuda and Saito (2007: 133) revealed that “*women have higher odds than men of feeling reluctant about using home help services,*” mainly because “*women would feel more possessive than men about things inside the house and would not like to be intruded on by an outsider.*” These hesitations might, however, disappear over time as the old-age group will be composed more and more by the post-war generation who experienced a different socialization in their own youth (Tsukuda and Saito 2007: 133).

Despite the inconsistencies regarding the gender gap when it comes to preferences in caregiving, we can conclude that, even today, health care that is performed by persons outside the family, in Japan, is generally on the rise. This is due to first, structural changes such as the introduction of the long-term care insurance, and second, accompanying changes in attitude toward outsourcing reproductive labor from within the realm of the family, which is prevalent in the caregiving and care-receiving generations alike (Vogt 2011: 336).

It is this second aspect that might come as a particular surprise. Tamiya et al. point to this process of attitudinal change by referring to the relationship between a daughter-in-law (*yome*) and her mother-in-law (*shutome*), which for centuries had been that of a servant to her master. Traditional Japanese family values dictate that a

self-respecting *yome* would not allow a stranger into her house to give care, much less send her *shutome* to day care.<sup>16</sup> As formal services expanded, these forms of care, however, gradually have become common and have been accepted, even in the most old-fashioned rural areas (Tamiya et al. 2011: 1188).<sup>17</sup> As anthropologist Long (2008: 212) puts it: “*What has changed is that other types of care giving [i.e., from outside the family, G.V.] have become legitimate alternatives.*” In other words, carework performed outside the realm of the family is no longer stigmatized, and elderly Japanese nowadays “*can be viewed as ‘service consumers’ [...] in the social welfare field*” (Tsukuda and Saito 2007: 122).

## 2.4 Growing of a Market: Professionalized Approaches to Health-Caregiving in Japan

Japan’s Ministry of Health, Labour and Welfare (MHLW, *Kōseirōdō-shō*), a couple of years ago, calculated the personal risk of being in need of health care services to rise from 3.8% for 65-year-olds to 24.1% for 75-year-olds (Vogt 2011: 334). In fact, the percentage of beneficiaries of Japan’s long-term care insurance among these age-groups, already in 2013, have been reported by the ministry as lying above those probabilities: 4.3% of those aged 65–74, and 30.5% of those aged 75 and above were entitled to assistance under the insurance scheme (MHLW 2013). On average 17.2% of persons in the old-age segment, i.e., those aged 65 and above, require assistance under the long-term care insurance. This translates into 5.2 million people (MHLW 2013). The number is expected to continue to rise, as it has over the course of the first decade after its implementation in 2000, when the ministry reported 2.2 million beneficiaries (MHLW 2012: 234). The ministry calculated an expected 8.4 million beneficiaries by 2025 (Vogt 2011: 334).

This previous and future rise alike can be attributed to two developments: First, it has been triggered by a rise in the number of the population aged 75 years and above, i.e., the population segment of the “old-old” (cf. Fig. 2.4). Second, it also reflects a shift in attitude toward accessing the services provided by a state-run beneficiary system (cf. Sect. 2.3.3). Both the insurance system itself (cf. Sect. 2.3.2) and the potential beneficiaries’ changing attitude toward receiving health care from outside the realm of the family have been dealt with in more detail in the above sections.<sup>18</sup>

<sup>16</sup>Refer to Morimoto (2011) for an introduction to the household (*ie*) system, within which reproductive work was generally confined.

<sup>17</sup>In fact, “*older people living in urban areas showed higher odds than those living in rural areas of feeling reluctant about using home help services*” (Tsukuda and Saito 2007: 133). Urbanites may simply be (or have become) more self-sufficient, probably also because the *yome/shutome* bond had long been weakened in urban settings.

<sup>18</sup>Refer to Sawada (1997) for the situation before the implementation of the long-term care insurance.

