

The Necessity of Reduced Working Hours under the Re-familization of Elderly Care

IKEDA Shingou

While Japan's Long-term Care Insurance System has sought to ensure the "de-familization" of long-term care through greater provision of long-term care services, financial constraints resulting from increases in the numbers of people requiring long-term care have prompted the gradual "re-familization" of long-term care for the elderly. If this re-familization of long-term care progresses in the future, companies may be forced to further expand and improve the measures that they have in place to support employees to combine work with providing long-term care. However, looking at a system to reduce scheduled working hours, for example, the demand for such system is low and seems unlikely to increase in the future. Even where family members take on the task of providing care, it is only in cases where the care recipient has severe care needs that the family carer goes to the extent of reducing their working hours to make time to provide care. This is due to the widespread tendency toward encouraging care recipients to do as much as they can themselves, an approach referred to as "autonomy-oriented caring¹." It is important that future systems for supporting workers to combine work with providing long-term care are premised on this new approach to long-term family care, rather than allowing the re-familization of long-term care to spell a return to family carers providing complete assistance for all of the care recipients' needs ("devoted caring") as was expected in the past.

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I. Introduction

Long-term care for the elderly has been an issue in Japanese society for a number of years due to the declining birth rate and aging population. A quarter century has passed since the enactment of the Act on Childcare Leave, Caregiver Leave, and Other Measures for the Welfare of Workers Caring for Children or Other Family Members (the "Child Care and Family Care Leave Act") in 1995² and two decades have passed since the implementation of the Long-term Care Insurance System in 2000. There are, however, still many outstanding issues regarding what constitutes an effective system to support those who need to balance providing long-term care with work. Japan

urgently needs to develop such systems given that it is already the nation with the world's highest population aging rate (percentage of the population aged sixty-five and over) and is heading toward what is expected to be the Age of Long-Term Care, a time of unprecedentedly high demand for long-term care set to start in 2025 when the baby boomers pass the age of seventy-five.

The amendment to the Child Care and Family Care Leave Act in 2016 saw major revisions to the existing framework of the system for supporting the combination of work and care to develop a support system to cover the period from the initial timing at which the person requiring care (care recipient) begins to require care (start) to the point at which they no longer require care (end), as shown in Figure 1. The JILPT conducted survey research on the balance of work with providing long-term care to investigate the effects of said revised system and elucidate any further issues regarding the combination of work with providing care. This paper will introduce the key points of that research, while also focusing on reduced scheduled working hours as a core issue and drawing on data to shed light on the demand for such systems.

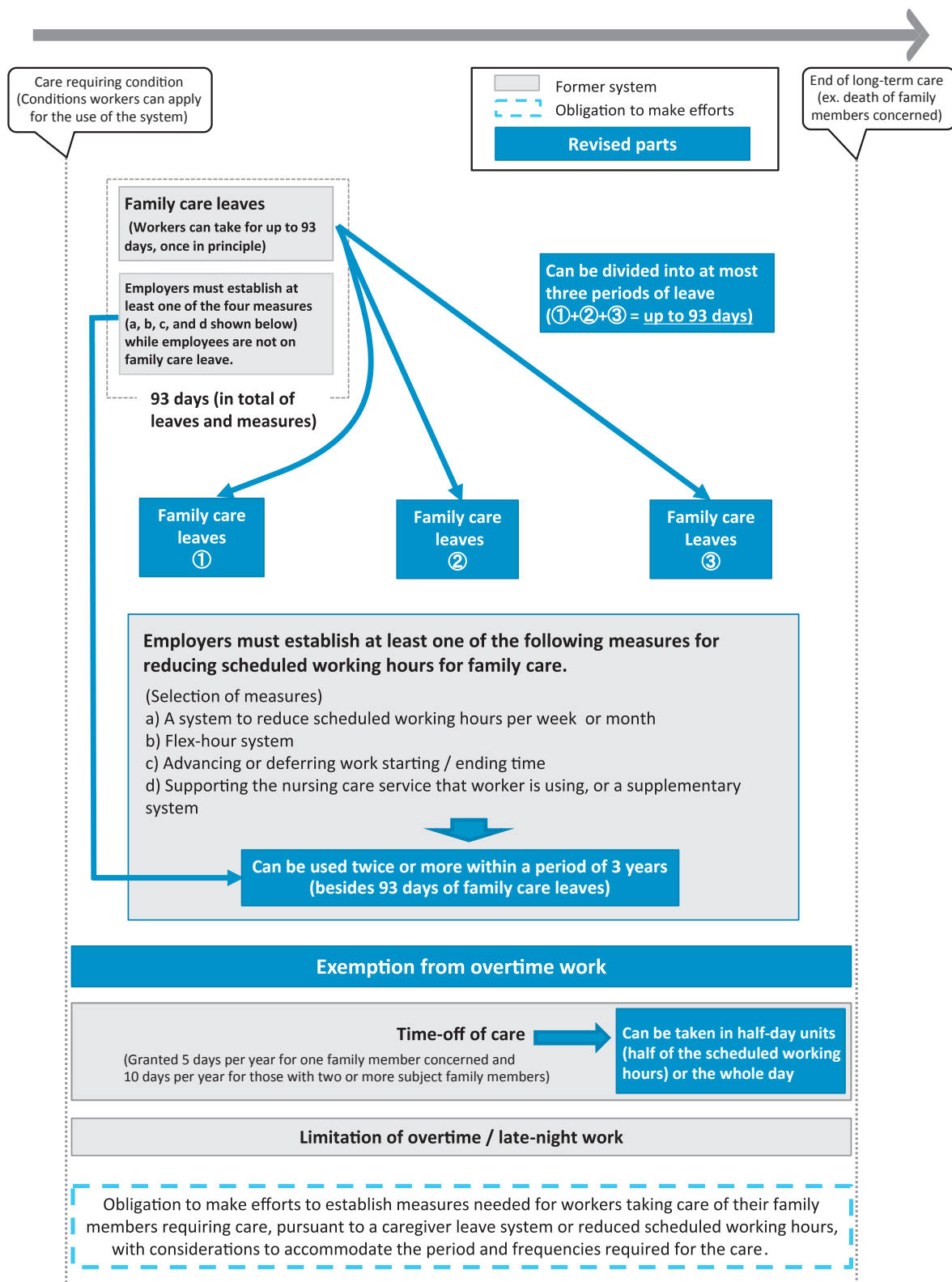
The amendment to the Child Care and Family Care Leave Act in 2016 has been covered in an earlier edition of this journal (Ikeda 2019). Here we will introduce most recent research which addressed the 2016 amendment in the context of Japan's shift back to the provision of care by families—the “re-familization” of care—and sought to verify the demand for support for combining family care with work that may arise amid the re-familization of long-term care in the future. The opposite approach to re-familization—namely, “de-familization”—was previously pursued in Japan with the Long-term Care Insurance System implemented in 2000, following the enforcement of the Child Care and Family Care Leave Act the previous year. This Long-term Care Insurance System sought to achieve the de-familization—or “socialization”—of long-term care by social services to substitute the care that was being provided by family members. However, there has in practice been relatively little progress in the de-familization of care. In fact, issues have arisen due to limitations on the provision of long-term care services and there is a growing trend toward re-familization, by which social services cover less areas of care and the areas assumed by families are increased again (Fujisaki 2009). This trend in the Long-term Care Insurance System formed the background to the 2016 amendment. While the re-familization of long-term care was not explicitly discussed at the time, it could be suggested that the 2016 amendment and its measures to ensure that family carers are able to work while fulfilling care responsibilities in various areas of daily life were the first to respond to the high likelihood of the re-familization of long-term care along with birth rate decline and population aging. Japanese companies are understandably concerned and braced for the challenges that may arise as further birth rate decline and population aging in turn prompts further re-familization of long-term care, putting them under pressure to greatly develop their measures to support employees providing long-term care for their family members to balance those commitments with work.

