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Twelve Years Experiences of the Japanese Long Term Care Insurance

—Actual Problems and Its Future Challenges—

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Abstract

In 2000, the Japanese government implemented the Long Term Care Insurance (LTCI) as a new scheme for the frail elderly in order to socialize the ADL care services for the dependent elderly. After 12 years of implementation, LTCI has become an important infrastructure to support the QOL of frail elderly. This situation has caused, naturally, a large increase in users and expenditures. LTCI expenditures have increased from 3,953.5 billion JPY in 2000 to 7,930.8 billion JPY in 2010. The average monthly premium has increased from 2,911 JPY to 4,972 JPY in 2012. This rapid increase of LTCI expenditures are one of the most important political issue for today's Japanese society. In 2012, the Japanese government has 10 trillion of debt. As the expenditure of social security is the largest among national budget, the reform of social security system becomes an urgent political issue for the Japanese society. In order to maintain the universal coverage of LTCI scheme, policies are needed to reconcile projected demand for (and cost of) LTC, with financial sustainability. A toolkit of policies to strike this delicate balance between fairness and fiscal sustainability is now to be prepared. We have to overhaul our LTCI scheme from the following four viewpoints; reducing the demand for care, cost-sharing on LTC benefits, an appropriate mix of formal and informal service and reconfirmation of principle of LTCI scheme among the citizens.

Key words: LTCI, dependent elderly, finance, health reform, Japan

❖Introduction

In 2000, the Japanese government implemented the Long Term Care Insurance (LTCI) as a new scheme for the frail elderly. The background factors of this reform are as follows:

The first factor is the rapid ageing of the Japanese society. In 1970, the population of 65 years old and more was 7% of the total, and after only 40 yr, in 2010, it became 21%[1]. The National Institute of Population and Social Security Research (NIPSSR) forecasts that this percentage will be 26% in 2035[1]. The second factor is both demographic and sociological. With fewer children (Total Fertility Rate is 1.2 in 2000), more women working, and changing attitude toward family responsibilities, the traditional system of informal care-giving is widely perceived as inadequate to take care of the increasing number of the frail elderly. In fact, about 40% of the households with elderly people are now so called "aged households", that is, single old person's household or old couple's household.

The introduction of LTCI has been expected to counteract to these situations. Instead of the optimistic perspective at the moment of introduction, it confronts to various problems by maturation of the scheme. In this article, the author describes the general perspective of LTCI and its current problems and future challenges.

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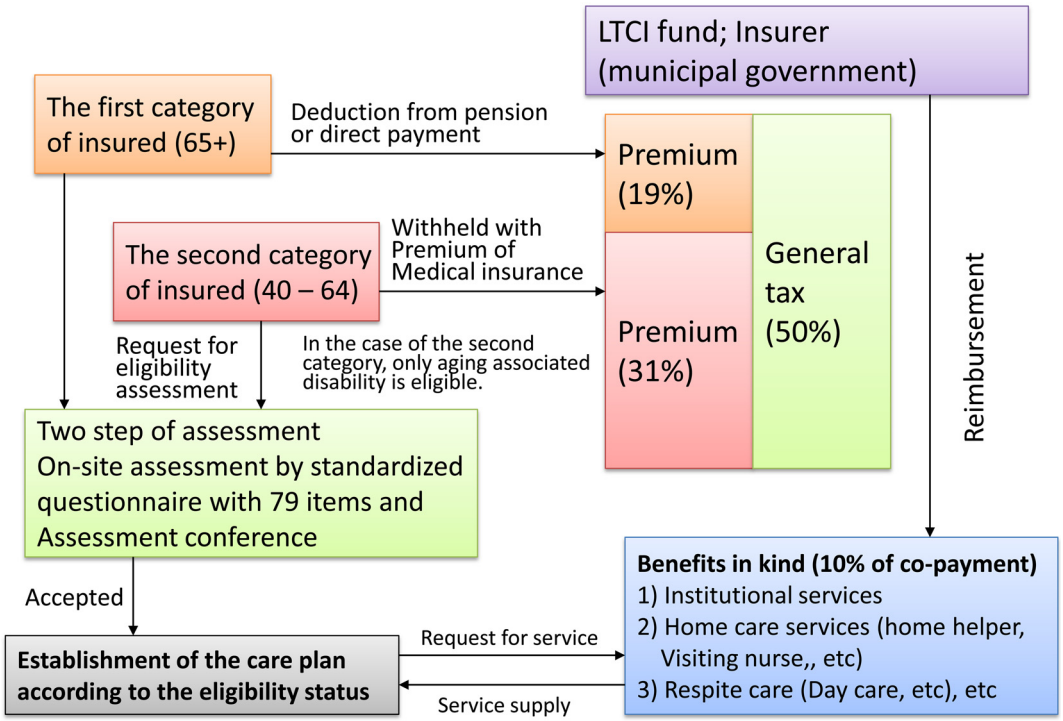

