Part 1-CHAPTER 3

Long-term Care Provision in Japan

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CHAPTER 3

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1. Historical Background and Context of Long-term Care Insurance

In 2000, the universal public insurance system for long-term care for the elderly and those with chronic diseases started as Japan witnessed a rapidly ageing population and socialised long-term care service provision became an urgent need. Institutional long-term care was set up in 1874 just after the Meiji Restoration as part of public assistance to the poor, the fragile, and those with no relatives to rely on. In 1933, they were accommodated in publicly funded relief facilities and hospitals and in private relief organisations. The pre–World War II idea of providing public financial support to and regulating private welfare entities and of supporting the physical and daily needs of the elderly has been continued after the war.

In 1962, the universal medical insurance system was introduced, covering long-term medical needs. In 1963, the Elderly Welfare Law introduced new approaches to long-term care for all the elderly, not just the poor, and launched care at home (home help) (Table 3.1). From 1963 to 2000, the long-term care system was based on separate medical insurance services and institutional welfare care services. The medical clinical service system for long-term recuperation of the elderly and the welfare care service for the elderly needing long-term care evolved in parallel. Those with long-term care needs, however, prefer to use medical rather than welfare services because it is simpler and also because of the stigma attached to welfare services. Along with rapid ageing (the elderly who are 65 years old or above made up 7% of the population in 1970 and 14% in 1996) and the deterioration of families' ability to provide domestic care fostered overdependence on medical insurance, which resulted in disruptive increases in national medical expenses. The insurance cost was allocated to employers, who shouldered 50% of the medical insurance premium.

Social welfare reform in 1990 required all municipal governments to prepare long-term care service infrastructure, mainly by improving community-based care service and introducing private resources into care services. Socialising long-term care resulted in (1) creating a mechanism of universal provision of long-term care by setting up an independent long-term care insurance system that exempted companies and employers from monetary contribution, (2) giving caregivers wider employment options through social care services or stay-in care, and (3) devolving service management to municipalities because of geographic and demographic differences in ageing and care needs and because local planning and governance of daily life support and community-oriented service provision can be profitable.

Table 3.1. Institutionalising Long-term Care – Timeline

Before 1963	Long-term care is part of public assistance
1962	Universal health and medical social insurance established together with pension insurance scheme
1963	Elderly welfare service law enacted • Intensive LTC facilities established • Home-helping service provided
1963–2000	Dual system of LTC by medical providers and the welfare system
1982	Health and Medical Services Law enacted • Medical spending cuts, with universal preventive services
1989–1999	LTC provision universalised • LTC service infrastructure enhanced • LTC at home improved
1995–1996	Critical policies drawn up to universalise service
1997	LTC Insurance Act passed (enforced in 2000) • Quasi-market and socialised LTC
2005–2018	Shifting towards community comprehensive care system

2. Institutional Framework of Long-term Care

The Long-term Care Insurance Law was enacted in 1997 and, after a 3-year trial, fully implemented in 2000. The system's basic concepts are (1) support to enable independent living and security, from primary (preventive) care to terminal care; (2) guarantee of user's choice of services and user–expert collaboration to create the service process; and (3) public, not social, insurance funded equally by public spending and insurance premiums. Because the system reflects social welfare practice, the social work function of supporting human autonomy and independent living is inevitably embedded in it. Therefore, preventive primary care, daily living support, ecological coordination, community living, planning by care managers, and consultation of clients about their own care, amongst others, are the core categories of long-term care. Strictly interpreted, these are substantially living-support services, not long-term care. Because the system is compulsory, 50% funded by public taxes (25% by the central government, 12.5% each by prefectural and municipal governments) and 50% by insurance charges on those aged 40–64 and 65 and above, LTC insurance prioritises medical services for those aged 65 and above and services for eligible handicapped persons.

Japan's long-term care insurance system is unique and may be (1) single, (2) universal, (3) independent, or (4) locality based.