However, many issues remain unclear regarding the impact that workers' long-term care commitments have on their work. Continuous research on this topic by the JILPT since the mid-2000s has successively revealed new problems that were not foreseen at the outset. This paper addresses future approaches to support for combining long-term care with work from these latest perspectives.

II. Three types of issues on combining work and care

1. Time budgeting

Combining work with family life is—even outside of the context of the Child Care and Family Care Leave Act—most commonly treated as an issue of time budgeting. Such a perspective was originated from the support provided for combining work with raising children. Combining work and long-term care, however, entails problems that are rarely addressed in relation to combining work with raising children. The JILPT's research thus far³ suggests that issues regarding the balance of long-term care with work can be roughly divided into three areas.



Source: Ikeda (2019), <https://www.jil.go.jp/english/jil/documents/2019/015-04.pdf>, based on Ministry of Health, Labor and Welfare, <https://www.mhlw.go.jp/english/policy/children/work-family/dl/160802-01e.pdf>.

Figure 1. The system for combining long-term care commitments with work under the 2016 amendment to the Child Care and Family Care Leave Act (Workers can use the following system for each family member concerned in a condition requiring long-term care)

The first of these is time budgeting. The Child Care and Family Care Leave Act adopts this perspective in laying out a system for supporting the combination of work with providing long-term care. This is based on the recognition that working carers may require leave, time off, or changes to working hours where they need to address tangible care tasks that arise during working hours. For instance, the 93 days of leave for providing long-term care (“family care leave”) are intended as a preparation period to deal at short notice with hospital admittance and release procedures and other such tasks that arise in the case of the onset of cerebrovascular disease or other such primary diseases, and conduct the subsequent discussions within the family about providing care and procedures for using long-term care services. It is based on the concept that workers require a long period of leave in which they can focus solely on providing care, as it is not possible for them to allocate time to work within their daily time budget during such a period. The provision of time off for family carers is also based on the assumption that they will need to carry out tasks such as accompanying the care recipient on hospital visits—that is, they will be unable to come to work because they must allocate time to provide care.

Ikeda (2010; 2017a; 2017b) has confirmed that the family care leave system is effective in curbing the tendency for workers to leave jobs. Moreover, as addressed later in this paper, the latest research by the JILPT has confirmed the effectiveness of the system in curbing the tendency to leave jobs within one year after starting to provide care. On the other hand, the reducing of working hours and other such flexible working arrangements—the period for which was extended under the 2016 amendment—involve a number of issues that need to be investigated in the future.

Even outside of Japan, there is relatively little research investigating the role of flexible labor environments, and results remain inconsistent. For example, Pavalko and Henderson (2006) indicate that among employed women in the US who are responsible for providing family care those who are employed in positions in which they have flextime systems, unpaid family leave, paid leave and sick leave tend not to leave their jobs or decrease their working hours. Likewise, Schneider et al. (2013) notes that in Austria, flexible labor environments are effective in limiting tendency to leave jobs exclusively among employed women. In contrast, in examining trends among employed women in the UK, Henz (2006) shows that the job flexibility has no impact on decisions such as whether to take on care responsibilities or whether to leave the labor market.

2. Carers’ health issues

Even workers who do not have a problem with time budgeting for their work and care commitments are likely to damage their health due to fatigue or stress if they spend their entire day working and providing care with no time to rest.

For instance, many working carers caring for dementia sufferers who sleep during the day and stay awake at night may also accumulate additional fatigue and stress in the evenings and at night when they should be recovering from the strains of the working daytime. Reports of carers who have struggled with such a lifestyle for extended periods resorting to suicide or violence toward care recipients are not uncommon in the Japanese media. There are also clear risks to carers’ abilities to fulfil their responsibilities at work, such as the risk of falling asleep during work or causing major mistakes or accidents (Ikeda 2016; 2019).

While such health issues may ultimately result in workers leaving their jobs, in the prior stage they may lead to presenteeism—namely, a worker coming to work despite health issues that cause reduction of productivity (Ikeda 2013; 2014; 2015, Ikeda 2016; 2019). In terms of the fact that taking time off may increase burden on other workers, the problems of workers taking care leave, time off and reducing working hours due to time budgeting issues are very similar to that of absenteeism caused by health issues. However, as it is clear that in reality the costs of presenteeism are higher than those of absenteeism, employers’ interests are beginning to shift toward managing the health of the employees who *are* coming to work (Wada et al. 2013).

There are in fact few employees who leave their workplace—that is, quit their jobs or take time off or care leave—to provide care. Rather, it has been revealed that it is more common for workers to see a decline in

their performance because they are coming to work tired or under stress due to their care commitments (JILPT 2015). It is essential to uncover the potential factors behind such difficulties combining work and care as we further investigate the issues of support for combining these commitments.

At the same time, it is difficult for companies to identify poor health in employees who are coming to work as usual. Burden on carers outside of working hours are particularly difficult for companies to see. Health problems imply the possibility that care-related problems arising in such areas that are not visible to companies may be having a negative impact on work.

3. Human relationships

Let us now address an aspect that is even less visible for companies: human relationships. Whether a person has good human relationships with the people around them has a significant impact on their ability to combine work with providing care.

