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The Japanese voluntary sector's responses to the increasing unmet demand for home care from an ageing population

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ABSTRACT
As Japan faces the challenge of the increasing demand for home care from its ageing population in an era of economic constraints, the expectation has evolved that the voluntary sector will fill the shortfall in statutory provision through semi-volunteers providing affordable home care. Drawing on qualitative interviews with managers from 15 voluntary organisations, this article explores their experiences in trying to meet this expectation. Even though most organisations provided supplementary home-care services, the empirical evidence indicates a limited capacity to deliver this expectation, with respondents aware of the deteriorating situation. It has been ascertained that supply mechanisms differ between the traditional voluntary – and the new hybrid – organisations. The former employ 'cost-efficient' labour such as 'paid volunteers' on below minimum pay rates. In contrast, the 'hybrids' use paid employees at regular pay rates, a finding that contradicts optimistic assumptions about the ideological role of 'traditional' voluntary organisations. This article suggests the importance of acknowledging diverse responses from the voluntary sector, including the new hybrids with their acknowledgement of voluntary and commercial imperatives. Open mindedness and a preparedness to revise interpretations of the earlier 'models' of the voluntary sector are essential. The conclusion proposes that the best strategy to unlock the voluntary sector's full potential to deliver supplementary home care is a multi-platformed approach, with adequate public purse funding, which pragmatically maximises resources.

KEY WORDS – voluntary sector, Japan, home care, domestic support, older people, hybrid organisations, supplementary home care.

Introduction

Globally, societies face pressing challenges to address the growing demand for social care from rapidly ageing populations (Colombo *et al.* 2011;

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Swartz 2013). This is true of all industrialised countries, but particularly so of Japan where currently a quarter of the population is aged 65 or more – the highest ratio in the world (National Institute of Population and Social Security Research 2012; Hayashi 2014). The government's response in 2000 was to introduce a comprehensive statutory long-term care system through the Long-Term Care Insurance (LTCI) Act of 1997 but these measures failed to meet all the care needs of the increasing older population. Furthermore, continuing financial austerity together with the impact of demographic and social changes engendered a range of reforms from 2005 onwards which restricted statutory services – especially home care[1] – by curtailing LTCI care expenditure (Tsutsui and Muramatsu 2007).

In this context, the Japanese government sought to augment the provision of home care, particularly domestic support for low-needs groups, more cost-efficiently. To achieve this, the government turned to the voluntary sector to fill the growing shortfall (Ministry of Health, Labour and Welfare (MHLW) 2013).[2] This expectation by the government of the role of the voluntary sector was informed and affirmed by commentators and proponents of the sector (Tanaka, Asakawa and Adachi 2003). This expectation derived from a prevailing perception that the role of voluntary organisations throughout the 1980s and the 1990s had been successful in cost-efficient terms (Adachi 2000; Coulmas 2007). These earlier voluntary organisations, which based their principles on mutual help and independence, had as their core role the provision of supplementary home care for older people outside the statutory framework. Such organisations deployed volunteer or semi-volunteer workforces and therefore delivered more affordable home care (domestic support) for those unable to pay the market rate.

The earlier successes (against cost-efficiency criteria) of the voluntary sector in the 1980s and 1990s were recorded in a substantial range of literature (Adachi 2000; Cyoju Shakai Bunka Kyokai 1998; Kawai 1990; Shibukawa 2001; Tanaka, Asakawa and Adachi 2003; Totsuka 1992; Yamaguchi and Takahashi 1993). However, there are few studies investigating the specific role of delivering supplementary home care for older people by the post-2000 increasingly diversified Japanese voluntary sector – including the new type of *hybrid* organisation (explained shortly). This partly reflects the heavy reliance of the Japanese government, reinforced by other agencies, on the examples of the voluntary sector of the 1980s and 1990s – with the consequential strengthening expectations.

The article intends to provide empirical evidence gained through qualitative interviews with managers from both traditional voluntary

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and the new *hybrid* organisations. The findings should enable us to assess these government-held expectations that the current, and by now diversified, Japanese voluntary sector could provide supplementary home care in a reliable replication of the 1980s and 1990s models – including the all-important cost-efficiencies. In doing so, the article has three main aims:

1. To investigate how the Japanese voluntary sector perceived these mounting expectations to provide supplementary home care for older people.
2. To explore whether – and how – the voluntary sector is responding to these expectations.
3. To measure the impact of the sector's responses against the expectations to meet the increasing need.

This article will commence with a Japanese-specific historical and cultural overview of the provision of home care since the 1970s – and the role of the voluntary sector within it. This will add to an understanding of how the Japanese voluntary sector evolved by tracing its provenance through the intervening decades to the variegated and hybrid examples under review. This developmental context will go some way to explain both the perceptions and expectations of the voluntary sector by government, other agencies and the organisations themselves.

The opening overview will focus on policy interventions concerning home-care provision and how these have encouraged the growth of the Japanese voluntary sector, examining both statutory home-care and non-statutory supplementary home-care provision. Due to the significant lack of statutory home-care provision, the voluntary sector acquired the crucial role of supplying supplementary home care. Following the inauguration of the LTCI system in 2000, new types of *hybrid* organisations have emerged, purportedly combining commercial and voluntarist approaches. These hybrids are licensed not-for-profit organisations (LNPOs), licensed under the LTCI to provide statutory home care at prescribed rates. Being citizen-led (and not-for-profit) they are expected to provide supplementary home care to meet the increasing shortfall (Shibukawa 2001; Tanaka, Asakawa and Adachi 2003). Being innovative and integral to the home-care provider sector, these models merit inclusion within the scope of this article.

Progressing from the contextual overview, the article then presents its research questions together with the methods informing the empirical section, followed by discussion and evaluation of the research findings. In conclusion, the article revisits the research questions and reflects on the implications of the findings.