(1) Single means all-inclusive provision of medical and co-medical clinical practices, physical and mental care, counselling and guidance, care management, social work (including social participation and legal affairs), comprehensively packaged. Single insurance promotes effective and efficient resource allocation and better services, and separates long-term medical spending from medical insurance.[1]

[1] The medical insurance system has the following characteristics. (1) It has several kinds of insurance: medical insurance for self-employment, health insurance established by big companies, social insurance for employees of small and medium-sized enterprises, health insurance for civil servants, amongst others. Some insurers are subsidised by tax revenue, but not big companies because of their strong financial base. (2) The medical insurance fee is flat nationwide and applied to any insurer. Medical facilities submit claims to insurers to ask for the payment in accordance with each item of the medical services provided. Amounts claimed have had no maximum limit (although that is changing now and lumpsum payment system in accordance with the status of patients is being introduced). As a result, many people who do not need intensive medical care but do need LTC remained hospitalised, benefiting hospitals and patients but leading to skyrocketing 'medical expenditures' (the amount paid through medical insurance, including for such not-necessarily-hospitalised patients).

(2) Universal means that all citizens aged 40 and above must contribute to the long-term care insurance fund as set by each municipal government, so that anyone who needs long-term care services can utilise them as assessed by a commission. There are two preventive levels and five care support levels. Insurance payments to the service providers are calculated by service points used, and users are free to choose services within the limits of service points of each level, conditional on 10% direct charge payment to the service providers. Now direct charge payments are 20% (since 2012) and 30% for those who can afford it (from 2018).

(3) Independent means that the system is independent from the medical insurance system: the municipal government is an independent insurer, service users are limited to the elderly, and the insurance premium is charged to those aged 40 and above. The insurance premium charge system is also independent from that of medical insurance, enhancing quasi-market service consumption through a consumer contract between service user and provider, and deregulating welfare service providers. This system also improves consumer protection, claiming procedure, service information, quality of service, public administrative planning of service resource rationing, amongst others.

(4) Locality based means each municipal government is responsible for providing insurance service and collects contributions from all local inhabitants aged 40 and above, without exemption. The municipal government insures long-term care, charges insurance premiums and controls the fund, decides on the charge rate every 3 years, draws up administrative plans every 3 years, allocates resources, and organises community care meetings of service providers and multidisciplinary experts.

3. Practices of Long-term Care Services

3.1. Updated Figures: Increasing Institutional Costs

Table 3.2 shows the latest figures on long-term care

Although long-term care insurance is a universal system, only 18.1% of the elderly are certified users. Those aged 85 years and above, especially those in their 90s, are more likely to be the beneficiaries of LTCI services. Nevertheless, the total insurance budget for 2018 was about JPY10 trillion, equivalent to the combined budgets for education, science, culture, and sports, and for national defence. Total spending is estimated to double by 2025. The average insurance premium per elderly person per month in 2018 was JPY5,869 or about US$52, which is double that in 2000. The highest municipal charge is JPY9,800 or US$87. The average national pension (non-employee and self-owned business) payment per person per month in 2017 was JPY55,000 or US$491. Average charges in 2018 for the advanced-elderly medical service system for people aged 75 and above, managed by 47 prefectural governments, was JPY5,857 or US$52. Those 75 years and above have to contribute more than 20% of their pensions (in the case of national

Such medical expenditure, which is spent for LTC and supposed to be categorised as social welfare cost, must be separated from medical insurance and placed under LTC insurance. Medical expenditure cost in Japan is about JPY40 trillion per year, while LTC cost is JPY10 trillion per year. The introduction of LTC succeeded in separating them. The global standard is to exclude LTC cost from 'medical expenditure'. As a result of such separation, the burden on big companies' and civil servants' medical insurers has lightened, because the premium of LTC insurance is not covered by companies but by individuals. Of the budget of LTC insurance, 50% is covered by tax revenue (national government 25%, prefecture 12.5%, and municipalities 12.5%), the rest 50% by individuals.