The relationships among the family members responsible for providing care, for instance, may entail differing views on the approach to providing care, or cases where siblings are estranged in the first place. In contrast, a good relationship with one's family may reduce the burdens a carer faces in providing care—both in terms of time budgeting and health-related issues—helping them to combine care with their work. If carers have good relationships with local people or acquaintances, they may be able to handle the aforementioned time budgeting and healthcare issues by receiving support in the form of opportunities to relieve their stress by discussing their care-related concerns or such people checking in on the care recipient in their place. In the workplace, if carers have developed relationships with their superiors and colleagues which allow them to easily seek consultation about their care commitments, they may find it easier to receive support regarding areas of time budgeting such as taking time off or leave or changing working hours. And if they have concerns about their health, they may be able to receive support to prevent it from hindering their work.

Such informal means of assistance built on human relationships undoubtedly play a significant role where the provision of formal care services is no longer sufficient due to the financial constraints on the Long-term Care Insurance System. In that sense, it can be suggested that human relationships will occupy an important position in Japanese society in the future as the re-familization of care progresses. However, human relationships are an aspect that is considerably difficult for companies to recognize. Even in the case of human relationships in the workplace, it would be wrong to make the sweeping suggestion that workers with good relationships in their work are also able to receive support for their care commitments, and the state of carers' relationships with family members and local people or acquaintances are even more difficult to ascertain. There is a tendency for carers to take on care responsibilities alone without confiding in anyone because they feel that the care recipient's condition—that is, the reason why they require care—is not a topic to be discussed with just anyone. These carers are more likely to quit their jobs.

Such problems are set out in Figure 2. The Child Care and Family Care Leave Act shown in Figure 1 established a system for supporting the combination of care commitments with work from the start to the end of the period for which care is required, and these long-term care periods are generally growing longer. There are three sources of support for providing care over such long periods: the company at which the carer is employed, local long-term care services, and family. However, all three of these sources are highly likely to experience severe labor shortages as population aging and decline continue. Moreover, the actual challenges faced by carers are not limited to time budgeting concerns that can be addressed by taking time off or leave or reducing working hours. They also include factors such as healthcare problems resulting from the fatigue or stress caregiving, as well as the underlying human relationships with the care recipient and other family members and their human relationships with the superiors and colleagues with whom they need to be able to consult with regarding their care commitments.

Amid this circumstance, it is important to take a more diverse approach to examining the kinds of problems faced by working carers in such areas rather than limiting ourselves to the problems of leaving jobs

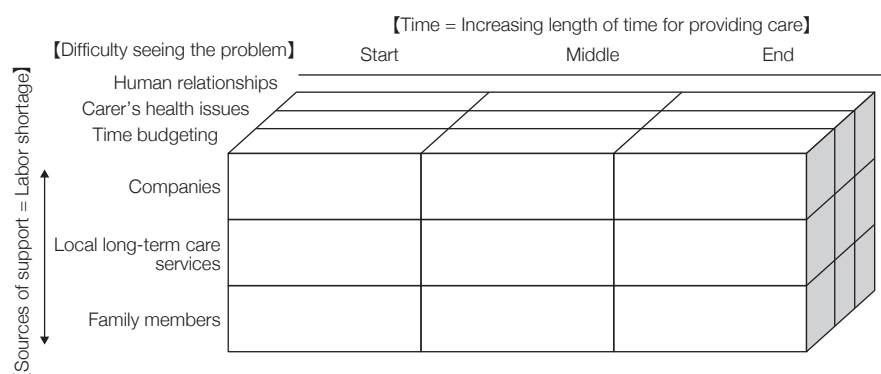


Figure 2. Three-dimensional image of combining work with providing long-term care

due to care commitments and the system for supporting combining work with providing care. While it is not possible to cover all of these in this study, below we present the new issues regarding support for combining work with providing care that we have shown through analysis of various topics regarding the combination of those commitments.

III. Survey on work and long-term family care

1. Outline of the survey

The following analysis utilizes data from the “Survey on Work and Long-term Family Care” conducted by the JILPT in February 2019. The survey investigated trends in leaving jobs due to long-term care commitments and the employment situations of family carers. It is intended to reveal further potential issues with regard to support for combining work with providing care, in light of the revisions to the support system under the 2016 amendment to the Child Care and Family Care Leave Act (implemented in January 2017).

The survey covered men and women who had experienced the long-term care of a family member in or after April 2000 and fulfilled one of the following conditions:

1. Currently providing care and currently between 20 and 69 years of age, or
2. Finished providing care but age at the end of the care period was between 20 and 69

*Includes cases where the care recipient live/lived elsewhere or is/was cared for at a care facility, as opposed to only cases where the carer and care recipient live/lived together.

The sample was selected by conducting a screening survey of the monitors registered with a survey company (2,212,088 registered monitors as of April 2018). The monitors were screened and requested to response until 4,000 responses fulfilling the following conditions had been acquired. Respondents completed the survey online using a browser or similar format. The following aspects were taken into consideration when gathering the responses to minimize bias within the sample as far as possible.

- 1) Gather responses such that the employment rates and percentages for different forms of employment by gender and age at the end of the care period (at present for those currently providing care) closely resemble the distribution ratios for people providing care to family members set out in the 2017 *Employment Status Survey* by the Ministry of Internal Affairs and Communications.
- 2) Likewise, gather responses such that the figures for occupation at the end of the care period (at present for those currently providing care) closely resemble the distribution ratios for people providing care to family members set out in the 2017 *Employment Status Survey*.
- 3) For place of residence, gather responses from across the 47 prefectures in order to avoid bias toward the large urban areas such as the Tokyo Metropolitan area or cities in the Kinki area.

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- 4) Gather at least 1,000 responses from people whose relatives became in need of care in or after January 2017.
 - 5) Gather at least 1,000 responses from people whose relatives became in need of care in or before December 2016.
 - 6) Ensure as far as possible that around half of the respondents are people currently providing care and around half are people who have finished providing care.

