

Structural Reform of Social Welfare and Care Service Labor in Japan

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1. Introduction

1) Aging Society

According to the Census, the population age 65 or older in Japan reached 22.27 million in 2000, or 17.5% of the total population. This proportion is expected to be as high as 27.4% by 2025, even based on conservative estimates.¹ This rapid increase in the aging population has had a substantial impact on Japanese society, and it has become one of the priority policy areas at the national level. Changes in wages and in the human resource system include an extension of the retirement age and rehiring, which has induced labor policy reforms for the elderly. The national government has had to quickly rebuild credibility for the matured pension system and deal with increased health and medical expenditures. The Japanese government has been reforming these policy areas with the guidance of the Government Council on Social Security System for the 21st Century.²

Additionally, the social welfare of Japan, which had not received sufficient attention in the development of Postwar social security policy³, has now become a crucial issue, and has led to the launch of a new set of national programs for caretakers of the elderly.

2) Caretaking

Caretaking is a physical, psychological, and social support for people with physical or psychological disadvantages so that they can lead self-sufficient lives to the greatest extent possible. The main objective is to prevent deterioration or to maintain minimum standards of living for people who are disadvantaged. For example, a physical support for an individual with leg problems can allow him or her to go outside of the house and to participate in social events. This support can minimize the deterioration of daily life activity. Alternatively, a support for domestic chores can maintain proper sanitation, prevent unhealthy conditions, and establish a comfortable living environment. Moreover, caretaking can create rhythms in life, which can potentially improve human relationships. In short, caretaking represents a support that can improve the quality of life (QOL) for people with physical, psychological, and social disadvantages.

3) Caretaking for Elderly as a Social Problem

In 2001, a survey pointed out that the number of people with a need for long-term caretaking was 2.82 million.⁴ The former Ministry of Health and Welfare estimated that this number would reach 5.8 million by 2025, and that the types of caretaking services needed would substantially increase. With the nationwide administrative reform in 1999, the Ministry of Labor and the Ministry of Health and Welfare were merged to one ministry, the Ministry of Health, Labor and welfare. Traditionally, family members have cared for the bedridden elderly. However, the increasing number of nuclear families and single elderly households, combined with the aging of family members, has lowered the capacity for caretaking in family-based settings. Additionally, as caretaking burdens have become lengthier and more demanding, caretaking at a social level has become necessary.

Previously, as in the Elderly Welfare Law, administrative branches, especially cities and towns, provided welfare-based caretaking services. While most of these caretaking services traditionally targeted low-income families, the need for establishing a new caretaking system at the social level emerged as caretaking expanded to non-low income households.

4) Establishing a Platform of Caretaking Services

Since the demand for caretaking surged, providing welfare facilities for the elderly and training personnel has become an emergent policy issue. The former Ministry of Welfare, Ministry of Finance, and Ministry of Internal Affairs set ten-year goals from the fiscal year 1990 to 1999, and established the Ten-Year Strategic Plan for Health and Welfare of the Elderly (the Gold Plan). However, as the demand exceeded the original estimates established by the Ministry of Welfare, the New Gold Plan was modified in 1995. As the goals of the New Gold Plan were met, the government established the Ideas for Health and Welfare for the Elderly in the Next Five-Years (the Gold Plan 21) in 2000 and developed the service infrastructure based on the caretaking insurance services.

2. Caretaking Services at the Market

1) Caretaking Insurance and Services at the Market

(1) Establishment of Caretaking Insurance

In July 1995, the Council on Social Security Law recommended the “Restructuring of the Social Security System” in light of the social security needs for Japan in the 21st century. The Recommendation evaluated positively the role of Postwar economic growth in improving the social security system and fulfilling the basic rights of life for citizens. However, it also pointed out that specific social welfare needs were increasing for which the Postwar system was not functioning sufficiently. To address these needs, the Restructuring recommendations called for the establishment of a new social insurance system for physically and mentally disadvantaged people and the elderly with caretaking needs so that these individuals could conduct basic activities in their lives. This philosophy called for a transition from the previous social welfare system of ‘guaranteeing the minimum life standard’ to a new welfare service system of “universality,” “fairness,” “totality,” “entitlement,” and “effectiveness” including the establishment of public caretaking insurance based on social security.⁵ As a result of the Recommendation, the source of funding for caretaking services was shifted from the general revenue to an insurance-based system that clarified the entitlement of service recipients.