Table 3.2. Latest Figures on Long-term Care (as of December 2018, unless otherwise noted)

Proportion of population 65 years and above	28.2%						
Number of insured 65 years and above	35.14 million						
Number of the certified as needing LTC or support	6.578 million (18.3% of the insured of LTCI category 1) Male 2.069 million Female 4.509 million						
Number of service users	At-home services 3.775 million (home visits, day care, rehabilitation)						
Multifunctional integrated community care	0.873 million						
Care and rehabilitation facility services	0.944 million						
Proportion of service users by age and gender to the total population of each age and gender group (as of November 2017)							
Ages	65–69	70–74	75–79	80–84	85–89	90–94	95 above
Male	2.4 (%)	4.4 (%)	8.1 (%)	16.0 (%)	29.9 (%)	48.0 (%)	70.9 (%)
Female	1.8 (%)	4.1 (%)	9.7 (%)	23.4 (%)	44.9 (%)	65.3 (%)	86.8 (%)

Source: Statistics Bureau, Ministry of Internal Affairs and Communications (2018); Social Statistics Office to the Director-General for Statistics and Information Policy, Ministry of Health, Labour and Welfare of Japan (2018); and Ministry of Health, Labour, and Welfare (2018.

pension scheme) every month to long-term care and medical service insurances whether they use the services or not.

3.2. Marketisation

In 2016, there were 12,865 institutional and 148,014 non-institutional care service providers, including preventive rehabilitation service providers. More than half were in the private sector. There are 233,239 private residential homes with care services outside long-term care insurance, whilst there were 12,869 care facilities covered by long-term care insurance.

Insurance services are shifting from institutional to non-institutional care, relying more on family domestic resources. The long-term care provision system is a mixed system of insurance and business, of institutions and non-institutions, and of public and private sectors, including family resource integration.

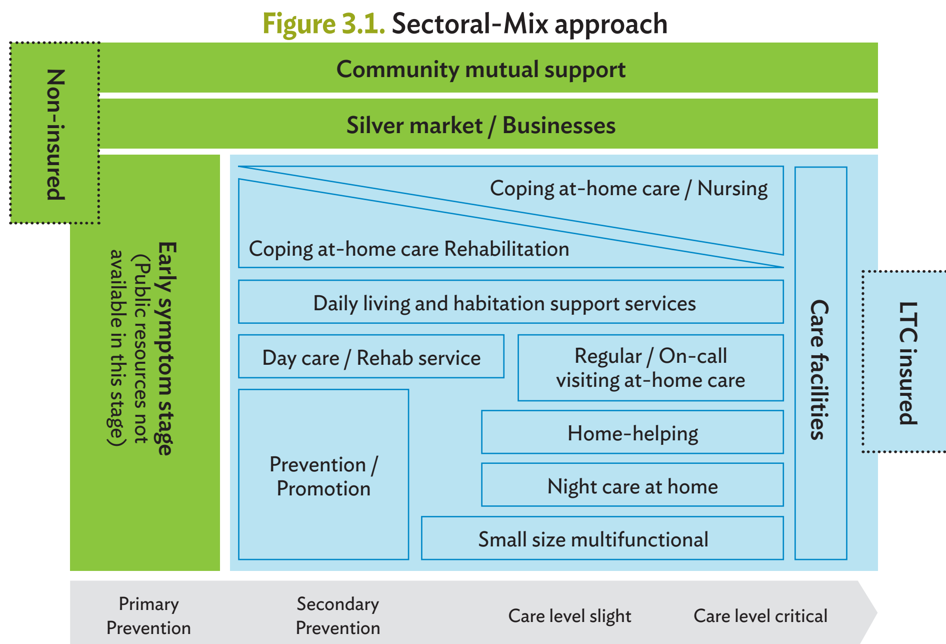
Considering that long-term care spending is expected to double in 2025 because of the rapid increase of the population aged 75 and above, and that, by 2040, one-third of the population is estimated to be aged 65 and above, and that the birth rate is declining, privatisation of service providers and promotion of services outside the insurance system are inevitable. The single solution for the crisis is to share responsibility and resource contribution amongst the public–private, profit–non-profit, and even official–folk sectors with the locality-based comprehensive sectoral mix.

3.3. Challenge in Sectoral Mix

Facing increasing institutional costs and shortages in formal insurance services, the government enhances the sectoral-mix approach to benefit clients and develop the best solutions for individual cases. The idea of community comprehensive care was emphasised from 2008 at the theoretical experimental level and from 2012 at the policy level. The social security reform enhancement law of 2012 and the long-term care reform act of 2012 introduced community comprehensive care as a goal.

Figure 3.1 shows wholesale sectoral-mix pattern of the policy.

Figure 3.1. Sectoral-Mix approach



Source: Author.