2. Main findings

The JILPT research group analyzed the data gathered from various perspectives. The results revealed the following:⁴

- 1) Curbing effects of support for combining work with care and flexible working arrangement on tendency to leave jobs: If the correlation with the legally prescribed support system for combining work with care is controlled, the family care leave system has a significant curbing effect on the tendency to quit jobs.
- 2) Extent to which the amended Child Care and Family Care Leave Act has become recognized: Carers who are aware of the amendment are not likely to leave their jobs in the future. However, the degree of awareness of the amendment is relatively low, and there is no widespread understanding of the systems of time off, reduced scheduled working hours, and exemption from unscheduled work.
- 3) Demand for reduced scheduled working hours: The system to reduce scheduled working hours and exemptions from unscheduled work are based on the thinking that it is preferable that family members provide care for the day-to-day activities such as bathing, eating meals, and using the toilet. However, there is a growing trend toward emphasizing the autonomy of the care recipient which has seen a decline in demand for such measures.
- 4) Working carers' wellbeing and inclination to leave jobs: The trends differ among currently employed carers between those who responded that they are "unable to continue" working and those who responded that they "do not know" whether they wish to leave their jobs. Those who respond "do not know" have issues such as a tendency toward depression or having no one to confide in.
- 5) Marital status and likelihood of job continuation: In the case of people who have a spouse, likelihood of job continuation is affected by their relationship with the care recipient, their ability to consult with family or relatives and their workplace having an environment conducive to talking about private matters. In the case of people who do not have a spouse, likelihood of job continuation is affected by whether they have access to care services that fit with their working hours, and whether there are other people who are able to do their work.
- 6) Negative impact on marriage among young carers: There is a significant decrease in the likelihood of marrying among women who start to provide care in their thirties and forties. Use of care facilities has a significantly positive influence on likelihood to marry among both men and women.

Of these points, the first and second are concerned with the effects of a system of support for combining work with care that has been developed from the perspective of time budgeting, while the third suggests that human relationships—particularly the relationship with the person requiring care—have an impact on the issue of time budgeting. The fourth indicates that human relationships (whether the carer has someone to confide in) and health issues (depression) may correlate. In that sense, this reveals that the three areas covered above—namely, time budgeting, health issues, and human relationships—are deeply connected. The issues for single people as noted in the fifth and sixth points are a key concern when considering future approaches to the balance of work with care given the progressive tendency among Japanese people to remain unmarried.

Support for combining work with providing care can be divided into the tangible—such as managing working hours (time off, leave, changing working hours), long-term care services (in the home or at care facilities), health management, and financial support—and the intangible—that is, human relationships with

superiors, colleagues and family, people to confide in, and sources of information. It is important to ensure that working carers receive not only tangible support but also these intangible forms of support in order to ensure that they are able to combine providing care with work and do not leave their jobs due to their care commitments. The dilemma that Japan will face in seeking to provide support for combining work with providing care in the future lies in the fact that while efforts to develop the tangible forms of support will become ever more in earnest as the numbers of single carers rise, there is also the risk that labor shortages and financial constraints will prevent such improvements to tangible support.

The issue of shortage of tangible means of support for combining work and care will be particularly serious in the event of an increase in the numbers of single carers as noted in the fifth and sixth points above. The needs for support for combining work and care differ according to whether the carer has a spouse. In the case of carers who have a spouse, a good relationship with the care recipient and a workplace environment conducive to discussing private matters raise the likelihood of the carer's job continuation, and developing support in intangible terms is therefore important. On the other hand, in the case of single carers, who have come to account for a conspicuous portion of carers in recent years, factors such as whether the hours for which the care facility is fit with the carer's lifestyle and whether there is a colleague who can take over their work duties raise the likelihood of job continuation (JILPT 2020, chap. 5). That is, single carers have a greater need for the *tangible* forms of support as opposed to the intangible. Moreover, the analysis of the impact of caregiving experience on marriage also shows that use of care facilities increases the likelihood of getting married (JILPT 2020, chap. 6). In that sense also there is a high demand for development of tangible support.

However, it is unlikely that care services will be expanded to solve the issue of available hours not fitting with working hours. It is also difficult to imagine that care facilities will be expanded to allow carers to improve their private lives—that is, to allow them to get married. These problems are the structural result of the demographic trends in Japanese society. As the population declines, regional society faces labor shortage for running care services. This trend prompted the course reversal from the de-familization to the re-familization of care. At the same time, the families who will be expected to take on such care are also becoming smaller in size. Moreover, company workplaces—where those families' work should be supported—are seeing increasingly chronic labor shortages. The impact of this “triple downsizing” in the support offered by society—that is, the decline in manpower on the three fronts of companies, families and local society—is concentrated in single carers.

The following section will address how this issue can be solved in the context of the re-familization of care by reexamining the role of family members as carers assisting day-to-day activities as noted in point three above, and setting out the future approaches to support for combining work with care.

IV. Reconsidering family care and working hours

1. Considering the demand for reduced scheduled working hours based on the relationship with the care recipient

Here we will address a system to reduce scheduled working hours as a tangible form of support for combining providing care with work. The Child Care and Family Care Leave Act obliges employers to provide carers with one of a number of measures such as reduced scheduled working hours, flextime, staggered hours or assistance with the costs of care (“measures including the reducing of working hours”) and the 2016 amendment expanded the period within which such measures can be taken to three years. The most popular of these measures is a system to reduce scheduled working hours and providing the system for people raising children has been obligatory for companies since 2010.

For caregiving, the 2016 amendment introduced the obligation for companies to allow exemption from unscheduled work, but the introduction of a system to reduce scheduled working hours was not made obligatory. The existing act recognizes the choice for scheduled working hours to be worked through flextime

or staggered hours systems rather than reduced scheduled working hours. In other words, it assumes that, unless there are special circumstances, the carer will work the scheduled working hours as usual. In terms of time budgeting, the current act defines that work takes precedence over care commitments during the scheduled working hours, while care commitments take precedence over work during overtime.

However, due to the aforementioned constraints on the supply of care services, it is possible that demand for reduced scheduled working hours may increase in the future. This is because a system to reduce scheduled working hours will conceivably be closely connected with hours of availability of care services as is the case with the opening hours of childcare services for workers raising children. It is also possible that child raising and providing care differ in terms of the relationship between services and working hours.

Japan's public childcare services take into account the employment situation of family members in providing childcare, however the Long-term Care Insurance System does not. In fact, the existence of families is not even defined within the system in the first place. The system consists of three parties: the older person (insured person or service user), the local government (the insurer), and the service provider. The family is not part of this structure. In terms of the fact that even older people who do not have a family are able to receive care by arranging for themselves a contract with a service provider and using those services, this is a "de-familized" system of care. However, as, in reality, the existence of a family is not a *part* of the system but a *premise* upon which the system is based, it is an issue that the family's role in providing care has not been defined (Ikeda 2002) (JILPT 2020, chap. 2–3). The fact that the role of the family is not defined but assumed as a premise for the system may spell the indefinite expansion of the role of the family as the re-familization of care progresses.

It would be natural to assume that this would in turn increase the necessity for a system to reduce scheduled working hours. However, it is important to note that, unlike children, elderly relatives who require care are unlikely to require constant assistance. Even in cases where the care recipient is bedridden and requires extensive assistance on a daily basis, there are few cases in which the carer must permanently observe them. It is commonly said that though such care recipients' physical functions may have declined, they have the mental capacity of a mature adult, and although they may not physically be able to do anything, they are quite capable of spending a few hours alone in bed, perhaps watching television or similar.