Overview: Japanese home-care provision and the voluntary sector since 1970

Limited public home-care provision and the expanding role of the voluntary sector

Since the 1970s, Japan has been grappling with an unprecedented demand for home care in the context of a rapidly ageing population, social change and slow economic growth (Kono 2000; Peng 2002); however, alternative resources beyond traditional family care remained limited (Hayashi 2011). Recognising this, the Japanese government had, in the early 1970s, envisaged an expanded public provision but this was aborted after the widespread impact across the economy of the 1973 oil price-rise shock. Instead, post-1974 governments championed a 'Japanese-style welfare society', proposing supplementary state involvement with an enhanced role for individuals, the family and the community – emphasising distinctive Japanese traditions and cultural norms (Lee 1987; Hayashi 2013).

The two key features of the resulting home-care arrangements were the disappointingly slow development in statutory home-care provision and a greatly expanded role for the voluntary sector in both statutory and non-statutory home-care arrangements (Kawai 1990; Fujimura 1999). While expansion of statutory home-care provision remained limited, its delivery mechanism changed. Local authorities increasingly outsourced their home care, with 40 per cent of 3,200 authorities doing so in 1981, but over 90 per cent by 1999 (Kawai 1990; Ministry of Health and Welfare (MHW) 2001). They outsourced exclusively to local 'welfare councils' – technically not-for-profit organisations (NPOs) but in effect quasi-public quangos, with legal recognition and corporate status. Established in each locality and working under strict guidelines, they received public funding and also benefited from tax allowances (Adachi 2000; Yamaguchi 2000). Other voluntary organisations and private enterprises were largely excluded from the statutory home-care market before 2000. The shift achieved cost-savings, with hourly home help in the quasi-public sector a third cheaper than local authority rates (Kanaya 1999). Furthermore, welfare councils and other newly established quangos played an important role in developing their own supplementary home-care services to fill the growing shortfall in statutory home-care provision.

The voluntary sector's response to provide supplementary home care

Facing continuing fiscal constraints, central government saw 'active participation and contributions of residents' as a viable and economical extension to existing limited statutory home-care provision (MHW 1975: 87). To achieve this, from the 1980s, urban local authorities started to deliver their

own home-care services by utilising existing quangos (*e.g.* welfare councils) or establishing 'welfare corporations' (another form of quango) (Coulmas 2007; Totsuka 1992). These operated on a mutual help ethos, recruiting and deploying local residents, predominantly middle-aged housewives, as 'paid volunteers', who offered modestly priced home care for payment at or below minimum wage or market rates (or sometimes receiving time credits redeemable to buy care later in life or for relatives living elsewhere) (Adachi 2000; Hayashi 2012). These quango-led initiatives operated outside the statutory home-care system. They were funded through membership fees and service-charges, supplemented by public subsidies (Fujimura 1999).

In areas lacking such quangos, such as dormitory towns, outer suburbs and relatively remoter rural regions, new citizen-led voluntary groups and co-operatives spontaneously emerged, and became the seedbed of the later (as will be discussed) NPOs and LNPOs, to deliver similar services based upon principles of mutual help and independence involving paid volunteers (Adachi 2000; Yamaguchi and Takahashi 1993).

The concept of paid volunteers – paid less than conventional workers – generated debate over their utilisation as a cheaper alternative to paid care workers and the inevitable blurring of boundaries between voluntary and paid work (Ito 1996; Morikawa 1999; Noguchi 1990). Yet it was this concept that helped to expand the workforce for home care, which involved a demanding and regular commitment. Payment attracted different, more varied participants, including highly motivated recruits who could not afford to participate without payment to cover expenses not usually provided by voluntary organisations in Japan (Takano 1993; Takechi 1993). This became important as conventional volunteers remained scarce in the area of home care (Takagi 1992). Moreover, payment seemingly equalised the relationship between paid volunteers and older recipients who may possibly have felt some embarrassment at receiving free help from conventional volunteers (Tanaka 1996). Above all, lower payment to paid volunteers kept service-fees low, another key cost-efficient consideration (Yamaguchi and Takahashi 1993). For many service-users, private-sector home-care services, on average three times as expensive, were simply not an option, with less than 10 per cent of older people being able to afford such private provision (Kase 1993).

Both quangos and citizen-led groups who fulfilled supplementary home care were given the generic term 'resident participatory-type home-care provider organisation' (Jumin Sanka-gata Zaitaku-fukushi Sabisu Dantai Zenkoku Renraku-kai (JSZSDZR) 2006). Central government, endorsing paid volunteers and regarding these organisations as the key to its 'resident participatory-type welfare society' vision, encouraged further expansion (MHW 1993*a*, 1993*b*, 1996). With such organisations, particularly

citizen-led ones, requiring little or no public money, they appeared to be economically attractive. The number of these organisations increased significantly, from just 138 in 1987 to over 1,900 by 2000 (JSZSDZR 2006).

The onset of this large-scale citizen-involved initiative by the voluntary sector attracted considerable interest from government, researchers and the sector's own proponents, resulting in substantial research (Adachi 2000, 2008; MHW 1993*a*; Totsuka 1992). Verdicts were mixed, but a shared conclusion was that the grouping of diverse and different organisations under such a generic term risked blurring important differences between these bodies, particularly between quangos and citizen-led groups in terms of size, finance, priorities and the relationship with the public sector (Totsuka 1992).

The term also risked minimising distinctive and positive features of the citizen-led bodies. Unlike quangos, these were typically small, local, independent and without legal recognition, all of which had benefits and disadvantages (Adachi 2008; Totsuka 1992). They enjoyed maximum autonomy, thereby enabling them to offer user-led services flexibly. As such, they could pursue robust voluntarism with less professionalism and bureaucracy. Yet independence from the public sector meant that they struggled financially, lacking public subsidies. In addition, they failed to win the credibility among the general public which quangos continued to enjoy (Totsuka 1992).