Figure 1 System of Long-Term-Care Insurance in Japan

❖General Perspective of the Japanese Long Term Care Insurance

Finance

Figure 1 describes the LTCI scheme. The budget of the insurance is based on 50% from the general tax and another 50% from the premium of the insured. There are 2 types of insured; the first category of insured who are 65 yr old and more, and the second category of insured that is between the age of 40 and 64. The first category of insured is asked to pay a premium deducted from pension or direct payment for insurer according to their pension status. In the case of the second category of insured, his or her premium is withheld from the medical insurance premium. It is important to know that the premium is different among the insurers according to the expenditures of each insurer. That is, the inhabitants uses more LTCI services, they have to pay more premium. For example, in 2012, the highest monthly LTCI premium was 6,680 JPY (Sekikawa town, Niigata prefecture), and the lowest was 2,800JPY (Mishima village, Kagoshima prefecture)[2]. Furthermore, the premium is different among the insured of the same insurer according to personal income. Table 1 illustrates an example (Kitakyushu city, Fukuoka prefecture). Even though the average premium set for 5,270 JPY, the richest person has to pay 11,070 JPY and the poorest pays only 2,640 JPY. This sliding scale is set based on the solidarity principle among the persons under the same insurer.

Eligibility assessment

The eligibility process begins with the individual or his/her family applying to the insurer (usually municipal government). A 2-step assessment process follows and determines the limit of benefit. The first step is on-site assessment using the 79 items of a standardized questionnaire, each with a choice of three or 4 levels, plus space for comments on any particular aspects to be remarked on. The 79 items are analyzed by an official computer program to classify the applicant into one of 7 levels of dependency or to reject eligibility. The 2 lightest levels are “assistance required level 1 and level 2” which are subject to preventive services; the other 5 levels are called “care required level 1 to level 5”. The detail of classification logic is described in another article of this issue[3]. The second step is the assessment conference by health care professionals. The conference reviews the classification made by a computer program by taking into account the descriptive statement plus a report from the appli-

Table 1 An example of monthly LTCI premium (Kitakyushu city, Fukuoka; 2012–2014)

	Eligible	Monthly premium (JPY)
Level 1	Beneficiary of public assisstance	2,640
Level 2	The household of the insured exempt from municiparity tax and the yearly income of the insured is less than 800,000 JPY	3,170
Level 3	The household of the insured exempt from municiparity tax and the yearly income of the insured is less than 1,200,000 JPY	3,690
Level 4	The household of the insured exempt from municiparity tax and the yearly income of the insured is more than 1,200,000 JPY	3,960
Level 5	The insured exempt from municiparity tax and the yearly income of the insured is less than 800,000 JPY0	4,75
Level 6	The insured exempt from municiparity tax and the yearly income of the insured is more than 800,000 JPY	5,270
Level 7	The insured subject to municiparity taxation and the yearly income of the insured is less than 1,470,000 JPY	6,060
Level 8	The insured subject to municiparity taxation and the yearly income of the insured is less than 1,900,000 JPY	6,590
Level 9	The insured subject to municiparity taxation and the yearly income of the insured is less than 3,000,000 JPY	7,910
Level 10	The insured subject to municiparity taxation and the yearly income of the insured is less than 4,000,000 JPY	9,230
Level 11	The insured subject to municiparity taxation and the yearly income of the insured is less than 6,000,000 JPY	10,540
Level 12	The insured subject to municiparity taxation and the yearly income of the insured is more than 6,000,000 JPY	11,070