While a system to reduce scheduled working hours are a tangible factor, such a relationship with the care recipient is an intangible factor. It may be assumed that if a care recipient can be left alone for certain periods, the carer can dedicate that time to work and is unlikely to require reduced scheduled working hours. In contrast, if a care recipient constantly requires someone present, the shortage of care services directly increases the family's care burdens, which accordingly increases demand for reduced scheduled working hours.

This problem can therefore be divided into the following two stages. The first stage is the likelihood that the growing tendency toward a familialist approach to care—namely, the shift toward the family providing care as opposed to professional services outside of the family providing care (de-familization)—will increase the burdens of providing care upon the family. However, family members who provide care may not be with the care recipient at all times. There may also be an approach to care by which carers do not go to the extent of taking reduced scheduled working hours in order to dedicate time to provide care, as, although the care recipient may require care, they complete the tasks that they are capable of doing by themselves and spend what time they are able to be alone. Given such a perspective on the provision of care, it is important to clarify the approaches that carers currently adopt toward providing care and how they perceive the boundary between work and providing care.

In terms of form of employment, a part-time worker may work even shorter hours as a result of providing care, but as in such cases the original working hours are not clear, we only analyze full-time regular employees. This analysis excludes subjects who had finished providing care and focusses only on those who were providing care at the time of the survey.

2. Demand for a system to reduce scheduled working hours

While among child-raising workers a system to reduce scheduled working hours have high usage rates and are in high demand, the demand for these systems among workers providing care is comparatively low. Table 1 shows that no more than 14.9% of regular employee carers are working reduced scheduled hours. Furthermore, the right-hand side of Table 1 shows that 79.6% of those not working reduced scheduled hours⁵ felt that such systems are “not necessary.”

Another problem that is often noted with regard to the demand for reduced scheduled working hours is that the available hours for care services do not fit with the carers’ daily lifestyles. It is typical to see cases where a working carer is forced to reduce working hours because their scheduled working hours do not fit with the available hours of the care service. If we look at the middle section of Table 1 from that perspective, there are higher percentages of carers working reduced hours and higher percentages of carers who believe a system to reduce working hours to be necessary among those where there is a mismatch with the service hours, in comparison with among those where there is no mismatch with the service hours. This may indicate that greater constraints on the provision of care services in the future may prompt a rise in demand for reduced scheduled working hours.

Another factor related to the demand for reduced scheduled working hours that we should address is the impact of the carer’s health issues. The bottom section of Table 1 shows that there are higher percentages of carers working reduced scheduled hours and higher percentages of carers who believe a system to reduce scheduled working hours to be necessary among those who responded that providing care entails physical fatigue, in comparison with those who responded that it causes no fatigue. Even if a working carer is able to budget their time such that they can work full-time, they are likely to experience increasing physical fatigue if all of their time is occupied with work or providing care. Many of those middle-aged or older people who are particularly common among working carers take on care burdens despite already having concerns about their own physical fitness and health. If workers in such a position are able to reduce their working hours by one or two hours, they can enjoy a less physically demanding time. These are the kinds of scenarios in which a system to reduce scheduled working hours are required. If there is a rise in the numbers of the aforementioned single working carers and other such working carers who do not share care commitments with other family members there may be a greater need to investigate the approaches to a system to reduce scheduled working hours from a health management perspective.

However, even with regard to factors related to care services or fatigue among carers, the majority of respondents do not work reduced hours and do not believe it is necessary. Let us consider the potential reasons

Table 1. Percentages on the necessity of a system to reduce scheduled working hours

	Working reduced hours (%)	Not working reduced hours (%)	Scheduled working hours are variable (%)	N	Necessary (%)	Not necessary (%)	N
Overall figures	14.9	75.2	9.9	444	20.4	79.6	334
Men	17.0	72.3	10.6	282	15.2	84.8	204
Women	11.1	80.2	8.6	162	28.5	71.5	130
Mismatches with the service hours	28.7	61.4	9.9	101	37.1	62.9	62
No mismatches with the service hours	10.8	79.3	9.9	343	16.5	83.5	272
Caregiving causes physical fatigue	24.6	65.3	10.1	199	38.5	61.5	130
No physical fatigue	6.9	83.3	9.8	245	8.8	91.2	204

Note: Percentages for the necessity of a system to reduce scheduled working hours are the responses for those currently “not working reduced hours” and those whose “scheduled working hours are variable.”

for this by looking at the role of the family in providing care.

3. Familialist approach to care roles

The Child Care and Family Care Leave Act was originally set out on the assumption that family members would provide care only in emergency situations where people other than family members are unable to act as substitute, while assistance with daily activities such as taking a bath, eating meals, or going to the toilet would be provided by professional services such as in-home care services or care facilities. However, as, in reality, family members are also providing support for daily activities, the 2016 amendment to the Child Care and Family Care Leave Act expanded the period in which measures including the reducing of working hours could be taken to three years.

The aforementioned re-familization of care has largely been prompted by the shortage in provision of services resulting from financial constraints in the Long-term Care Insurance System, but surely another important factor is whether the family members themselves are willing to take on care commitments. Is it possible that the low demand for a system to reduce scheduled working hours is due to family members not wanting to become that closely involved in providing care? With this question in mind, let us look at families' attitudes regarding the division of care responsibilities between family members and professional carers.

Table 2 shows the attitudes of family members regarding the preferable division of care commitments between family and external professionals for each type of care provided. People who responded that a task should be done "entirely by the family" and "mainly by the family" can be described as having a familialist approach to care. In contrast, people who responded that a task should be done "mainly by professionals" and "entirely by professionals" can be regarded as de-familialist.

The Child Care and Family Care Leave Act assumed that family members would take care of "admittance and release from hospital" and "determining treatment plans" and handle the taking the care recipient to hospital portion of "shopping, hospital appointments and other such trips" by taking time off. When considering the assumption that families would receive assistance from home helpers and other such professionals for "daily activities such as bathing and eating meals," the concept that family members should take care of daily activities in particular is thought to be a strongly familialist approach. It is also imaginable that family members who take on providing care for daily activities rather than entrusting those tasks to professionals will have to decrease their working hours accordingly.