Emergence of hybrid organisations – LNPOs delivering home care – since 2000

Government responses to the challenges faced by citizen-led groups delivering supplementary home care were crystallised in legislation from the late 1990s. Firstly, the Act to Promote Specified Non-Profit Activities, introduced in 1998, gave citizen-led groups legal recognition and corporate status, thereby facilitating and promoting wide-ranging not-for-profit activities and volunteering, and so contributing to an enhanced public wellbeing (Kingston 2004). Subsequently, some groups became corporate NPOs, while others continued as voluntary groups without corporate status (Pekkanen and Simon 2003). Secondly, the prospects for financial independence and stability crystallised with the public LTCI Act of 1997, introduced in 2000. The aim of LTCI was both to expand and further diversify existing quango-dominated statutory home care (Campbell and Ikegami 2003).

Accordingly, NPOs, but not non-corporate voluntary groups, along with other types of agencies (*i.e.* local authority, quango and commercial enterprise), could become licensed agencies, authorised to provide statutory

home-care provision for eligible older people by using paid care workers. In return, licensed home-care agencies earn officially determined service-fees (*e.g.* 2,350 yen=£13.50 for 45-minute domestic support and 2,540 yen (£14.60) for 30-minute personal care in 2013), 90 per cent of this coming from LTCI funds and the remaining 10 per cent paid by service-users themselves. Importantly, service-fees boosted financial resources for licensed home-care NPOs (LNPOs), giving them self-sufficiency; conceivably, LNPOs might even make a modest surplus. Indeed, the 'entrepreneurial' scope for LNPOs has increased considerably, compared with that of voluntary groups and NPOs which chose not to become licensed home-care agencies (Tanaka, Asakawa and Adachi 2003; Adachi 2008).

However, the narrative changes as the LNPOs' *relative* share of LTCI home-care providers is examined in comparison with that of other licensed agencies in the new competitive LTCI home-care market. The overall size of this market expanded massively, with the number of licensed home-care agencies rising from 9,800 in 2000 to over 28,000 by 2011 (MHLW 2002, 2012*b*). Of the 28,000 agencies, nearly 60 per cent were in the private sector, up from 30 per cent in 2000. The reverse trend was witnessed in the public and quasi-public sectors, their combined shares dropping from 60 per cent in 2000 to 32 per cent by 2011. The LNPOs increased incrementally in both absolute numbers and relative terms, but this growth was relatively modest. In 2011, some 1,600 LNPOs accounted for 5.6 per cent of all licensed home-care providers (MHLW 2012*b*).

Despite their relatively modest position within the LTCI home-care market, LNPOs attracted disproportionate attention from government, commentators and their own proponents (Adachi 2008; Hashimoto 2000; Tanaka, Asakawa and Adachi 2003). This attention intensified throughout the aftermath of the range of reforms from 2005 onwards, as the government continued to foster expectations that the LNPOs would fill the widening provision gap (MHLW 2012*a*, 2013) – a gap represented in the substantial 40 per cent reduction in the delivery of LTCI domestic support hours in 2006 (Mori 2008; Okifuji 2010).

Behind these growing expectations was the prevailing perception of the earlier successes of voluntary agencies in the 1980s and 1990s, as discussed above. These agencies delivered supplementary home care, deploying volunteer or semi-volunteer workforces and therefore providing modestly priced home-care provision to local elderly – and often financially constrained – clients, significantly undercutting the private sector. Much of this was recorded in a body of literature (Adachi 2000; Cyoju Shakai Bunka Kyokai 1998; Kawai 1990; Shibukawa 2001; Tanaka, Asakawa and Adachi 2003; Totsuka 1992; Yamaguchi and Takahashi 1993). Most contributions, however, concentrated on the 1990s and the early 2000s and highlighted

pioneers or proponents of 'good' practice. Some literature has provided quantitative data which, although useful, does not differentiate the role of providing supplementary home care from other forms of provision or different types of voluntary organisations (National Welfare Council (NWC) 2011; Hongo *et al.* 2011).

In short, there has been little investigation particularly into the grassroots experiences and realities of individual organisations across the current, diversified voluntary sector, specifically the new LNPOs. As a result, we do not know the extent to which the current voluntary sector is able to respond to the government's growing expectations. Nor do we know the nature, manner or extent of the sector's responses – particularly those of LNPOs.

Research questions

This article builds on extant literature by providing empirical evidence gained from the responses to the following research questions put to managers from a range of voluntary organisations:

1. How do managers in the voluntary sector perceive the mounting expectations that their organisation would meet the increasing need for the provision of supplementary home care?
2. Whether – and how – the voluntary sector is responding to these expectations to provide supplementary home care – and what is the impact of the sector's responses?

Methods

Given the exploratory nature of the research questions and the dearth of qualitative data specifically relating to the functioning of supplementary home care, a qualitative approach was adopted as the technique for data collection. Accordingly, the experiences of voluntary organisations were explored through a series of semi-structured, in-depth interviews with managers from 15 organisations in Japan between April 2013 and July 2013, eight LNPOs and seven traditional voluntary organisations.

Considering the concentration on successful and innovative cases in current literature, a purposive sampling approach was applied to select organisations. Therefore, as shown in Table 1, the sample included ordinary and 'front-runner', both new and established sector agencies, and small and large within and across urban and rural areas. The urban–rural axis allows for any variables such as socio-economic and demographic trends, income

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TABLE 1. *Field study: interview participants*

Participant identifier	Organisation type[1]	Size of workforce[2]	Length of time in operation[3]	Location[4]
A	LNPO	S	A	U
B	LNPO	L	B	U
C	LNPO	S	B	U
D	LNPO	L	B	U
E	LNPO	M	A	R
F	LNPO	L	A	R
G	LNPO	M	B	R
H	LNPO	L	B	U
I	NPO	M	B	U
J	NPO	M	B	U
K	Quango	L	B	U
L	Quango	L	A	U
M	Quango	L	B	U
N	Quango	M	A	R
O	NPO	S	A	R

Notes: 1. LNPO: licensed not-for-profit organisation, licensed to provide statutory home-care provision under the Long-Term Care Insurance (LTCI) Act; NPO: not-for-profit organisation. 2. The number of care workers employed: small (S): 0–30; medium (M): 31–50; large (L): 51+. 3. B: before 2000; A: after 2000. Note that 2000 is the year of the implementation of the LTCI Act. 4. U: urban; R: rural.

levels, cultural norms and tangible resources to be averaged out. In doing so, a more balanced analysis was potentially achievable, although it is acknowledged that the sample was treated as an example to provide detailed, diverse and complex accounts between organisations and within the sector, rather than a more fully representative sample.