The rising numbers of beneficiaries under the system of long-term care insurance not only result in a larger budget becoming necessary to finance the services needed by more and more people, it also poses the very practical yet pressing question of who will be performing the actual care work? This question is situated at the intersection of questions of labor market structures including the working conditions in the health care sector, and the changing role of families as the former (and possibly continuing) primary caregivers in this setting. It thereby goes to the core of any study on the political demography of Japan's eldercare. While the role of the family as health-caregivers is addressed in more detail in Sect. 2.3.3, the following paragraphs focus on the labor situation of the professionalized health-caregiving sector by introducing the basic numbers and policy responses—actual and possibly advisable, which are applicable to the health-caregiving profession.

In Japan, in contrast to other OECD nations, the problem of recruiting qualified personnel for health-caregiving is even more pronounced than the challenge of supplying enough beds in approved institutions. Almost two thirds (62.4%) of all nursing personnel in Japan are already employed in welfare facilities for the elderly (JNA 2008, 2010). Boosting the number of personnel in health-caregiving is among the most urgent issues of Japan's welfare policy-making. So far, much effort has been put into enhancing the number of personnel by encouraging a higher female labor force participation, and by recruiting youngsters, in particular those 'not currently in employment, education or training' (NEET). Also, substantial research funding has been channeled into developing robotic care assistance, ranging from the famous *paro-chan* health care seal toy to mechanical suits, which help stabilize a caregiver's spinal column when lifting patients (Kōno 2006/02/20; Wagner 2013).

The Japan Institute for Labor Policy and Training expects the rising number of beneficiaries under the long-term care insurance program to also translate into a rising demand for a long-term care workforce: From 1.49 million in fiscal year 2012, to an estimated 2.37–2.49 million by 2025, when the baby boomers of the post-war years will have entered the "old-old" population segment of those above 75 years of age (JILPT 2015: 55). This breaks down to a "necessary net increase of between 68,000 and 77,000 care workers per year through 2025" (JILPT 2015: 59). It does, however, get harder and harder to recruit workers into the profession, and to also keep them motivated on the job. In fact, the turnover rate varies from job to job, and with 24.4% (among 3295 providers) it is the highest among care workers in nonregular employment status (JILPT 2015: 65).

A large-n survey conducted by the Care Work Foundation (CWF, *Kaigo rōdō anteī sentā*) reveals insights into the problems the health-caregiving sector faces. The survey is conducted among health-caregivers on a yearly basis. In the 2015 survey ( $n = 6684$ ), a total of 61.3% of respondents claimed to be dissatisfied with their job. This was up to 2% from the previous year. Numerous reasons were mentioned that apparently made the profession so unattractive: low wages (57.4%), physically and mentally hard work (48.3%), low esteem in society (40.8%), difficult to take vacation days (23.0%), and instable employment situation (16.6%) were the top five reasons for dissatisfaction on the job (numerous options possible) (CWF 2016). The given reasons reflect a mix of the actual hardships of the profession on

the one hand, and the low acknowledgment of the profession—in terms of financial remuneration and societal recognition—on the other hand.

The Japan Institute for Labor Policy and Training in their 2015 report suggested for employers to tap into hitherto neglected pools of labor supply when aiming to fill caregiving positions—one of them being “*middle-aged and elderly men*” (JILPT 2015: 60). Apparently nowadays, some companies have started to employ a significant number of staff of retirement age. *The Japan Times* reports of a company in Saitama Prefecture with 30 of a total of 85 caregivers employed there being 60 years old and above; the oldest is 75 (JT 2014/08/04). While the retirees work to supplement their pension, they also seem to feel rewarded by their work. Shigeto Hirata, 73 years of age, who is working 6 days a week for the above-mentioned company in Saitama, says about a 69-year-old patient he is taking care of: “*I feel close to him because we are in the same generation*” and “*I work with a sense of mutuality because I could be a recipient of nursing care services tomorrow*” (JT 2014/08/04). The creation of mutuality over care work in Japan’s local communities, actually is a goal the Japan Institute for Labor Policy and Training is aiming to accomplish. They state that they want to foster “*mutual support among community residents and support for formation of organizations*” (JILPT 2015: 61). Put differently, next to alleviating the existing and predicted labor shortage in the caregiving sector, community building—and thus the activation of social capital—is another goal behind the recommendation of expanding the labor pool to groups who have hitherto not been at the center of attention of recruiters.