Looking at the results in Table 2, we can see that for the tasks related to "admittance and release from hospital," 71.9% advocate a familialism ("entirely by the family" (43.5%) and "mainly by the family" (28.4%)), and for "determining treatment plans," 59.1% agree with an approach ("entirely by the family"

Table 2. The preferable division of care roles between family and external professionals

	Familialist (%)		Neutral (%)	De-familialist (%)		N
	Entirely by the family	Mainly by the family	Half and half	Mainly by professionals	Entirely by professionals	
Admittance and release from hospital	43.5	28.4	12.5	8.3	7.2	457
Determining treatment plans	30.9	28.2	14.9	15.5	10.5	457
Shopping, hospital appointments and other such trips	40.7	24.7	12.7	12.0	9.8	457
Person to confide in	24.3	33.7	23.9	10.9	7.2	457
Daily activities such as bathing and eating meals	24.9	25.2	12.7	18.8	18.4	457
Figures regarding daily activities by gender						
Men	26.4	26.0	10.8	16.3	20.5	288
Women	22.5	23.7	16.0	23.1	14.8	169

Table 3. Percentages on the necessity of reduced scheduled working hours by the preferable division of care roles between family and external professionals with regard to assistance with daily activities

	Working reduced hours (%)	Not working reduced hours (%)	Scheduled working hours are variable (%)	N	Necessary (%)	Not necessary (%)	N
Familialist	19.6	71.4	8.9	224	21.9	78.1	160
Neutral	20.0	70.9	9.1	55	25.6	74.4	39
De-familialist	6.7	81.8	11.5	165	17.0	83.0	135

Note: Percentages for the necessity of reduced scheduled working hours are the responses for those currently “not working reduced hours” and those whose “scheduled working hours are variable.”

(30.9%) and “mainly by the family” (28.2%). In contrast, for “daily activities such as bathing and eating meals,” the percentage advocating a familialist approach is relatively low, at 50.1% (“entirely by the family” (24.9%) and “mainly by the family” (25.2%)). At the same time, the percentage supporting a de-familialist approach to care for daily activities is also low at 37.2% (“mainly by professionals” (18.8%) and “entirely by professionals” (18.4%)), suggesting a strong tendency toward a familialist approach. There are no differences between men and women with regard to these trends.

However, such a familialist approach to care roles does not directly lead to the necessity to reduce scheduled hours in order to take on care commitments. Table 3 shows the percentages of working carers according to whether they work reduced scheduled hours at their current workplace and the perceived necessity of reduced scheduled working hours for those carers who are not working reduced hours according to the approaches to the family’s role in daily activities that we have looked at above. To show the trends more clearly, we have combined “entirely by the family” and “mainly by the family” as “familialist” and “mainly by professionals” and “entirely by professionals” as “de-familialist.”

There is a higher percentage of working carers working reduced hours among the “familialist” in comparison with the “de-familialist.” Likewise, the percentages regarding the necessity of reduced scheduled working hours show that a greater percentage of the “familialist” respondents believe that it is “necessary.” At the same time, even among the familialist, the majority are not working reduced scheduled hours (71.4%) and responded that it is not necessary (78.1%). It could be assumed that carers who have accepted the need to provide care for daily activities would need to decrease their working hours, but this may not be the case. Let us pursue this with more in-depth analysis.

4. Involvement with the care recipient

Even among those who believe that family members should provide care, there are differences in opinion on the level of involvement with the care recipient—in other words, to what extent assistance should be provided.

While there are carers who engage in “devoted caring”—providing such assistance that the care recipient feels as little discomfort as possible—there are carers who believe it is best to allow care recipients to do what they can themselves. This survey directly asked subjects—that is, the carers—which of these two approaches their own involvement with the care recipient more closely resembles.

Question: Of the following options, A and B, which is your involvement with the care recipient closer to?

A: I provide all means of assistance to ensure that the care recipient feels as little discomfort as possible.

B: I provide as little assistance as possible and allow the care recipient to do what they can themselves.

The approach described in option A shall be referred to as “devoted caring” and that described in option B shall be referred to as “autonomy-oriented caring.”⁶

Hirayama (2014; 2017) and others have noted that in terms of traditional gender roles, autonomy-oriented caring (B) can be seen as a male approach, while devoted caring (A) can be regarded as a female approach. It

Table 4. Involvement with the care recipient

	Devoted (%)	Somewhat devoted (%)	Somewhat autonomy-oriented (%)	Autonomy-oriented (%)	N
Overall figures	14.7	22.8	41.1	21.4	457
Men	14.6	26.7	39.2	19.4	288
Women	14.8	16.0	44.4	24.9	169
Familialist	14.8	25.8	38.9	20.5	229
Neutral	13.8	22.4	37.9	25.9	58
De-familialist	14.7	18.8	45.3	21.2	170
Long-term care level 1	9.4	18.8	39.1	32.8	64
Long-term care level 2	6.9	25.7	40.6	26.7	101
Long-term care level 3	13.9	21.5	49.4	15.2	79
Long-term care level 4	22.9	29.2	43.8	4.2	48
Long-term care level 5	37.5	27.5	22.5	12.5	40

Note: Familialist: Assistance with daily activities provided “entirely by the family” and “mainly by the family.” Neutral: Assistance with daily activities provided “half and half” (half by the family, half by professional services). De-familialist: Assistance with daily activities provided “entirely by professionals” and “mainly by professionals.”

can also be suggested that in the current long-term care policies, which seek to support the self-reliance of the care recipient, the autonomy-oriented caring (B) approach is preferred, due to the fact that devoted caring (A) may encourage the care recipient’s dependence on the carer.

The results for this question are set out in Table 4. Starting with the overall figures, 37.5% responded that their approach is closer to “devoted caring” (“devoted” (14.7%) and “somewhat devoted” (22.8%)), while 62.5% responded that they tended toward “autonomy-oriented caring” (“autonomy-oriented” (21.4%) and “somewhat autonomy-oriented” (41.1%)). Those adopting “autonomy-oriented caring” as an approach outnumber those pursuing “devoted caring” at a ratio of roughly 6 to 4. A comparison of the figures for men and women shows that the percentage for “autonomy-oriented caring” is slightly higher among women.

It is worth noting that even those who adopt the familialist attitude as introduced above have a strong tendency toward autonomy-oriented caring. Here the figures were divided according to whether respondents were familialist or de-familialist based on their responses regarding assistance with daily activities such as taking a bath or eating meals, and, as to be expected, even among the familialist around 60% pursue autonomy-oriented caring—a total of 59.4%, when “autonomy-oriented” (20.5%) and “somewhat autonomy-oriented” (38.9%) are combined. In other words, there appears to be a sense of balance in that even those who believe that the family—as opposed to an external, professional service—should provide care do not go to the extent of providing devoted caring (namely, providing all means of assistance to spare the care recipient discomfort).