The eight LNPOs were disproportionately represented in the sample due to their distinctive nature. As acknowledged previously, LNPOs are licensed home-care NPOs under LTCI, authorised to provide LTCI home care to eligible older people. In addition, they are citizen-led and not-for-profit bodies, and so are expected to provide supplementary home care. Given these salient characteristics, LNPOs could be categorised as *hybrid organisations* which have recently received growing attention in the context of 'disorganised welfare mixes' (Bode 2006; Evers 2005). The remaining seven bodies sampled included other voluntary organisations which were *not* licensed home-care agencies, and whose focus was supplementary home care *outside* the LTCI home-care market. These included three NPOs and four quasi-public bodies – the equivalent of 'quangos'. The inclusion of these is of value, particularly when illuminating differences and similarities between these and LNPOs about the scope, nature and approach of the supplementary home-care role.

The key initial point of contact was made through the Association for Resident Participatory-type Home-care Provider Organisations, including LNPOs, within the National Welfare Council. Drawing on the comprehensive data collected by the Association (NWC 2011) and an interview with its Director, relevant organisations for the interview sample were identified. Only managerial staff were selected for participation in interviews, a decision which reflected the research questions' proposal to seek experiences at an organisational level. In the identification and pre-selection process (of managers to be interviewed), it was decided to set aside considerations of biological age and gender (as these factors were deemed to be neutral), however it was decided to approach those managers with a minimum of ten years in the care services sector (post-interview analysis indicated that the actual care services sector experience ranged from ten to 22 years). The minimum number of years – ten – was chosen as a selection criterion as it would assure a realistic level of care service-sector knowledge, understanding and experience. It is acknowledged that the managers interviewed may have held views which were potentially biased and possibly defensive. However, the respondents were overwhelmingly open and frank in their responses – a feature which the author will revisit in the concluding evaluation.

All of the interviews were conducted in Japanese and audio-recorded with the respondents' pre-arranged consent. They were fully transcribed in Japanese with relevant findings translated into English, with personal and organisational details anonymised. Interview guidelines were constructed to explore experiences and views of managers towards their organisation's role and capacity of meeting unmet home-care needs. Specifically, each interviewee was asked whether he or she felt that their organisation was able to meet the government's (and other agencies') expectations that the growing need for supplementary home care would in fact be met by their organisation. If so, interviewees were asked if their organisation was equipped to develop delivery mechanisms for the provision of supplementary home care. In more depth, interviewees were then asked how this was achieved – and for an impact assessment of this provision.

Analysis of the interview data was undertaken to allow themes to emerge, be identified and labelled – before undergoing comparative analysis. Interviewees' accounts were analysed and compared through various axes, including their organisation's capacity and capabilities to provide supplementary home care and the operational methods deployed to deliver supplementary home care. Three 'operational' (supply strategies) approaches emerged from the range of interviewees' responses, and as these were confirmed by data analysis, they were identified and labelled. Responses to questions regarding impact evaluation identified and highlighted the factors which helped or hindered success in that function.

Due to format constraints, a representative selection of quotations is included to highlight the varied and authentic experiences and views expressed by the respondents. The oral testimonies of 15 managers are identified using one random letter per interviewee, which matches the organisation to which he or she belongs, referred to as A, B, C, D, E, F, G and H in LNPOs and I, J, K, L, M, N and O in other voluntary organisations.

Findings and discussion

Constraints on LNPOs' capacity to deliver supplementary home care

Interviews with the selected LNPO managers cast considerable doubt on the fundamental assumption about their organisations' capacity and capabilities to deliver supplementary home care, in addition to their commitments to provide statutory home care under LTCI. One manager responded by saying that 'I just don't have the staff to take on these extra duties' (A) and another manager observed that 'We are just able to co-ordinate and deliver our core [LTCI] business obligations' (C). All respondents understood clearly the expectations placed on them by government and others, but they considered such expectations 'unreasonable' (E). One noted that 'The basis of their [*i.e.* the government's] assumption that we [*i.e.* the organisation] should deliver the extras [supplementary home care] is unrealistic' (F).

The prevailing reason expressed by respondents was their overstretched LTCI business commitments. For example, 'The money [funding for supplementary home care] is just not there' (C). Preoccupied with fulfilling this duty, they generally felt pessimistic about undertaking any further responsibilities (C, E). Compounding this was the deterioration of the core business, specifically the drop in income from reduced official service-fees for LTCI home care. This loss of revenue-stream affected staff working conditions, payment and the strategic investment in staff (B) and so further impacted on staff recruitment and the retention of stable and contented workforces (D). One manager said,

> Our competitor providers in the private sector were able to sustain higher rates of hourly pay [*i.e.* for staff] ... and so we lost many of our staff to them [private-sector providers]. (B)

> Many of those who stayed on [*i.e.* who tended to be older and had longer-time served with the organisation] liked their zero-hour contracts with the built-in flexibility ... and so lacked commitment. (B)

Staffing is a serious problem facing home-care provider agencies of all sectors in Japan (Hotta 2007). In these circumstances, the respondents explained that any surpluses accruing from their business were being increasingly eroded, leaving little scope to invest in any additional activities (C). None of the LNPOs in the study were planning to apply a cross-subsidisation strategy to undertake additional tasks: they typically believed that any such activity must be financially self-sufficient, either breaking even or making a modest profit, 'Because to maintain our organisation is our top priority, so any deficit must be avoided at all costs' (D). In addition, another manager observed, 'Extra money [*i.e.* profit on turn-over] made by our [LTCI] business should be put back into our business . . . for example, we need to keep our staff' (E). In the same mode, a third manager said 'We've invested much of our surplus in staff training' (B). In her responses, it emerged that she had organised many staff support programmes, to which experts were invited.