## 2.5 Activation of Social Capital: Community-Based Approaches to Health-Caregiving in Japan

The local communities play a crucial role in Japan’s eldercare. Not only do many health care services take place here, communities also provide center stage when it comes to building social capital, i.e., an asset that can directly and indirectly support health care for the elderly (cf. Sect. 2.2.3). It is in particular Japan’s 300,000 neighborhood associations that are the nucleus organizations to generating the nations’ social capital.

**Neighborhood associations** are voluntary groups whose membership is drawn from a small, geographically delimited, and exclusive residential area [...] and whose activities are multiple and are centered on that same area. (Pekkanen 2006: 87; bold print in the original)

Subgroups, such as the women’s associations (*fujin-kai*), the children’s associations (*kodomo-kai*) and the elderly people’s clubs (*rōjin-kai*) are attached to most neighborhood associations or operate in close interaction with them. 83.1% of Japan’s neighborhood associations claim to run programs supporting the elderly in the community (Pekkanen and Tsujinaka 2008: 709). Another 51.4% claim to maintain cooperative linkages to aged people’s clubs beyond their own association (Pekkanen and Tsujinaka 2008: 713). Their networks are widespread and knit

tightly, and they contribute to the creation of social trust in the communities. Survey data revealed that members of neighborhood associations not only showed a higher level of trust in their neighbors, but have “*higher levels of trust in anyone*” (Pekkanen and Tsujinaka 2008: 714). This suggests that participation in neighborhood associations in fact “*could directly increase levels of generalized trust and thus contribute to the building of social capital*” (Pekkanen and Tsujinaka 2008: 714).<sup>19</sup>

Japan’s neighborhood associations implicitly and explicitly support programs in the realm of lifelong learning (*shōgai gakushū*) practices. The implicit dimension has been touched upon in the paragraphs above: neighborhood associations “*provide an outlet for citizens to enjoy social life*” (Vogt 2010: 38). The “*cultural model*” (Ogawa 2009: 602) of social capital is stressed in this aspect. On the other side, i.e., with regard to the neighborhood association’s explicit contribution to lifelong learning the following two major avenues can be identified: First, neighborhood associations contribute to raising awareness about health issues, for example, by organizing trips to local health care facilities, in order for the elderly to familiarize “*with the available health resources and how to access them*” (Pekkanen and Tsujinaka 2008: 714). Second, neighborhood associations in their position “*at the backbone of creating networks between local residents and enriching these networks with social trust*” (Vogt 2010: 38), serve as partners to local governments. As such they, for example, take over public services such as delivering “*meals to the lonely elderly*” (Pekkanen and Tsujinaka 2008: 714). On a subtler note, they also ensure informal flows of information between residents and local governments and vice versa, and serve as an informal institution when it comes to implementing policies in the communities.

This mechanism of neighborhood associations acting as informal institutions in close cooperation with local governing bodies has historical roots—in fact it is said to date back to the Edo period (1603–1868) system of taxing household groups rather than individuals. Nowadays close cooperation between state and nonstate actors is highly contentious, and it triggers the re-emergence of a political and societal discourse centering around the question of “*who is a good citizen?*” Is it the one who cooperates with state entities—even if it is for the “*public good*”—or the one who takes over one of the more classic roles of civil society organizations by being a “*watchdog*” to the doings of state authorities (Avenell 2010; Gluck 1998: 277–278)?

Japan’s civil society is famous for leaning toward cooperation rather than confrontation with state authorities. While with many contentious policies a cooperative structure proves problematic for achieving their goals, it turns out to be a highly favorable model to civil society organizations in the welfare sector. State entities increasingly see them as organizations that “*contribute to [the] solution of problems*

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<sup>19</sup>The analytical concept of trust is elaborated on in more depth in Chap. 4.