The sectoral-mix approach is orthodoxy in public management and nothing new in long-term care policy. What is new is that it is not simple deregulation or privatisation but incorporation of non-insured areas into long-term care insurance system management.

Two areas are to be incorporated. One is the 'missing market' or 'early symptom stage', where formal services are absent. This stage is critical to prevent the need for care, and various community-based activities and market services have been innovating in this area. The second is mutual support in the folk and private sectors, which supports various attractive services and practices to improve quality of life .

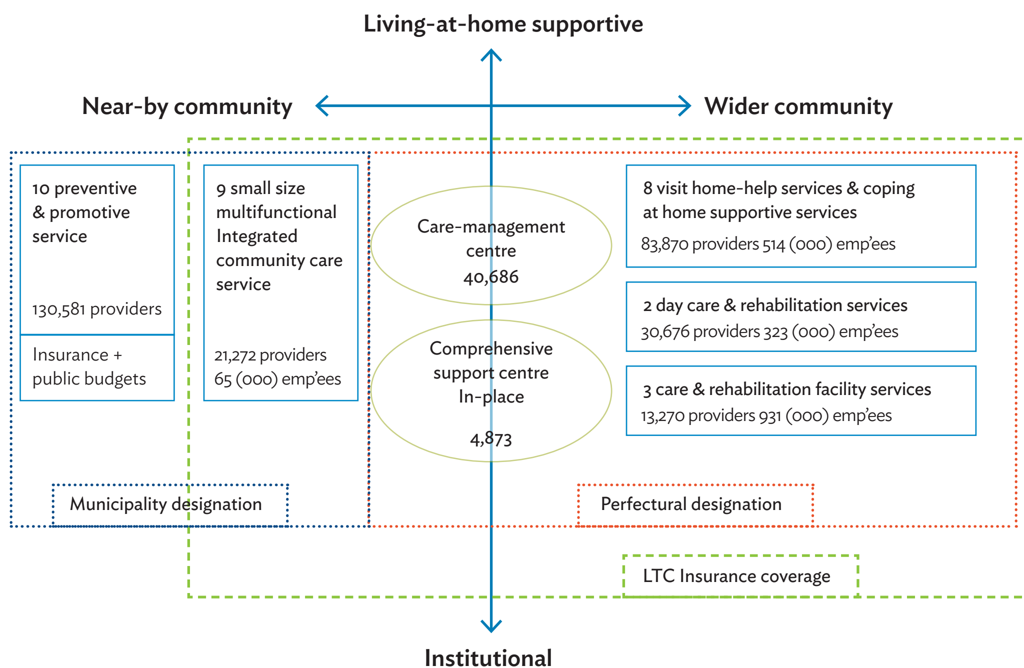
The key to incorporate the two areas into an insurance managerial system is care management. Guidelines from the Ministry of Health, Labour, and Welfare requests care managers to use non-insurance services and voluntary mutual support practices in formal care planning, and asks that non-insurance services coordinate within long-term care institutional infrastructure.

3.4. Community Care Management

Figure 3.2 shows the whole-service provision structure under long-term care insurance.

The types of services provided in the community comprehensive care network consist of 'near-by community', 'wider community', and 'institutional'. Services are vertically and horizontally integrated. A comprehensive support centre (CSC) is the central control and works with a highly trained senior care manager, social worker, and public health specialist together with a daily-living coordinator to counsel and guide the client, provide preventive care and comprehensive and continuous care, and protect the client's human rights. The CSC is also the gateway to long-term care insurance service, a one-stop centre for long-term care matters, and an organiser of community care meetings to find a team solution to complex and difficult cases. The CSC analyses the community's challenges to advocate improvement in service and clinical quality and reform in municipal long-term care policy.

Figure 3.2. LTC Insurance Service Complex (community comprehensive care service network)



Source: Author.

There are two types of care management in the LTC insurance system. One is that practiced in 'three types of care and rehabilitation facilities' (Figure 3.2, right bottom blue rectangle). These facilities accommodate older people who need intensive care (certified as in the higher care-need level) and beneficiaries are all institutionalised. Their care plans must be made by care managers, who are employed by the facilities; independent (outside the facilities) care managers may not make the care plans. Beneficiaries of other facilities and LTC providers designated by the LTC insurance system are allowed contract with any certified care manager.