Generally, respondents concluded that the risks associated with financial diversification into supplementary provision should be avoided wherever possible (B, D–F), although in reality cross-subsidisation, albeit limited, did occur in larger or multi-business LNPOs, including three in the study (B, D, F), resonating with the findings of recent surveys (Hyogon Fukushi Net 2010). These findings undermine the common assumption that LNPOs are financially sound to take up additional roles because of their involvement in LTCI business which would generate surpluses and these surpluses can then be reinvested into supplementary activities (Tanaka, Asakawa and Adachi 2003).

LNPOs' responses to growing unmet home-care demand

Although overstretched by LTCI business, all respondents, through their routine work with clients, recognised that the scope of LTCI home-care provision was increasingly failing to address or resolve the growing needs of older people. One manager declared, 'We just can't keep up with the ever-increasing demands from our customers . . . or their families' (A). They accepted that the situation has deteriorated in recent years because of cuts in provision enshrined in the reforms from 2005 onwards (A, D). Significantly, they raised concerns about cuts in domestic support, 'We know about the cuts [*i.e.* for domestic support] our customers have experienced . . . particularly those on low-level needs . . . and those whose families are out [*i.e.* at work] all day' (G).

Accordingly, all LNPOs in the study undertook some kind of extra services. All except one engaged in providing supplementary home care. However, none of the LNPOs in the study had a volunteer workforce involved in delivering this specific service, although volunteers were used to a limited extent in other activities, such as in day centres (A, B, D–H) and to operate

meal services (D, H). One reason given was 'day-centre provision is a communal experience [*i.e.* team work] but home care is lone-working ... and isn't popular with our volunteers' (D).

The absence of a significant volunteer workforce requires two key explanations. First, respondents felt that their organisations simply lacked the resources to develop new volunteer workforces, involving recruitment, training and on-going support, in addition to their existing paid workforces (A, C, D, G). Secondly, and perhaps more importantly, they considered the use of volunteers for the delivery of home care (perceived as highly demanding, involving regular commitments and wide-ranging skills), 'inappropriate' (F), 'unrealistic' (C) and therefore 'unfeasible' (C, D, F).

It might be assumed that paid or semi-volunteers (volunteers in spirit but receiving below minimum or market rates of pay) could form an alternative to conventional volunteers to perform the supplementary care function (Tanaka, Asakawa and Adachi 2003). As already observed, paid volunteers were highly controversial when widely used by resident participatory-type home-care provider organisations during the 1980s and 1990s. Typically, LNPOs established before 2000 had their origins in these organisations and thus had a paid or semi-volunteer workforce. However, none of the LNPOs in this study, including three which had such origins, retained paid volunteers or had any intention of recruiting them.

The reasons for this are the same as those already noted, but a further fundamental obstacle to the use of paid volunteers is the precarious relationship between paid volunteers and conventional, paid care workers. As one manager put it, 'Paid volunteers are likely to perceive themselves or be perceived by others as being in some sense "inferior" to our conventionally paid employees' (B). Another noted, 'Those recruited as helpers [paid volunteers] but having a care qualification would soon want to work as paid carers within the LTCI system ... the helpers will thus flow into the LTCI business' (D). In addition, it was further remarked by two managers:

> We really need to stop thinking of or using female workers as a cheaper source of labour ... and offer all our workers the proper hourly rate for any work. (G)

> Many of our staff tend to be the main breadwinners [*i.e.* single mothers] ... another reason why we have to pay [the proper hourly rate of pay]. (F)

As discussed later, this did not, however, prevent other non-hybrid voluntary organisations, not engaged in LTCI business and thus having no paid care workers, from employing paid volunteers to provide supplementary home care. This distinction further emphasises the large cultural difference between hybrids (LNPOs) and non-hybrids, and illustrates the impracticability of deploying paid care staff alongside semi-volunteers within the same organisation.

Given this perplexing range of difficulties, LNPOs in the study unsurprisingly saw no option but to rely on their existing care worker employees to deliver supplementary home care. Accordingly, they experimented to find ways which were feasible and cost-efficient to encourage their existing workforce to help deliver the required function. This revealed further complexities, but also helped to rectify and refine their operational methods – particularly supply mechanisms – identifying factors which promote or hinder success in fulfilling this role. We can now consider the three strategies (identified during interview data analysis) trialled by the seven LNPOs.

Supply strategy 1: Encouraging employees to undertake voluntary work

First, to cope with their core LTCI business, some LNPOs in the study have applied subtle moral pressure on their care staff to perform additional, voluntary duties, stressing their organisation's voluntary-minded status and mission: 'As our organisation is run on non-profit lines, we should all buy into the voluntary ethic' (E). The danger here is that roles and motivations can become blurred. Care workers, predominantly middle-aged and older women on zero-hour contracts, may find themselves effectively fulfilling both paid and voluntary roles. The perceived pressure to take on a subsidiary 'voluntary' role was understandably often resented by otherwise dedicated workers, as reflected in poor staff retention in at least one LNPO in the study. Here, the manager reported, 'We've lost nearly half of our staff . . . because of all of this [*i.e.* volunteer working]' (D). Another manager was slightly more guarded in her response, but did admit in confidence that 'We are aware of several complaints about this issue of voluntary working' (G).