This system of caretaking insurance allows for a variety of emerging caretaking services, deregulates caretaking service providers (organizations), and creates a new market-based system with better and more types of caretaking services. Before this caretaking insurance system, municipal governments (cities, towns, and villages) were the main providers of the services based on the Elderly Welfare Law and Elderly Health Law. However, that model of completely government controlled service provision was against the principle of the Structural Reform⁶ under the Hashimoto Administration. Therefore, the government conducted a major policy reform to create a market to balance the demand and supply of caretaking.

(2) Quantity and Quality of Caretaking Insurance Services

There are two large categories of caretaking services under caretaking insurance: in-house services and facility services. The quantity of caretaking services started to increase even before the implementation of the social insurance system. According to a survey of 96 municipalities conducted by the former Ministry of Welfare in April 2000, compared to one year before the insurance was implemented, certified organizations for in-house services increased 164.4% including a 230% increase in home-help services.⁷ After social welfare organizations, for-profit businesses were second in total caretaking services, representing 26.4% of the 33,721 organizations reported. In term of home-help services, for-profit organizations consisted of 37.8% of all organizations, after social welfare organizations (40.6%). In March 2001, one year after the implementation of the social insurance system, for-profit organizations surpassed social welfare organizations in service provision at 40.4%⁸, which implies that deregulation was successful, at least, in expanding the quantity of caretaking services.

According to the Annual Report of Caretaking Insurance, the expenditures for caretaking services from April 2000 to February 2001 were 3.227 trillion yen (US\$29.5 billion). Including the 10% self-paying, the total amount was 3.5 trillion yen (US\$31.5 billion). In 2001, the market size for caretaking reached 4.77 trillion yen (US\$38.1 billion). The incorporation of market concepts can improve the cost performance of service providers, create better services for consumers, and eliminate low quality providers. Additionally, it requires managerial responsibility for caretaking service providers. This could induce reforms in the managerial systems of organizations and labor conditions including the hiring and training of professionals, which eventually can bring substantial changes in overall caretaking services.

2) Enacting Social Welfare Law and the Structural Reform of Welfare Services

(1) Reforms of Eight Welfare Laws and Caretaking Services

With the changing environment in social welfare, the national government established the Special Committee on Three Joint Welfare Councils⁹ in 1986, which recommended the structural reform plan, the Future Policy of Social Welfare. Based on this recommendation, the government passed laws that partially amended the Elderly Social Welfare Law and other related laws in June 1990. The implementation process began in August and the plan was fully enacted in April 1993. Other amended laws included the Social Welfare Organization Law, the Welfare for Physically Disadvantaged Law, and six others. The major amendment was to enhance in-house services and to promote the decentralization of welfare services. This series of amendments strengthened supports for in-house caretaking by officially acknowledging three major social welfare organizations as Type 2 Social Welfare Organizations: home-help services, day services, and short stay services.

(2) The Social Welfare Law and Structural Reform of Social Welfare

The core of the 50-year Postwar social welfare policy was institutional measures and facility services. From the turmoil of the Postwar and rapid economic growth periods, it was effective to raise the welfare standards in Japan. However, as the society matured with decreasing fertility, an increase in the elderly and a general population in need of a variety of caretaking and nursery services, the strategy of the government has shifted from the previous institutional measures based on administrative disposition¹⁰ to a new social welfare framework.

The first contract-based system in welfare services was incorporated in the Revised Child Welfare Law in June 1997. This framework introduced competition among welfare service providers by abolishing the administrative disposition method, in which municipal governments decided on the entry or exit of a child into nursery school or kindergarten. As a result, parents of the child could select a nursery school or kindergarten based on a contract. The same contract principle applied to caretaking services between the provider and the recipient, allowing for fairer position of the recipient in relation to the provider. Theoretically, this market principle should bring higher quality services.

In addition to the areas of caretaking and nursery school, the government also discussed the overall environment for social welfare organizations. In June 1998, the Sub-Committee on Social Welfare Basic Structural Reform under the Council on Central Social Welfare recommended in its mid-term report the introduction of market principles as part of the shift from the administrative disposition to the contract system and to diversify service providers. This approach was based on the welfare reform of the Thatcher Administration in 1979, whereby private firms and non-profit organizations increased the quantity of services while the British government shrank its own public services.