At the same time, the more severe the care recipient’s condition, the more carers tend toward devoted caring rather than autonomy-oriented caring. The final section of Table 4 shows the percentages for devoted caring and autonomy-oriented caring respectively by the levels of care required by care recipients as set out in the Long-term Care Insurance System. The higher the long-term care level, the higher the percentage for “devoted caring,” and, at long-term care level 5, over half of the respondents (65.0%) tended toward “devoted caring” (“devoted” (37.5%), “somewhat devoted” (27.5%)). However, there are still 35.0% who tend toward autonomy-oriented caring.

Why do the majority of carers tend toward autonomy-oriented caring? If we consider the insights of Kasuga (2001) and Iguchi (2007), it would not be surprising for the majority to tend toward devoted caring.

Firstly, issues of carers’ health may play a role in this trend. Table 5 shows the differing impacts on carers’ health depending on their involvement with the care recipient. The percentage of those who responded

Table 5. Impact on carers' health by the level of involvement with the care recipient

		Yes (%)	A little (%)	Not really (%)	No (%)	N
Illness or injury due to care commitments	Devoted	8.8	23.4	22.8	45.0	171
	Autonomy-oriented	5.6	10.5	22.0	61.9	286
Physical fatigue from care commitments	Devoted	23.4	36.3	24.0	16.4	171
	Autonomy-oriented	11.2	25.2	33.6	30.1	286
Mental stress from care commitments	Devoted	25.1	41.5	19.3	14.0	171
	Autonomy-oriented	24.5	32.5	23.4	19.6	286

Table 6. Time mismatch with care services by the level of involvement with the care recipient

	There is a mismatch (%)	Slight mismatch (%)	Not much mismatch (%)	No mismatch (%)	N
Devoted	5.8	24.6	33.9	35.7	171
Autonomy-oriented	7.3	11.2	25.9	55.6	286

“yes” and “a little” when asked if they have experienced illness or injury due to their care commitments was higher among those tending toward devoted caring than among those pursuing autonomy-oriented caring. In contrast, a high percentage of those tending toward autonomy-oriented caring responded that they had experienced no illnesses or injuries. The percentages for physical fatigue and mental stress (total of “yes” and “a little”) were also higher among those pursuing devoted caring, while a high percentage of those pursuing autonomy-oriented caring had experienced no such problems.

In the short term, devoted caring may appear to be a good approach, one which suggests that a carer really cares for their family. However, as the period for which care is required grows ever longer, fatigue and stress accumulate, placing the carer at high risk of damage to their health. It is conceivable that a high percentage of carers tend toward autonomous care in the sense that they are appropriately distancing themselves from the care recipient in an attempt to avoid such a buildup of stress and fatigue.

Table 6 addresses another potential reason why the majority tend toward autonomous caregiving: namely, the question of time budgeting. It is significant that a high percentage of people pursuing devoted caring feel that there is a mismatch between the hours of the care services and their own lifestyles. Devoted carers are trying to provide care in such a way that the care recipient experiences as little discomfort as possible. They undoubtedly wish to use care services at times when they are unable to provide care. On the other hand, carers who pursue autonomy-oriented caring feel little inconvenience if they are unable to use care services when they cannot provide care for the care recipient themselves, because they believe that the care recipient is able to spend time alone.

It is also possible that the perception that while care recipients may require care, they are able to spend short periods of time alone is curbing the demand for reduced scheduled working hours. Table 7 shows the demand for the systems across two axes: familialist vs. de-familialist and devoted vs. autonomy-oriented caring.

Even among those with a familialist approach, if carers tend toward autonomy-oriented caring, only a low percentage are working reduced hours, and a high percentage believe a system to reduce scheduled working hours to be unnecessary. It appears that even those who believe that it is preferable for family, as opposed to professional services, to provide care do not feel they should go to the extent of decreasing their working

Table 7. Reduced scheduled working hours and the demand for reduced scheduled working hours by involvement with the care recipient (by opinion on roles of family and external professionals in providing care)

		Working reduced hours (%)	Not working reduced hours (%)	Scheduled working hours are variable (%)	N	Necessary (%)	Not necessary (%)	N
Familialist	Devoted	34.8	54.3	10.9	92	38.0	62.0	50
	Autonomy-oriented	9.1	83.3	7.6	132	14.5	85.5	110
Neutral	Devoted	28.6	61.9	9.5	21	15.4	84.6	13
	Autonomy-oriented	14.7	76.5	8.8	34	30.8	69.2	26
De-familialist	Devoted	1.8	87.5	10.7	56	12.2	87.8	49
	Autonomy-oriented	9.2	78.9	11.9	109	19.8	80.2	86

Note: Familialist: Assistance with daily activities provided “entirely by the family” and “mainly by the family.” De-familialist: Assistance with daily activities provided “entirely by professionals” and “mainly by professionals.” Neutral: Assistance with daily activities provided “half and half” (half by the family, half by professional services). Devoted: I provide all means of assistance to ensure that the care recipient feels no discomfort. Autonomous-oriented: I provide as little assistance as possible and allow the care recipient to do what they can themselves. The figures for the necessity of reduced scheduled working hours are responses from those “not working reduced hours” and those who responded “scheduled working hours are variable.”

hours to ensure that the care recipient does not experience discomfort in their daily life. Moreover, the percentage of familialist, autonomy-oriented caring carers who are working reduced scheduled hours (9.1%) is approximately the same as the percentage of de-familialist, autonomy-oriented caring carers who are working reduced scheduled hours (9.2%). Among de-familialist carers, the percentage those working reduced scheduled hours is lower among those who tend toward devoted caring (1.8%). However, it is possible that in this case carers are using professional care services to ensure the care recipient has no discomfort in their daily life. There is a severe strain on the public finances required to maintain the Long-term Care Insurance System that is expected to answer such demands. Table 7 indicates that the demand for reduced scheduled working hours will rise if care is re-familialized with an emphasis on devoted care. However, given that the majority tend in fact toward autonomy-oriented caring, it appears that there will be little increase in demand for reduced scheduled working hours.

When the Child Care and Family Care Leave Act and the Long-term Care Insurance System were first established, carers were suffering under heavy care burdens probably due to the fact that they were expected to provide devoted care. While the Long-term Care Insurance System responded to the recognition that such devoted caring was unsustainable by seeking to ensure the de-familization of care, in reality there has not progressed as expected in the de-familization of care, and, quite the opposite, the re-familization of care has been developed. At the same time, these analysis results seem to suggest that this re-familization of care does not spell a reversion to the devoted caring expected prior to the de-familization of care under the Long-Term Care Insurance System, but a shift toward a new kind of familization where emphasis is placed on the autonomy of the care recipient.