Source: Kitakyushu City, http://www.city.kitakyushu.lg.jp/files/000106164.pdf

cant's home doctor. The eligibility decision is then communicated to the applicant within 30 days of applying.

Services use

Each eligibility level entitles the applicant to an explicitly defined monetary amount of services. In the case of public medical insurance, it is strictly prohibited to mix the insurance covered services and those not covered. On the contrary, LTCI permits that a user mixes the services that covered by LTCI scheme and not covered. That is, if a user wants to use more LTCI services than the pre-determined monetary threshold, he/she can do it by paying extra money. Behind the introduction of this scheme, there was apparently an intention of government to expand the LTCI related care business in order to stimulate the Japanese economy. It is very important to recognize that the Japanese LTCI is not formulated to cover all care needs that the frail elderly have, even though the Japanese LTCI scheme offers a wider range of services compared with that of other countries. It has a presumption that a dependent aged uses the LTCI covered services and not covered services according to his/her will. Mal-understanding of this principle is one of the reasons that LTCI management confronts today.

Table 2 shows the services provided by LTCI scheme. The scheme covers both home and institutional services. However, a frail aged of "assistance required level 1 and level 2" cannot use the institutional services. As LTCI services re-organized former medical and social services, its classification of services is very complicated. For example, there are two kinds of "day service". The first is day care services provided by medical institute and the second is day service provided by welfare organization. The staffing requirement of day care is more medical and so that the payment is higher, even though the user is not always aware of difference of the two services. The same problem can be pointed out for the 3 LTCI insti-

Table 2 Services covered by LTCI scheme

In-home services	Institutional services
Home help services	Special nursing home
24 hour's round home visiting care services	Medical nursing home
Home visit bathing services	(Health care facility for the elderly)
Home visit nursing services	Medical ward under the LTCI scheme
Home visit rehabilitation services	
Care instruction by doctor, nurse pharmacists, etc	
Day services at welfare facility	
Day services at medico-welfare facility (Day care service)	
Short stay at nursing home	
Short stay at medical nursing home	
LTC services at the communal living facility for the elderly with dementia	
LTC services at residencial home for the frail elderly	
Integrated care services at the multifunctional facilities (ex: day services and short-stay,etc)	
Welfare equipement rental services	
Allowance for puechasing welfare equipements	
Allowance for modifying house	
Care management	

tutional services, Medical ward under the LTCI scheme, Medical nursing home and Nursing home. Another complicated thing is that visiting nursing services and visiting rehabilitation services are both under medical insurance and LTCI. This situation causes confusion among the users.

Care management

Theoretically, users are free to choose services, but in reality, the care-manager who constitutes a care plan, a weekly time schedule of services, intervenes in this process and co-ordinates the services for the applicant. A care manager is entrusted with the entire responsibility of planning all care and services for individual clients. According to the results of needs assessment of the client and his or her wish, a care plan is drawn up. The care manager organizes the care specified in the care plan and works with the client, supervises and evaluates the care process (monitoring). When necessary, the care plan is adjusted. It is very important to know that a care manager has an ability to decide the type and volume of services under the individualized budget envelop corresponding to eligibility level. This financial authority makes them possible to negotiate with service providers.

In this way the care manager plays a pivotal role in the LTCI scheme. The LTCI fund pays a fee of care management for each care manager (3,000 – 13,000 JPY per month per each case: = 37.5 – 162.5 US$; 1 US$ = 80 JPN).