The three types of care and rehabilitation facilities have their own care management centres. The over 40,000 centres (Figure 3.2) plan services other than facilities. The comprehensive support centre passes individual cases to the care management centre, supports and advises it on improving quality, frequently invites it to community care meetings, and monitors how it solves cases.

4. Linking with Medical Reform

The medical and long-term care systems liaise with each other. Reforms to rationalise the medical system will be completed by 2024. The reform will enhance functional segmentation and specialisation of hospitals, from the acute to the terminal stages, and strengthen the links amongst medical service facilities to shorten hospital stays and improve the bed turnover rate.

A growing number of patients who still need medical monitoring will be obliged to be discharged from hospitals because rehabilitation-oriented medical service facilities and convalescent-responsive medical resources are insufficient. The number of hospital beds for dying people is also insufficient. About 80% of death in Japan take place in hospitals now. If this percentage does not change though the government encourages to die at home or any residential facilities to alleviate the shortage of hospital beds and to reduce the medical expenditure, more hospital bets will be required and the hospital beds which are registered as the beds for general patients should be converted into the beds for exclusive terminal-care use (In Japan's medical service system, the use of hospital beds should be registered depending on its usage). Of the growing number of people outplaced from medical institutions, most are elderly and must be placed elsewhere and receive long-term insurance services.

The Community Comprehensive Care Strengthening Act of 2017 and related Medical Law reform, together with the medical service fee revision in 2018, aim to accelerate the functional link between the medical service and long-term care service systems. The medical service system is a vertically integrated from acute to terminal care, whilst the long-term care service system is a community-based horizontal functional liaison (Figure 3.2). People prefer to stay in hospital if they become disabled by senility or senility-related diseases (including stroke, bone fracture, amongst others) and are unable to live independently. Because of rapid population ageing, however, they cannot be accommodated. Their continued stay in hospital will affect the ability of hospitals to provide medical care or even hinder acute care, which is the main role of hospitals. The cost of medical care (even if provided to clients who need only hospitalisation and not need acute care) is much higher than that of LTC. Medical service systems (covered by medical insurance) and LTC services (covered by LTC insurance), therefore, must establish a sustainable

system to care for older people. People who no longer need acute care in hospitals must be smoothly transferred to LTC facilities. This means that LTC services, particularly community and at-home types, must support the client's recovery and recuperation, which is challenging.

5. Quiet but Fundamental Transformation of Long-term Care

After almost 2 decades, long-term care insurance faces some fundamental systemic deadlocks: geographical and demographical partialities in service provision, limitation of service users, rising total cost, limited bearing ability of the insured population, and the need to extend service liaison with non-insured sectors. These are the challenges to long-term care insurance – single, universal, and locality based. The LTC insurance system faces the pressure to coordinate with medical insurance because it is encouraged to promote the seamless transfer from acute care facilities to LTC facilities and to avoid the overlapping of services, though the LTC insurance was established to achieve the 'independence' of LTC services from medical care services.

Disparities in finance and administration of the locality-based system are far more serious than initially estimated. Within disadvantaged municipalities or marginalised regions, 896 municipalities out of 1,718 are predicted to be in crisis by 2040 because of dynamic depopulation (especially the younger female population) and continuous ageing together with loss of economic sustainability. In urban–suburb municipalities, the ageing rate by 2030 will be far beyond anything ever experienced because of the overconcentration of post-war baby boomers. These structural changes are reflected in the diversification of municipal managerial strategies and resource allocation for long-term care insurance. The locality-based system is now fettered to municipality-managed insurance.

The sectoral mix for integrating non-insurance resources into insurance system management mechanisms, comprehensive care focusing on daily living in small communities and emphasis on the CSC's role in encouraging stakeholders' cooperation to rationalise service provision, and improvement of medical and long-term care service systems are all part of the quiet but fundamental transformation of long-term care provision.

Whether medical and long-term care insurances will integrate, whether long-term care services will be universalised to cover all generations' needs now covered by medical insurance, whether insurers will consolidate into a single or several regional administrative agencies, whether the CSC will become a more comprehensive community health and social service centre – all these issues will define the transformation of Japan's system.

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