*related to an ageing society*” (Potter 2008: 692). A centerpiece to these combined efforts is the concept of lifelong learning. It creates valuable networks, because it:

[...] draws people together physically, for example to a community center, where some form of communal learning occurs. [...] over time, it also fosters the creation of a set of norms and social trust within the group of citizens involved, and even beyond the physical boundaries of this network (Vogt 2010: 35).

Lifelong learning thus becomes one of the cornerstone measures of governing aging populations. The local communities provide the grounds for lifelong learning, and government bodies foster the spread of the programs. This model was followed, for example, in the 2010 campaign on *Lifelong Learning and Social Education* initiated by the Ministry of Education, Culture, Sports, Science and Technology (MEXT, *Monbukagaku-shō*). The campaign explicitly stressed “*the need for learning in response to social and economic change*” (MEXT 2010)—thereby addressing the need for lifelong learning due to demographic change not exclusively among the elderly, but, more generally, in the overall population. This thought is in line with the fact that in 2006 the concept of lifelong learning had already been added to the Fundamental Law of Education (*Kyōiku kihon-hō*) (Ogawa 2009: 601). All citizens are supposed to have access to lifelong learning and to benefit from various programs in this realm.

A look at the on-the-ground reality, however, quickly reveals that it is mostly senior citizens, the bearers of Japan’s civil society, who are active in lifelong learning initiatives. One of the best-known lifelong learning initiatives is situated in rural Nagano Prefecture. For centuries salt (*shio*) had been transported there over some mountainous paths (*michi*); today the *salt-street* (*shionomichi*) is a famous path of recreation, inspiration, and learning. In 1974, a local citizens’ organization had decided to regularly clean and prevail the path. Over the years, they built several elaborate trails, suited for easy hiking, which, in addition, provide information on myths and fairytales of the Nagano Mountains, the historic relevance of salt trading, and the regional cuisine. There are seven suggested trails, all of which the group itself advertises in close connection to the manifold aspects of lifelong learning that can be experienced *en passant*, i.e., on the go (Shionomichi 2013).

A welcome side effect of this—and many more similar initiatives<sup>20</sup>—is a most needed revitalization of local economies through private businesses initiated by the elderly. Lifelong learning programs are a way of empowerment to the elderly and to Japan’s rural areas alike. In this respect, they stand at the core of numerous government initiatives aimed at redesigning citizens’ understanding of old age: Nowadays citizens are expected to make an effort, in order to ensure they age in an active and healthy manner, and not put extra strains on the welfare state (Ogawa 2008).

<sup>20</sup>The *Zero Waste Campaign* in the town of Kamikatsu (Tokushima Prefecture) may serve as an example for the revitalization of a local economy. Initiated mainly by senior citizens, a new production and consumption cycle that is based on sustainability, was established across town (Okumura and Vogt 2014).

## 2.6 Expanding Perspectives: International Migration and Health-Caregiving in Japan

While both approaches, i.e., the increase in numbers of professional health care workers (cf. Sect. 2.4) and the fostering of social capital as a means of strengthening the communal approaches to eldercare (cf. Sect. 2.5) have strong ties to the subnational level of administration, international health care migration, in its current systemic design, comes to the scene as somewhat of an outsider model. Health-caregivers, who are nowadays being recruited in Southeast Asian countries to work in Japan, are channeled into a system that only allows them to work in institutionalized health care—rather than in private homes or community centers where most of the care work actually takes place (cf. Sect. 2.3.2). Many of them are employed by large hospitals and nursing homes that do not encourage their integration into the local communities.

These predominantly female migrant workers are part of one of the major global trends of international migration flows, and one that is particularly pronounced within the Asian region, i.e., the feminization of migration (Vogt and Achenbach 2012: 16–18). This trend has predecessors in the historical evolvement of the composition of Japan's foreign population (Vogt 2012): Since the late 1980s, many rural and predominantly agricultural areas of Japan have seen some influx of foreign women, who mainly came to Japan as brides to be married to local farmers. They followed suit female migrants in the 1970s—both groups originated in the many countries of Southeast Asia—who entered Japan's labor market predominantly as workers in the sex industry (Komai 2001: 16–17).