Significantly, those workers most likely to leave LNPOs tended to be those themselves under greatest financial pressure, needing to work the maximum possible hours, and unable to afford what they saw as the 'luxury' of donating time voluntarily, according to one manager (H). In contrast, those employees most amenable to undertaking voluntary work tended, broadly speaking, to be experienced and longer-serving, coming from more privileged sections of society, with secure financial resources from their husbands in the form of salaries or occupational pensions (B, D), resonant with the findings of recent publications (Ueno 2011). As for the expectation of a voluntary additional role, one manager said,

> We have workers [*i.e.* longer-serving care managers] who take our customers to hospitals . . . and visit at 5 o'clock in the morning . . . completely on a voluntary basis . . . and I know this has caused some tension in our workforce . . . particularly new and younger ones. (E)

Not only LNPOs but older 'consumers' themselves sometimes encouraged care workers to do work voluntarily. The respondents described these consumers variably as 'highly consumerised' (B), 'incredibly sharp' (A) or even 'demanding' and 'cheeky' (D). One manager noted, 'They are unbelievably clever . . . they know exactly how to manipulate our care staff to do extra time and additional work for free' (G).

Another expressed a range of rather more ambivalent feelings,

> The vast majority of our older clients are poor and simply can't afford extra charges. So I understand that they take every opportunity to get free extra help. The easiest way for them is to ask our care staff to do some extra help just after our staff finish their statutory home-care services to them. Our staff are generally very committed and extremely kind so they feel sympathetic towards them or find it very hard to decline the requests. Then, they end up helping them for nothing. (B)

Some workers have expressed their unhappiness by leaving for employment with other agencies, often choosing day centres and the for-profit private sector, where rules and management practices designed to protect care workers from abuse were applied (F). Meanwhile, those remaining and doing 'voluntary' work appeared to be increasingly disconsolate: 'We did start to notice that in some cases certain staff started to avoid the more demanding customers' (D). Accordingly, managers increasingly recognised the importance of protecting their workers *as well as* responding to older clients' needs (B, D–G). Equally, they acknowledged the importance of demarcating clearly the roles of paid workers and volunteers and delineating the content of statutory home care and that of supplementary home care (A, F, G). This, in turn, underscores the complex and diverse nature of home care and the difficulties of providing flexible, informal and voluntaristic care within the regulated, standardised statutory framework.

Equally striking from the interviews is the extent to which older Japanese recipients cared about their rights as consumers. For example, one manager reported that 'They are so quick to phone us these days . . . if the care worker is a few minutes late, they complain . . . or they demand a change of care worker for no real reason' (A). These views contradict the common view that Japan lags behind in practice of individuals' rights and person-centred care (Nakanishi and Ueno 2003).

An additional complication is that LNPOs faced pressure to operate within strict financial margins, not least because they had invested their business surpluses in staff training and support programmes (A, B, G). This encouraged LNPOs, including four in the study, to pay relatively low wages, at rates which were, ironically, below those paid in the private sector (Ueno 2011). As typically small, locally based organisations, LNPOs simply cannot compete with the private sector. One manager said, 'We haven't been able to raise the hourly rate of pay for care workers for at least four years and so we

cannot compete with the private-sector employers . . . we simply don't know how they manage to do this. . .' (H). Using economies of scale, sizeable capital and cross-subsidisation between various for-profit businesses, private agencies appear more cost-efficient and financially viable, enabling them to offer more attractive rates of pay. LNPO managers regarded these private agencies as 'financially better-positioned' (B) and thus a 'threat' to them (F).

This apparently confirms the belief of many respondents that considerably more public support and intervention is required to enable LNPOs to perform their business role in the competitive statutory care market, let alone the delivery of supplementary home care (A–D, F). Yet some studies reported the importance of 'a level playing field' and thus the irrelevance or unacceptability of privileging LNPOs within the statutory care market (Kanaya 2003). This might, in part, be justified by the finding that LNPOs were no better than the private sector, in terms of the quality of care provided under LTCI (Shimizutani and Suzuki 2007; Suda 2011).

Supply strategy 2: Deploying employees at cheap rates

Recognising the difficulties associated with inducing paid care workers to do voluntary work unwillingly, some LNPOs investigated yet another financial strategy to deliver supplementary home care. One initiative is for LNPOs to attempt to persuade their staff to discharge this duty at *lower* rates of pay than the rates paid for delivering core LTCI activities. If successful, this would enable LNPOs to increase their capacity to do this. Moreover, as not-for-profit organisations, LNPOs could, in theory, afford to pass on the resulting savings to their service-users through lower charges. This would extend the organisations' reach and include in the scope of their provision those sections of society in more need of help.

However, in practice, this strategy soon proved unrealistic and inappropriate on two grounds. First, managers felt that 'We have to use standard hourly rates of pay as an incentive to our workforce' (D). Secondly, they recognised both the demanding nature of discharging these duties and their staffs' high skills (B, D). In other words, as one manager observed, 'There is not much difference between statutory and supplementary duties so both should be done by skilled paid staff at the same rates' (B). This finding challenges the widespread traditional interpretation of the earlier model (delivering supplementary home care) based on non-hybrid, conventional voluntary groups in the 1980s and 1990s, involving typically unskilled (semi- or paid) volunteers. This in turn underscores contrasting views and methods towards the delivery of supplementary home care between new hybrid LNPOs and other non-hybrid voluntary bodies.

Supply strategy 3: Utilising employees at proper rates – a solution?

Accordingly, all seven LNPOs engaged in supplementary home care resulted in paying the same or standard wages for both tasks. But this extra financial outlay was inevitably reflected in increased service-charges, which in turn limited the reach and impact of the LNPOs' role. Most seriously, potential users may, on financial grounds, be deterred from seeking this service which LNPOs would like to offer, a point confirmed by respondents in the study:

> Many if not most of our customers are not wealthy and so cannot afford our supplementary home-care services let alone . . . the private sector. (A)

> Sadly, we had to pass on the increase to our customers . . . we had no choice. (F)

> Of our present customers I would say that only about a dozen can use our services regularly . . . others do use us but only once a month or less. (G)

The hourly service-charge for supplementary home care set by LNPOs in the study varied from 1,300 to 2,500 yen (£7.50 to £14.40), considerably higher than the ten per cent user-fees of 259 yen (£1.50) for hourly statutory domestic support under LTCI, subject to eligibility, with the amount being capped according to an individual's care needs. Drawing on data from ten voluntary-sector organisations, one study found the average cost of an hour's similar service to be 1,200 yen (£6.90) (Hyogon Fukushi Net 2010). This is still cheaper than the average service-charges of 2,000 yen (£11.50), set by private-sector providers, but using economies of scale and a larger workforce, private-sector providers now match or even undercut the LNPOs (Silver Service Shinkokai 2009). In short, LNPOs face challenges in the evolving competitive supplementary home-care market, as well as in the still more competitive statutory home-care market under LTCI.