In June 2000, the Social Welfare Organization Law was renamed the Social Welfare Law and enacted based on the recommendations from the above Subcommittee on Structural Reform. In contrast to the previous administrative disposition method, the new law established a system for selecting options from service users, and also established rights to protect users. The reform also included mechanisms for information disclosure about organizations and a system of external review. Furthermore, to enhance social welfare organizations, the law added new areas of services while allowing for the entry of private firms. In essence, the law deregulated services and created a framework to protect users (i.e., consumers).

The new services included nine areas such as support for Type 2 Social Welfare Organizations, which included organizations other than social welfare organizations. The new law established practical methods for implementation. However, from a policy perspective, the largest impact was on the deregulation of service providers through the acceptance of private firms in addition to traditional social welfare organizations. In short, this law established a framework for a market-based welfare system.

3. Caretaking and Welfare Human Resource Policy for the National and Municipal Governments

1) The Gold Plan and Subsequent Plans

As Japan began evolving as a hyper aged society, the demand for caretaking increased further and the need for infrastructure, such as welfare facilities and training for human resources, became an urgent issue. In 1989, the national government set the 10-Year Strategic Plan on Health and Welfare for the Elderly (the Gold Plan) to prepare the infrastructure between 1990 and 1999. However, the demand for caretaking exceeded the estimate of the former Ministry of Welfare and the target was raised by the revised New Gold Plan in 1995. The New Plan called for a supply of 200,000 caretaking personnel at designated facilities and 170,000 home helpers by 1999. Moreover, the Gold Plan 21 of 2000 called for an additional supply of 350,000 home helpers by 2005.

Table13-1 The Strategic Plan on Health and Welfare for the Elderly

in Five Years from 2000

In-House Services		
Classification	1999	2004
Home Help Services(Non-Medical Care)*	170000	350000
Home Health Care Services(Skilled Nursing)**	5000	9000
Adult Day & Health Care**	17000	26000
Short Term Care at SNFs***	60000	96000
*Number of Worker	**Number of Service Station	***Number of Beds
In-Facility Services(Number of Bed)		
Classification	1999	2004
Skilled Nursing Home(Non-Hospital Based)	290000	360000
Skilled Nursing Facility(Hospital-Based)	280000	297000
Assisted Living Facilities		
Classification	1999	2004
Board & Care Home for Alzheimer's & Dementia	-	3200
Care House	100000	105000
Geriatric Case Management Station	400	1800

Source: National Institute of Population and Social Security Research
(Annual Report of Social Security in 2000, 2001)

2) The Welfare Human Resource Law

In 1993, the government enacted the Welfare Human Resource Law to raise labor conditions at welfare organizations to those of conditions at private firms. This action was based on the Revised Law for Social Welfare Organizations and Social Welfare Facility Personnel's Retirement and Mutual Aids, and it had four components: (1) Setting the Basic Policy, (2) Appointing the Welfare Personnel Center, (3) Appointing the Fringe Benefit Center, and (4) Revising Retirement and Mutual Aids. The objective was to improve the qualifications of social workers and their labor conditions. The Welfare Human Resource Law was revised in 2000 by establishing the Grants for Training Caretaking Workers. The main objective of the grant program was to create new employment opportunities in caretaking and welfare services by supporting a part of wages for organizations to hire new caretaking workers and establish organizations to create caretaking training credentials such as the Rank 2 Home Helpers.

3) Establishing Certification Systems

The national government established the Law to Certify Social Workers and Caretaking Workers in 1987 to train and improve caretaking professionals. The purpose was not to monopolize caretaking businesses, but to provide high-quality caretaking workers at a national standard. The formulation of this Law was rushed; therefore, there were some debates left for broad discussion in the field. However, after ten years had passed, many

accepted that the level of caretaking personnel had improved drastically and the QOL of the service beneficiaries had improved.

Home helpers play the central role in in-house caretaking support. Workers who complete trainings are certified with a rank of one to three and their household support and physical caretaking services are officially recognized as a part of caretaking insurance services. As with caretaking welfare workers, the provision of certificates is intended to improve the quality of these home helpers. While this home helper training and certification can attract people who were previously detached from welfare practices, leading to a potential increase of caretaking personnel, it is unclear whether it will provide a long-term pool of caretakers.