Authors critical to the most recent opening of an avenue for international health care migration to Japan often refer to these predecessors and claim a similar degree of vulnerability between the previous (*zainichi*) and the more recent (*rainichi*) migrant groups exist. Social scientist Ballescas (2009: 137), for example, poses the following questions:

The case of *rainichi* Filipinos may be different from the *zainichi* but the former can be recruited as caregivers but what is there to stop the agents from making them do carework during the day and entertainment at night? What is there to stop *rainichi* caregivers as well not to transfer to more lucrative but unauthorized work like entertainment once inside Japan? What can also stop them from overstaying like their predecessors in Japan?

Ballescas expresses her profound concerns for the well-being of migrant health-caregivers in Japan. She fears for them to be exploited along the same lines as other female migrant workers had previously been in Japan. While expressing her concerns, though, Ballescas—probably unintentionally—also caters to the ongoing discourse on foreign criminality in Japan. She stresses previous cases of undocumented Filipino workers in Japan, i.e., those who engaged in work that their visa was not appropriate for, respectively, those who overstayed the duration period of their visa. The presence of undocumented foreign workers is a highly sensitive



issue to Japan's policy-makers and the general public alike, and criminal acts conducted by foreigners tend to be sensationalized in the national media (Behaghel and Vogt 2006: 141–142). It is in this atmosphere of ongoing government campaigns of cracking down on undocumented foreigners,<sup>21</sup> and the perseverance of a widespread perception of foreign residents as being somewhat dubious and shady that leaves almost no room to a successful introduction of a new migration scheme to Japan.

Via bilateral economic partnership agreements Japan, as of 2008, respectively, 2009, has opened the doors to its domestic labor market to health-caregivers from Indonesia and the Philippines. The fixed quota is 1000 health care migrants to Japan per year and nation. So far, it has not once been met. Not even nearly. In the 4 years of 2008–2011, a total of 363 Indonesian nurses and a total of 428 certified care workers came to work in Japan. This is 791 health-caregivers over the course of 4 years; a maximum of 4000 migrants would have been possible. The picture for Filipino migrants looks even more inauspicious. In the 3 years of 2009–2011, a total of 209 nurses and a total of 323 certified care workers entered Japan. This is 532 health-caregivers over the course of 3 years; a maximum of 3000 migrants would have been possible (Ogawa 2012: 99). The migration contingent of health care workers from Indonesia to Japan is utilized by 20%, that from the Philippines by 18%.

This migration scheme will be introduced in more detail in Chap. 3 of the book. However, even at this point, it is fair to conclude that the scheme so far has proven extremely unpopular. It lacks popularity with the potential migrants and their potential employers alike. On the one hand, to many migrants the scheme is unpopular because it requires migrant workers—regardless of their previous qualifications—to first be employed as assistants. Only after passing Japan's national exam for nurses or certified care workers—in Japanese language (!)—will they be granted their full professional status, an according salary, and the benefit of a long-term visa to Japan. Before that their life's outlook is completely up in the air. In a global labor market that competes for the best qualified workers, Japan turns out to be an unlikely destination, in particular so, when compared to other countries recruiting international health-caregivers. Many employers, on the other hand, are reluctant to hire foreign health-caregivers for two reasons. The first one is a very pragmatic one: potential employers are unsure about migrants' communication skills with the patients (60.8%) and unsure about migrants' nursing skill levels (47.0%) (Vogt 2011: 339).<sup>22</sup> The second reason for their reluctance to employ foreign caregivers is their somewhat xenophobic anxiety as to how patients and their relatives might react when facing foreign health-caregivers, as the head of a

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<sup>21</sup>For example, the Ministry of Justice's (MOJ, *Hōmu-shō*) *Campaign against illegal work by foreigners* (*Fuhō shūrō gaikokujin taisaku kyanpēn*), which was implemented in 2004, and called for assistance by employers and general citizens in identifying undocumented foreign workers (Vogt 2007: 20, 2014: 56).