In order to assure the enough number of care managers, the government prepared the standard curriculum and textbooks. Various professional associations, such as Japanese Nursing Association, have organized training seminars. In order to become a care manager, one must have enough experiences for geriatric services as medical and social professionals for more than 5 yr. And finally one must pass the national examination. In 2010, there are about 60,000 care managers in Japan. Most of them are nurses, therapists and social workers.

Ideally, a care manager should be independent of any provider's organization in order to be a real advocate of users. However, most of them belong to some kinds of provider's organization. This situation causes the problem of neutrality of care management as explained later.

❖Actual Problem and Future Challenges

After 10 yr of implementation, LTCI has become an important infrastructure to support the QOL of frail elderly. This situation has caused, naturally, a large increase in users and expenditures. Table 3 shows the

Table 3 Chronological changes of LTCI expenditures (2000–2010; fiscal year base) (hundred millions JPY)

	2000	2002	2004	2006	2008	2010
Total	39,535	51,918	61,782	64,345	70,494	79,308
In-home services	10,296	19,116	24,831	26,741	30,262	38,880
Home help services	2,901	5,424	6,981	6,859	6,634	7,368
Home visit bathing	407	514	550	534	542	569
Home visit nursing	1,013	1,191	1,229	1,249	1,287	1,456
Home visit rehabilitation	37	52	57	91	167	258
Day service	3,110	4,832	6,935	7,863	9,553	11,427
Day care service	2,494	3,053	3,452	3,511	3,874	4,284
Welfare equipment rental	335	1,095	1,700	1,663	1,750	2,051
Short stay	995	2,329	2,854	3,008	3,574	4,157
Care instruction by doctor, etc	164	212	220	257	334	436
LTC services at residencial home for the frail elderly	197	413	854	1,705	2,546	3,226
Care management	1,131	1,637	2,402	2,912	2,900	3,647
Community services				4,264	5,737	7,068
Night visit home help services				1	9	18
Day service for dementia elderly				481	641	751
Integrated care services at the multifunctional facilities				54	575	1,050
LTC services at the communal living facility for the elderly with dementia	158	744	2,240	3,686	4,288	4,780
Community LTC services at residencial home for the frail elderly				42	224	469
Institutional services	26,594	30,422	32,309	30,429	31,596	33,360
Special nursing home	11,672	13,113	13,923	14,217	15,386	16,701
Medical nursing home	9,288	10,430	11,179	10,532	11,253	12,436
Medical ward under the LTCI scheme	5,634	6,879	7,208	5,680	4,956	4,223

Source: All Japan Federation of National Health Insurance Organizations, http://www.kokuho.or.jp/statistics/st_kaigo.html

chronological change of LTCI expenditures stratified by the service type[4]. LTCI expenditures have increased from 3,953.5 billion JPY in 2000 to 7,930.8 billion JPY in 2010. The average monthly premium has increased from 2,911 JPY to 4,972 JPY in 2012.

This rapid increase of LTCI expenditures are one of the most important political issue for today's Japanese society. Table 4 shows the 2012 budget structure[5]. Thirty percent of expenditures are due to payment for social insurance and 25% are for payment for National Debt Services. In 2012, the Japanese government has 10 trillion of debt even though it has long been a manifesto issue of the past cabinets to realize the primary balancing. In order to realize the financial sustainability, the reform of social security system becomes an urgent political issue for the Japanese society.

As the Economist indicated, we face to the Japan syndrome[6]. Japan will be the first developed country that experiences the natural decrease of population. The ageing and population decrease will have a negative effect on the future Japanese economy. The long lasting economic slump will facilitate further graying and population decrease. It is an urgent issue for the Japanese government how to break this vicious cycle.