Table 13-2 Number of Key Occupations in Facilities (Full Time Conversion) 10/2000

	SNH(Non-Hospital Based)			SNF(Hospital-Based)			Convalescence Hospital		
	Total	Full Time	Part Time	Total	Full Time	Part Time	Total	Full Time	Part Time
Total	168257	150316	17941	137059	128084	8975	93736	89320	4415
Physician	1112	234	874	3007	2561	447	-	-	-
Nurse	5615	5144	471	9512	8830	686	15032	14135	896
Practical Nurse	7949	7378	571	16750	15807	943	27004	25657	1347
Caretaker	104028	93618	10410	73496	70213	3283	49179	44166	2012
PT	238	104	135	2407	2005	402	-	-	-
OT	103	67	36	1830	1624	206	-	-	-
Speech Therapist	14	9	5	195	177	17	358	338	20
Social Worker	5565	5524	41	-	-	-	-	-	-
Care Manager	3401	3344	57	2935	2889	46	2693	2611	82
Senior Nutritionist	2370	2344	25	2055	2025	30	2336	2280	56

Source: Ministry of Health, Labour and Welfare
(The Outline of Care Service Facilities and Business Research 2000)

Table 13-3 Number of Worker in In-House Services(Full Time Conversion) 10/2000

	Total	Nurse & Caretaker per Organization	Total Number of Users per One Nurse & Caretaker
Home Help Services	76973	7.6	67.2
Home Bathing Service	9426	4	24.6
Home Health Care Services	22302	4.5	49.7
Day & Health Care	70949	5.7	71.6

Short Term Care at SNF	98796	-	-
Board & Care Home for Dementia	4375	6	39.2
Caring Aids Leasing	8800	-	-
Care Management	32884	-	-

Source: Ministry of Health, Labour and Welfare
The Outline of Care Service Facilities and Business Research 2000)

4) The Caretaking Insurance Organization Program and Service Labor¹¹

(1) The Caretaking Insurance Organization Program by Municipal Governments

Within the framework of caretaking insurance that was implemented in 2000, municipal governments were established as the insurer and the Five-Year Caretaking Insurance Organization Plan (hereafter the Plan) was enacted to smoothly provide caretaking insurance services. The development of this Plan was based on the law Section 117, and it substantially affects workforce development. To illustrate the policy, this article uses a case of City B with 44,000 population and whose potential beneficiary is 15.2% of total population.

(2) Criteria for Estimating the Scale of Services

Municipal governments are responsible for estimating the types and scale of caretaking services based on a survey and national guidelines¹². The survey assesses the number and degree of beneficiaries. For example, the standard package for one beneficiary classified as Rank 1 includes the following number and type of services per given time period: five home help services per week, one visiting service per week, two rehabilitating day services per week, and a two-week short stay per six month period. The maximum monthly expenditure is 170,000 yen (US\$1,478). A beneficiary classified as Rank 4 can receive visiting and rehabilitating day services as well as dementia and medical services. A caretaking manager prepares each individualized care plan. The caretaking insurance guarantees the right to receive needed services; however, the benefits must be specified. In other words, the designated service amount, for example – 170,000 yen, cannot be used for just one item, and it must meet the appropriate sub-category standards.

+w Table13-4 The Estimated Visiting Caretaking Services by City B

		2000	2001	2003	2004	2005
Percentage of Average Service Demand(%)	A	38.15	45.78	48.08	50.38	52.7
Quantity of Required Service (Time/Week)	B	873	896	977	1064	1144
Estimated Quantity of Service Supply(Time/Week)	C	873	896	977	1064	1144
Percentage of Supply(C/B)	D	100	100	100	100	100
Percentage of Platform Provide(%)	AbyD	38.15	45.78	48.08	50.38	52.67
Quantity of Service(Time/Week)	BbyD	873	896	977	1064	1144

Number of Calls for Home Helper*	41	42	46	50	55
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Source: City B Program for The Caretaking Insurance Organization 2000

* Full Time conversion 5 hours/day 225days/year 1100hours/year

(3) Estimating Service Quantity and Human Resources for Visiting Caretaking

Chart 13-4 shows the estimated visiting caretaking services used by City B. The total quantity in 2000 was 873 times per week. By the end of the five-year plan in 2004 City B estimated a 30% increase. The previous section indicated an increase in the service quantity after the system of caretaking insurance was implemented because the plan reflected the varying degrees of needs among caretaking beneficiaries. If there are more estimated beneficiaries with higher needs, the total service quantity may increase. In fact, City B had a distribution of caretaking beneficiaries with smaller than the national average.¹³

The actual estimate is called the infrastructure development rate, and it is calculated based on both the quantities of demand and supply. The national average of supply estimated by the municipal government is divided by the potential demand of the elderly and is 40%. In the case of City B, the 873 visiting services called for 41 full-time home helpers.