<sup>22</sup>The percentage given is based on survey data ( $n = 334$ ) resulting from a survey conducted among the heads of nursing homes across Japan (Kawaguchi et al. 2009: 55).



nursing home in the city in Sendai mentioned in confidentiality during a conversation with the author in 2008.<sup>23</sup>

An additional problem to the system—although not identified as such by any of the core actors involved—is the alienation of international health-caregivers from the local community they are serving. Once chosen as an applicant, health-caregivers are dispatched to one of the health care facilities registered with the Japan International Corporation of Welfare Services (JICWELS, *Kokusai kōsei jigyō-dan*). Migrant caregivers are supposed to work full time while also studying Japanese language. In other words, they enter any random community as strangers and need to keep themselves very busy are they to stand a chance to pass the national exam. They will thus remain strangers in the community. This is in huge contrast to the early migrants of the 1970s and 1980s, some of whom nowadays pursue a second career as health-caregivers. As long-term residents to Japan they generally have a good command of spoken Japanese, and they have been living in local communities (and in many cases with their husbands' families) for some decades. Some of them have meanwhile enrolled in private educational institutions to obtain training as health-caregivers. In 2006, in Tokyo, the first successful alumni founded The Licensed Filipino Caregiver Association in Japan (LFCAJ). These *zainichi* Filipino caregivers are outstandingly more likely to make a successful career for themselves in Japan's health-caregiving sector than the newly arriving *rainichi* Filipinos. Yet, they remain confined to the less prestigious and less remunerated sector of home-helper services, while the newly arriving health-caregivers are confined to the institutionalized sector (Vogt and Holdgrün 2012: 83–90). More flexibility to the avenues accessing the health-caregiving system and a closer interconnectedness of health-caregivers to the communities they work in are only two of the alterations indispensable should the health-caregiving sector be opened to migrant workers for real. Under the current circumstances, however, international health care migration cannot yet contribute to alleviating the strains a growing number of elderly in need of health care is putting on the nation's politics to shape sustainable approaches to eldercare.

## 2.7 Discussion of Findings and Concluding Thoughts

This chapter introduced three vastly different approaches to health care work to the elderly. One of these approaches, the community-based approach of lifelong learning programs and fostering social capital in localities has some roots in Japanese history. It presents an established model of keeping local communities active and individuals agile. At the same time the community-based approach of eldercare proves to be flexible enough to adapt to the new challenges of “*a hyper-aged and depopulating society*” (Atoh 2008: 18). Some communities have become

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<sup>23</sup>More of this interview has found its way into Vogt and Holdgrün (2012: 88).

well known for their innovative approaches of keeping the elderly an integral and important part of the local community. Moreover, some communities even were fortunate enough to gain new business models through initiatives taken up by the elderly population. A community's flexibility toward accepting the challenges of demographic change expands also to cooperation with the demands of implementation of national-level policy reforms, such as the introduction of the long-term care insurance system. This system aims at the socialization of care work. As such one could have expected in particular the mostly conservative rural communities to oppose it. Yet, close cooperation with regard to hands-on practices (such as delivering meals) and with regard to psychological assistance (such as offering afternoon activities in community centers) takes place. The interwoven character of Japan's long-term care insurance into the local communities, thereby into the core of the Japanese state and nation, is the key to its success. It is exactly this point that distinguishes the successful implementation of long-term care insurance from the failures in implementing international health-caregiver migration to Japan. The care-migrants are dispatched randomly, heads of nursing homes are reluctant to accept them on staff, and some patients and their families are reported to meet them with some degree of anxiety.<sup>24</sup> On the other hand, long-term foreign residents to Japan, who have roots in local communities, and oftentimes speak Japanese fluently, ironically are largely neglected as potential care workers by government policies. Only some very recent initiatives of the current administration by Shinzō Abe (in office since 2012) show a change of attitude here. These will be introduced in the policy outlook provided in Chap. 5 of the book.