Yet, as previously noted, LNPO care workers are already working at full capacity in their core business roles, leaving little scope for them to engage in supplementary home care. One manager noted, 'We don't advertise our non-statutory [supplementary] services to the public, but only take requests [directly] from our existing customers' (B). Recent cuts in LTCI provision forced LNPOs to prioritise their LTCI business commitments. Indeed, one manager lamented, 'We recently had to stop our own domestic support service due to the lack of staff who could engage in the service' (C). In summary, when compared with the core LTCI business, the supplementary home-care supply was negligible. One manager reported it to be 'less than 10 per cent' (F); another said 'at most 20 per cent' (G) and a third manager – who originally delivered 100 per cent – currently delivered '40 or 50 per cent' (B). In a study it has been reported that about one-third of 864 LNPOs surveyed provide no supplementary services whatsoever and the

scope and nature of the involvement of the remaining two-thirds await evaluation (Hongo *et al.* 2011).

Supplementary home care – non-hybrid voluntary organisations' responses

In contrast, other non-hybrid voluntary organisations, not involved in LTCI business, were more successful in providing supplementary home care, mobilising a 'cost-efficient' workforce and hence with more affordable service-fees, resulting in a wider reach. The composition of this workforce differed among the seven organisations examined. One NPO utilises 'volunteers with rewards' who help older members with domestic support and in return earn 'time credits' for the hours they volunteer (I). They can use these credits to buy their own care in later life or buy care for their relatives living elsewhere. Those without time credits pay a 500 yen (£2.90) 'donation' for hourly domestic support, significantly undercutting other voluntary and private-sector providers. One unsurprising result has been an increase in registered service-users, which exceeds volunteers, and this difference has widened in recent years. It was reported that 'We have so many members [who want help] on our waiting lists ... including local authority referrals ... but we just don't have enough members [who volunteer to help other members]' (I). This reflects difficulties in recruiting and retaining volunteers to meet the increasing need of service-users, suggesting, perhaps, the limitations of time credits as a means to incentivise volunteers to undertake demanding activities like these (Hayashi 2012).

This partly explains why all except one of the remaining non-hybrid organisations in the study continued to deploy paid volunteers – paid less than conventional workers, or what are now defined as 'supporters' (O), 'members' (I) or 'helpers' (M) (to avoid controversy or criticism). 'We have to be careful ... no, I mean sensitive ... about the term "paid volunteers"...' (M). Nationwide, some 2,000 organisations delivering supplementary home care (and other services) are reported to be using such a workforce (NWC 2011). However, a semi-paid workforce inevitably raised service-fees, currently about an average of 944 yen (£5.40) per hour (NWC 2011), which matches the findings from the managers interviewed for this study. This was more than double the perceived affordable or acceptable charge, according to one study (Yamada 2005).

Interestingly, these non-hybrid voluntary organisations excluded from the statutory home-care market were more likely to receive public subsidies, helping further development. 'Public funding ensures two of our part-time admin posts, without which we really couldn't function' (N). This underscores the fundamental perceived need for increased public funding of supplementary home-care activity, and acknowledges the financial constraints

on potential service beneficiaries. 'We get public funding ... a subsidy ... which covers 50 per cent of our service costs ... which our customers benefit from directly' (M). In contrast, LNPOs have no such support, perhaps because 'We are seen as care providers to do business, not voluntary agencies' (B). However, public funding is declining at a time of budget stringencies: 'Recently, our local government subsidies have been cut ... we had to cut our services' (K). Moreover, recent government policy, specifically the raising of the retirement age, has affected volunteer recruitment, particularly among the 'young old' post-war baby-boomers, *i.e.* those born during 1947 and 1949, who are often compelled to choose continuing employment over opting for voluntary work, as expressed by one manager: 'We are disappointed by just how few baby-boomers came to us as volunteers' (J).

Conclusions

This study aimed to provide empirical evidence of the views and experiences through qualitative interviews with the managers of the Japanese voluntary sector – both traditional organisations and the new hybrid LNPOs authorised to supply statutory home-care provision under the LTCI system of 2000. Specifically, the focus of the study was to investigate and evaluate the role and function of both types of voluntary organisations to deliver supplementary home care to compensate for the under-delivery of statutory provision. To achieve this overall aim, the study asked the following two research questions:

1. How do managers in the voluntary sector perceive the mounting expectations that their organisation would meet the increasing need for the provision of supplementary home care?
2. Whether – and how – the voluntary sector is responding to these expectations to provide supplementary home care – and what is the impact of the sector's responses?

In the responses to the first research question, analysis of the oral testimony from LNPO managers confirms that their organisations' capacity to deliver supplementary home care is limited, suggesting that the rising expectations from government and other parties are unreasonable. Collectively, managers felt that their organisations were overstretched by their LTCI business, leaving increasingly diminished margins for this supplementary role. The situation was exacerbated following the reforms from 2005 onwards which impacted on LTCI operations, severely affecting LNPOs' income streams and workforce size and capability. Accordingly, with revenues shrinking, managers believed that any surplus should be reinvested to enhance their LTCI business and maintain workforce morale and viable structure.