4. Issues of Caretaking Labor under Caretaking Insurance

1) A Survey of Home Helpers¹⁴

The major purposes of the caretaking insurance were to increase the service quantity by deregulating suppliers and to improve the service quality by introducing market principles. In the meantime, this policy change substantially impacted the labor force of caretakers and the working environment. As Chart 13-2 and 13-3 demonstrated, there are different types of caretakers, roles, and working environment. This section introduces the working environment and issues of home helpers at several organizations: a social welfare cooperative (SWC), a non-profit organization (NPO), and a silver human resource center (SHC).

2) Overall Labor Conditions

(1) Employment Types, Tenure Years, Ages

Major employment types of home helpers were full-, part-time, and registered workers. In City B, there were seven full-time helpers at the SWC, four at the NPO, and two at the SHC. the SWC needed more full-time helpers because they provided 24-hour services. The average tenure was ten years for all three organizations, and all workers were female between the age of late 40s and early 50s. They primarily served in coordinating roles but also performed caretaking services.

There were 30 part-time helpers at the SCC, 105 at the NPO, and 180 at the SHC. Excluding SHC, 80% of workers were in their 40s and 50s, 10% were in their 30s, and another 10% were in their 60s.

Registered workers were found only at the NPO. These included 116 home helpers. Since the SHC used outsourcing or contract systems based on membership, it did not have registered helpers. Although the SWC used the helper registry system in the past

and still uses unpaid volunteers today, it abolished the system because it was difficult to maintain a sufficient number of workers. A local labor standard monitoring agency provides administrative guidance for improving the conditions. The part-time helpers at SWC work between 20 and 30 hours per month under the system of social insurance.

(2) Wages and Working Hours

There was little difference among the three organizations in terms of monthly wages. The first monthly wage for full-time helpers was 148,000 yen (\$1,287) at the SWC, 150,000 yen (\$1,304) at the NPO for 160 hours plus 32,000 yen (\$278) for helper and commuting benefits, and 150,000 for the SHC.¹⁵ Including other benefits, the total monthly wage was 170-180,000 yen (\$1,478-1,565), which was roughly 10% lower than the salary at the Central Welfare Center: 163,047 yen (\$1,418) for non-certified caretakers and 166,615 yen (\$1,449) for certified caretakers.

Wages for part-time helpers was 1,300 yen (\$11.30) per hour at the SWC, with no difference between physical caretaking and household assistance services, and 1,100 yen (\$9.57) at NPO (1,550 yen for late-night shifts). At the SHC, wages were 1,000 yen (\$8.70) for household assistance, 1,150 (\$10) for multiple tasks, and 1,300 (\$11.30) for physical caretaking, with different rates depending on skills and services. In October 2001, the Central Welfare Center provided 993 yen (\$8.63) for household assistance, 1,441 yen (\$12.53) for physical care, and 1,211 yen (\$10.53) for multiple tasks. In summary, the wage for household assistance was higher than the national average, but it was approximately 10% lower for physical caretaking.

Full-time helpers worked 40 per week, while the broad range of hours worked by part-time helpers made assessment difficult. Workers were paid only for hours at the houses of beneficiaries: commuting time from centers to beneficiaries or between beneficiaries was not included.

(3) Recruitment, Certification, and Training

All helpers at the three organizations were female. Though organizations did not intentionally discriminate based on gender in their hiring practices, they often ended up only with female workers. Male helpers were not always suited for household assistance and some female beneficiaries rejected services provided by male helpers.

Many helpers found their jobs through social networks such as friends. The NPO tried to recruit through Hello Work centers, job placement agencies established under the Ministry of Labor, but they received no applicants. In terms of age, the SWC did not hire anyone above the age of 55 due to efficiency reasons, while the NPO openly hired workers above age 60 if they were in good health condition. The NPO hired workers of higher ages based on their experience, willingness and flexibility to work on weekends, and their ability to provide a wide range of services. The SHC similarly provided a range of services with extended hours and multiple types of services.