A tight structural and emotional interconnectedness between the elderly, their families and communities on the one hand, and the caregiving and care-managing entities on the other hand, so far has proven to be the crucial factor determining success or failure of initiatives in the field of Japan's eldercare (Morikawa 2014; Tsutsui 2014). Additionally, we can conclude that successful initiatives in eldercare in Japan have triggered a general shift in attitude toward health-caregiving. Outsourcing of health care work to the elderly from the realm of the family into the communities, i.e., the Japanese approach of a socialization of care work, is now taking place, and—most importantly—it is being accepted by an increasing segment of the overall population. The internationalization of care work, i.e., the idea of Japan jumping onto the bandwagon of the global care-chain, however, has not yet found any enthusiasm with the majority of the Japanese population. Too distant from the everyday life in local communities and the local networks is this thought.

How do people and how do social institutions react to demographic changes? This is the central research question to political demographers (Goldstone 2012: 13). From this chapter, two concluding thoughts emerge: First, with regard to the

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<sup>24</sup>It should not go unnoticed that some ethnographic studies have managed to show how intensely patients, families and international care workers bond with each other. A case in point here is Switek's (2016) case study on Indonesian nurses' daily lives at their workplaces in Japan. Also, the more general topic of migrant workers' experiences at their workplaces will be further elaborated on in Chaps. 3 and 4 of the book.

impact to the Japanese people, a profound shift in attitude toward health care conducted by caregivers from outside the family can be observed. Outside care is increasingly being accepted in all generations. This shift in attitude may be rooted in an awareness of the simple need for outsourcing care, since many of the in-family caregivers now are aging themselves or since traditional living arrangements are in flux. For sure, however, the outsourcing is being smoothed by vivid local communities who turn the individual experience of the ongoing socialization of care into a local one, based in mostly familiar and intimate circles. Where this familiarity and intimacy are not guaranteed, for example, when it comes to international health care migration, the willingness to accept this particular aspect of a socialization of care declines.

Second, the need to manage health-caregiving to Japan's growing population of elderly impacts Japan's political system mostly on its subnational level. The expansion of health care services on the national level almost never turns out to be an issue of political contention, and the international level is still more or less irrelevant to the Japanese case. On a subnational level, Japanese politics is shaped by a generally close cooperation between state and nonstate actors. The pros and cons for this partnership are being discussed fiercely in Japanese political science. The discourse juxtaposes two thoughts: that of neoliberal politics exploiting citizens versus that of citizens being too weak, too little educated and too little interested in politics to be able to act as a solid political opposition within the municipalities (Ioka 2008; Morikawa 2014; Ogawa 2015). The case study of eldercare in Japan, however, is one that proves the merits of a tightly knit network of cooperating partners. In fact, citizens' engagement in eldercare (a) keeps citizens agile and healthy much longer than if they were reduced to simple care-recipients rather than active community members, and (b) it helps lowering the costs of the long-term care sector by outsourcing some tasks to the voluntary sector, which sometimes results in an even better quality of services.

Vivid local communities seem to be the key to managing Japan's rapid population aging. The structures and approaches already in place with regard to eldercare might also be transferable to the other two policy areas concerned with demographic variables, namely family policy and migration policy—much needs to be accomplished in these policy fields, too, in order to level the negative effects, predominantly the negative economic effects, of rapid population aging.

The following chapters of the book will introduce in detail the realm of migration policy, which deals with the Japanese government's attempts to regulate population inflow (and outflow), i.e., to administering mobility as—next to fertility and mortality—third demographic variable (Vogt 2008). Special consideration will be given to the following two questions:

- What role does international labor migration play in Japan's attempts to cushioning its demographically induced shortage in the health care sector, and how can the national level policies already in place be evaluated? (cf. Chap. 3)
- How prepared is Japan to actually accept large numbers of foreigners, i.e., what is the prospect of success in building a multicultural Japan? (cf. Chap. 4).

The first question will be addressed in a comparative perspective, adding Germany—a country that faces relatively similar demographic challenges, but has a vastly different history of migration policy—to the picture.

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