However, if autonomy-oriented caring is taken to excess, care recipients may feel lonely or isolated, and may not receive the appropriate care. The challenge for the future is to investigate such questions as whether carers who remain appropriately distanced from the care recipient may require a system to reduce scheduled working hours and in what kind of situation that may arise.

V. Conclusion

We have investigated the issues of support for balancing providing care with work that Japanese society will face in the future amid the progressive re-familization of care. As we address this issue it is necessary

to be aware of the premise that the families that are expected to take on care are also losing their capacity to assume the care burdens. Workplaces are also unable to allow workers the flexibility to take time off or change their working hours at any time. What are carers supposed to do when they have neither care services nor family to rely on but are still expected to avoid missing work?

The analysis results of this paper indicate that a new option may be the answer. That is the option for carers not to provide care all the time, in other words, the option for care recipients to be alone for a short period of time if possible.

In the 1990s, when the Child Care and Family Care Leave Act and Long-Term Care Insurance System were first established, carers were suffering from heavy care burdens because family members were expected to provide devoted caring. The Long-term Care Insurance System was expected to ensure the “de-familization” of care and liberate family carers from such heavy care burdens. However, in reality, there has been little progress in de-familization, and instead a growing trend toward the re-familization of care due to the rising numbers of elderly people and subsequent increase in the demand for care amid restrictions on provision of care services due to public financial constraints. However, these analysis results seem to suggest that this re-familization of care does not spell a reversion to the devoted caring expected prior to the de-familization set in motion by the launch of the Long-Term Care Insurance System, but a shift toward a new kind of familization where emphasis is placed on the autonomy of the care recipient.

Elderly people have the mental capacity of a mature adult even with need for assistance due to a decline in their physical functions. Prior to receiving care, they did what they could do for themselves and enjoyed an equal relationship with their family treated as an adult. Naturally, they feel constrained when they constantly receive care from their family members. Such an approach to providing care leads to the accumulation of fatigue and stress and is unsustainable on a long-term basis. If a care recipient has become less capable of doing daily activities for themselves but is still able to do certain activities, it is possible to ensure that care can be maintained on a long-term basis by respecting their autonomy within that scope and allowing them to be alone even in a short period of time where they are able to do so.

The analysis in this paper has shown that at present a greater percentage of carers prefer to emphasize the autonomy of the care recipient and provide as little assistance as possible, rather than pursuing devoted caring so that the care recipient experiences as little discomfort as possible. This tendency toward autonomy-oriented caring is keeping the demand for reduced scheduled working hours low even amid the growing re-familization of care. It is not easy to estimate how long a care recipient may need to receive care. As reduced scheduled hours is a special working style, a working carer will inevitably suffer disadvantages both in terms of their income and their career if they continue such a way of working indefinitely. The optimal solution would be for such working carers to be able to combine their care commitments with work without having to reduce working hours. Of course, neglect of care recipients may become an issue if carers visit care recipients less frequently and provide insufficient care. In fact, while carers’ job-leaving due to their care commitments is a growing problem, isolation among care recipients is also becoming an increasingly severe issue.

If a care recipient’s condition worsens, and they are able to do less and less alone, the carer must provide accordingly devoted caring. In such situations the carer is highly likely to require a system to reduce scheduled working hours. However, the system will not be so essential that anyone needs to work reduced scheduled hours. The system to reduce schedule working hours will be simply one of the necessary options.

The question of de-familization or re-familization of care demands the choice between care provided by professional services or by the family. There is the issue of whether to provide devoted caring and seek to spare the care recipient all discomfort, or to emphasize the autonomy of the care recipient while recognizing that they may experience some discomfort. At the same time, regardless of whether care is de-familized or re-familized, it is still difficult to provide such devoted caring that the care recipient feels no discomfort at all. In addressing the issue of long-term care in the future, it is important that the appropriate forms of support for balancing providing care with work will be considered on the basis that care recipients will be encouraged

to have autonomy, such that even those who are classed as requiring care and have become less capable in certain areas will look after themselves as far as they can.

This paper is based on “Saikazokuka suru kaigo to shigoto no ryoritsu: 2016 nen kaisei ikuji kaigo kyugyo ho to sono saki no kadai” [Balancing Work and the Re-familization of Elderly Care: Challenges after the amended Child Care and Family Care Leave Act of 2016], JILPT Research Report no. 204 (March 2017, in Japanese).

Notes

1. I use the term “autonomy-oriented caring” in this paper to emphasize the autonomy of *care recipient*, not that of *carer*, although this approach was mentioned as “autonomous caring” in Ikeda (2020).
2. The Child Care and Family Care Leave Act was enacted in 1995 after the provisions on long-term care were added to the 1991 Child Care Leave Act.
3. The JILPT’s existing research on combining care commitments with work has been published as JILPT (2006; 2013; 2015; 2016). The latest research that forms the basis for this paper has been published as JILPT (2020). While these reports are both in Japanese, the key points have been covered in English in Ikeda (2016; 2017a; 2017b).
4. See JILPT (2020) for more detail. The authors are Yoko Niimi (Chapter 1), Shingou Ikeda (Chapters 2 and 3), Mai Yamaguchi (Chapter 4), Kaoru Okaze (Chapter 5), and Yanfei Zhou (Chapter 6). The insights set out in (1) through (6) are the core findings of Chapters 1 through 6.
5. Those who responded “not working reduced hours” or “scheduled working hours are variable.”
6. Kasuga (2001) regards care as a “devoted labor” and addresses the severity of those burdens. Likewise, in recent research, Iguchi (2007) has noted the “infiniteness” of care commitments. While the concept of “devoted caring” described in A does not fit exactly with such research, the fact that the carer seeks to “ensure that the care recipient feels as little discomfort as possible” shows devotion where the needs of the care recipient, rather than the carer, determine the care, and the “providing all means of assistance” reflects the sense of infiniteness. On the other hand, “autonomy-oriented caring” is similar to what Hirayama (2017) describes as “minimum care.” And yet, if, from the perspective of supporting the self-reliance of the older person, we take the stance that it is natural not to assist an older person with activities that they can do themselves, it is possible to see autonomy-oriented caring as not the “minimum” but “sufficient” care, and any assistance above that as “excessive.” In that sense, this paper does not address what is the minimum or what is the maximum—that is, the different levels of commitment or the excess or lack thereof.

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IKEDA Shingou

Senior Researcher, The Japan Institute for Labour Policy and Training (JILPT). Research interest: Work-life balance.

<https://www.jil.go.jp/english/profile/ikeda.html>