In the responses to the second research question, the respondents in the study were very concerned about the deteriorating care situation, however, all LNPOs except one did provide (albeit limited) supplementary home care to varying degrees – which resonates with the findings of recent research (Kanaya 2012). The study, which examined the supply mechanism, identified and evaluated two approaches trialled by these LNPOs.

One (*i.e.* supply strategies 1 and 2 described earlier) involved attempts to tap into 'economical' labour, meaning encouraging existing employees to do extra work voluntarily or at cheaper rates. Both practices would, in theory, allow LNPOs to reduce their service-fees and maximise their reach. But in practice, as empirical evidence from this study has demonstrated, these benefits proved to be elusive. Identifiable obstacles to their achievement were threefold. Principally, LNPOs justifiably felt that the delivery of supplementary care was so demanding that it required properly paid and trained staff, rather than volunteers. Secondly, implementing a 'two-tier' workforce would inevitably create tensions between staff receiving different levels of pay effectively for the 'same' work. Finally, encouraging employees to undertake additional voluntary work might leave them vulnerable to exploitation both by LNPOs and service-users. This is potentially dangerous because it could threaten staff morale and motivation and blur the necessary boundary between statutory and supplementary home care. As the findings here imply, a balance is needed between ensuring adequate protection of the interests of care providers and of care recipients. This is of critical importance, given the potentially serious workforce shortages in the home-care sector.

The second method (supply strategy 3) adopted by all LNPOs engaged in supplementary home care involved paying employees at regular pay rates for any extra work. The advantage of this option is that it helps to keep workers motivated, reliable and contented, and less likely to feel exploited. The fact that LNPOs have recognised the benefits of offering regular pay is a finding that promises to illuminate current debates still dominated by optimistic assumptions about the role – and implicit ideology – of 'traditional' voluntary organisations and the 'economical' use of labour. There are, nevertheless, limitations. Given that LNPOs already find themselves overstretched by their LTCI business, they needed to prioritise that business, giving workers little time to perform any further tasks. Furthermore, paying workers at appropriate rates obliged LNPOs to pass on these costs to users, in the form of higher service-fees. Negative consequences included reduced reach for LNPOs in the community since, although the rates remained lower than typical private-sector rates, the majority of potential beneficiaries tended to be disadvantaged financially. Funding to assist the financially disadvantaged to pay for their supplementary home-care requirements was very limited

through charitable revenue streams in Japan (Yamauchi 1999), a situation which strongly suggests the need for public financial underpinning.

Other voluntary organisations, unconstrained by LTCI business, have been free to concentrate on developing and mobilising volunteer labour, allowing them to offer a more affordable service-charge structure, and so maximising the organisations' reach. Furthermore, because they, unlike the LNPOs, were perceived by public authorities to be 'charities' in the traditional sense, these organisations sometimes benefited from receiving public funding. This has helped to optimise their reach, though largely restricted to quasi-public bodies, and recently they have all faced financial pressures.

In conclusion, the findings of this research suggest that it is essential to acknowledge diverse and potentially diverging responses from the Japanese voluntary sector in meeting the unmet home-care demand, particularly the new hybrid LNPOs that embrace both voluntary and commercial imperatives, especially during times of on-going financial constraint and rapidly growing need for home care. Of equal importance is the concept of policy makers recognising the capacity and limitations of the voluntary sector in performing supplementary home care and other services and not imposing unrealistic demands or expectations upon them. Similarly, the organisations themselves need to understand their different roles, approaches and capabilities. While challenging the growing and optimistic expectations that government has of the voluntary sector, the findings in this study clearly indicate the need for more preparedness among those holding these expectations to review and revise traditional or ideological interpretations of the voluntary sector collectively, or actually adjust the prevailing focus on pioneers or successful 'models' from the 1980s and the 1990s.

No discussion of these themes would be complete without acknowledging the wider, distinctively Japanese *cultural* context in which the overall system of home-care provision is developing. Current discussion in Japan reflects an entrenched concern emphasising the central importance of social *harmony*, a strong work ethic and a willingness to subordinate individual interests and circumstances to the authority of the collective good. Significantly, the discreet techniques and many of the difficulties examined here would not normally be aired openly: powerful cultural constraints, including attitudes of deference and compliance, militate against outspoken public criticism of conventional 'consensus' or 'moral' views. This highlights the value to researchers of oral testimony gathered confidentially. Equally striking is the discovery in the findings that older Japanese service recipients hold distinctly 'consumerist' views. This contrasts with the received wisdom that Japan lags behind (the West) in attitudes towards individuals' rights and empowerment.

Finally, in light of the experience of various organisations examined here, the best strategy, most likely to impact upon the most beneficiaries, appears to be a multi-platformed approach, maximising various resources in a pragmatic and flexible manner, unrestricted by ideological preconceptions. However, the inescapable if unsurprising conclusion would seem to be that an effective system of supplementary home care operated by the voluntary sector must receive adequate public financial and other assistance – given that the recipients were largely less affluent and charitable donations were significantly absent. With such resourcing, the sector's full potential may be realised. Moreover, this kind of public support may contribute to compensating the LNPOs for the depredations they have suffered in the wider home-care (both statutory and supplementary) market at the hands of the more competitive private sector. The findings of the study are not only pertinent but also timely and relevant to Japan itself together with Europe, the United States of America and other societies facing challenges similar to Japan's (Costa-Font 2011; Swartz 2013) – issues beyond the remit of this article but certainly worthy of investigation.

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NOTES

1 In the Japanese context, home care has two components: *personal care* and *domestic support* (Yamashita 2011). Personal care involves help with activities of daily living such as washing and bathing, dressing, toileting and feeding. Domestic support covers essential activities such as cooking, cleaning, laundry and shopping. While some home care is provided through the LTCI statutory system, there remains a considerable unmet need, particularly domestic support for low-needs groups.

2 Although the voluntary sector performs various roles, this article will focus on supplementary home care outside the statutory framework, that is, mainly domestic support for low-needs groups. *See also* Note 1.

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