Coordinators were required to have a Rank 1 Certified Caretaker, and helpers were required to have the Rank of 2. At the SHC, they previously recruited Rank 3 Caretakers, however they were seeking to hire more Rank 2 workers. In September 2001, 90% of vacant positions posted through the National Welfare Human Resource Center required the Rank of 2 for full-time helpers. The demand for Rank 3 was limited following the compensation standard set by the new caretaking insurance system. About five percent

of the demand for helpers required Rank 1 Certified Caretakers and 25% of total Certified Caretakers were full-time positions.

All three local organizations provided half-a-day training for new hires. Additionally, the NPO provided a two-day training, and the SWC provided a three-month on the job training. They also provided periodic biennial trainings for caretaking technologies and communications.

3) Issues for Employment Management

(1) Employment Types

The first finding from the survey was a shift from full-time to part-time helpers in order to improve the efficiency of organizations. If organizations intended to provide 24-hour services, like the SWC, they had to hire full-time helpers in addition to part-time workers. Therefore, we estimate that the employment of full-time helpers will increase, especially for specific types of service provision. The most emergent issue is the registration system for helpers. This system is still a remnant of volunteers registered at municipal governments before the caretaking insurance was established. In the future, these volunteers should be distinguished from non-paid helpers, and the registered system of paid helpers should be abolished. It is important to clarify differences between those who are employed, outsourced, or contracted.

(2) Wages and Working Hours

The wage of full-time helpers, 160-170,000 yen (\$1,391-1,478) per month, was the equivalent of the initial salary of cash register receptionists at supermarket, and according to the Wage Structure Basic Survey in 2000, represents only 60% of the wages earned by nurses. Considering the human-oriented nature of the services and workload demands, the wage level should be higher. Some organizations paid the same rate for caretaking, household assistance or for a combination of the two services. Moreover, they did not count commuting time or compensate for commuting transportation costs. Thus, the real wage level would be 20-30% lower. We expect a rational improvement in wage and compensation methods despite the difficulty of managing work hours. The first reform should be an improvement in the wage level of household assistance helpers, which is only one third of that of physical caretaking helpers.

(3) Improving Services and Training

Home help services are human services. They are never simple domestic assistance tasks, but require an individualized approach to improving the living standard of recipients and meeting their needs. As the National Home Helper Cooperatives suggests, the term “household assistance” can be misleading and mask the objectives of services. Therefore, it should be renamed “daily life caretaking” to clarify the nature services for recipients. To address these problems, the Ministry of Health, Labor and Welfare has set guidelines for services covered under household assistance. However, this is still insufficient. The boundary of daily life caretaking is still unclear, and in many cases it is decided on a case-by-case basis by each helper. At the same time, narrowing the range of services can also increase problems.

The best way to improve services is to increase the specialization and skills of helpers. Knowledge of human assistance technology and medical practices is required and

an increase in the range of services is needed to properly care for the elderly. This requires fundamental changes in the training system for helpers.

Note

- ¹ National Institute of Population and Social Security Research 1997. “Estimating Mean Total Population and Population Growth”
- ² National Social Security Council 1995. “Recommendation of Social Security Reconstruction 1995”
- ³ Ibid Recommendation,, Chapter 1 Basic View for Social Security”
- ⁴ Hoken March 2001 .“Gekkan Kaigohoken “ P.9
- ⁵ Ibid Recommendation, Chapter 2 “Reform for the Society “
- ⁶ Social Security Reform is one of the main political marks for Hashimoto Cabinet in 1996
- ⁷ Hoken June 2000. “Kaigohoken” P.10
- ⁸ Hiroshi Hayakawa 2001. “Data book of Kaigohoken 2001” p.141
- ⁹ Joint Meeting of National Council of Social Welfare, National Council of Disabled and National Council of Child Welfare
- ¹⁰ National Council of Social Welfare 1998. “ Social Welfare Reform “
- ¹¹ Hirokazu Tanaka 2000. “Kaigohoken Jigyokeikaku to Koyo Soshutsu; Kyoto Fu Kozohenka tou Koyotaisaku Kyogikai Kyoto Fu no Koyokaihatsu”
- ¹² National Council of Medical Insurance April 1999. “ Kaigohoken Jigyo ni kakawaru hokenkyufu no enkatsu na jishi o kakuho surutameno kihonteki na shishin”
- ¹³ 75% quantity of City A in Kyoto prefecture with total population 54,000
- ¹⁴ NPO in Shiga prefecture 2001. Interview by Hirokazu Tanaka
- ¹⁵ Caret Service Labor Center March 2001. “Kaigorodosha no rodokaizen ni kansuru Chosakenkyu Hokokusho”

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