The reform of LTCI is discussed under this concern. The 2006 Health reform tried to control the LTCI expenditures by introducing the preventive activities. As explained by another article in this issue[7], this program has not succeeded to the extent formerly expected. However, there are some possible solutions, such as a paid volunteer scheme of Inagi city, Tokyo. This workfare type program combines the health promotion program and paid volunteer activities as substitution services of LTCI. Compared with health insurance scheme, LTCI is easy to combine different

Table 4 Budget for Fiscal year 2012

	2011	2012	Structure 2012	Δ 2012–2011
(Revenue)				
Tax revenue	40927.0	42346.0	46.9%	1419.0
Other revenue	7186.6	3743.9	4.1%	Δ 3442.7
Government Bond Issue	44298.0	44244.0	49.0%	Δ 54.0
of which			0.0%	
Construction bond	6090.0	5909.0	6.5%	Δ 181.0
Special deficit finanicing bond	38208.0	38335.0	42.4%	127.0
Total	92411.6	90333.9	100.0%	Δ 2077.7
(Expenditure)				
National Debt Service	21549.1	21944.2	24.3%	395.1
Primary Balance Expenses	70862.5	68389.7	75.7%	Δ 2472.8
Social security	28707.9	26390.1	29.2%	Δ 2317.7
Local Allocation Tax Grants, etc	16784.5	16594.0	18.4%	Δ 190.5
Contingency Reserve for Economic	810.0	910.0	1.0%	100.0
Crisis Response and Regional Revitalization			0.0%	
Transfer to Special Account for Reconstruction		550.7	0.6%	550.7
from the Great East Japan Earthquake			0.0%	
Others	24560.1	23944.8	26.5%	Δ 615.3
Total	92411.6	90333.9	100.0%	Δ 2077.7

Source: Ministry of Finance, http://www.mof.go.jp/english/budget/budget/fy2012/e20111224a.pdf

sectors of services. As mentioned earlier, the LTCI premium increases according to the consumed amount of services by each community. If a community succeeds to control the volume of services, its premium can be stable. This mechanism is not fully understood by neither the local governments nor inhabitants. Therefore, the dependency prevention program must be organized as a community movement from the viewpoint of population approach. However, the current prevention program puts too much importance on the high risk group approach and lacks the viewpoint of population approach. We have to reset the strategy that makes it possible to balance the two approaches.

Another important issue of re-consideration of LTCI scheme is the coverage of services. Compared with the LTC scheme of other countries, the Japanese LTCI covers a wider range of services. As mentioned above, the Japanese LTCI is not formulated to cover all care needs that the frail elderly have. It is not comfortable for politicians to explain this fact for citizen because this kind of policy should be an unpopular one especially for the aged who are the most important voters today. However, it is important to recognize that this populism is one of the most important reasons of today's socio-political difficulty in Japan.

❖Conclusion

Because of rapid graying of the society and long lasting economic slump, Japan is required to re-organize its LTCI scheme. As mentioned above, the recent expansion of LTCI covered services has caused a doubt about the financial sustainability of Japanese LTCI scheme. Colombo et al estimated that LTC spending of Japan might at least double or even treble within the coming 20 years[8]. They suggested that most cost growth is likely to occur if new LTC beneficiaries receive formal care in institutional settings.

In order to maintain the universal coverage of LTCI scheme, policies are needed to reconcile projected demand for (and cost of) LTC, with financial sustainability. A toolkit of policies to strike this delicate balance between fairness and fiscal sustainability is now to be prepared. We have to overhaul our LTCI scheme from the following four viewpoints.

Reducing the demand for care

Reducing the demand for care could mitigate the anticipated rise in LTC expenditure and the need for LTC workers. One strategy is to target services more narrowly towards those most in need of care. This seems to be occurring in the aftermath of the economic crisis. Compared with other countries, the Japanese LTCI covers the less dependent aged. There is an opinion that the support should be targeted where the need is the highest. Another strategy is to reduce the demand for care through preventive approaches and enhancing self-management. That is the strategy adopted by the 2006 Japanese LTCI reform. Up to now, there have been few evidences to support this hypothesis.

Cost-sharing on LTC benefits

It is apparent that the rapid graying of Japanese population will make it impossible to support the LTCI financing mainly based on the inter-generation solidarity principle (money transfer by tax and premium). Therefore, we have to prepare other way of cost-sharing in order to support the LTCI financing. It will be one of the debates how to mobilize real estate, for example. Home ownership can provide means to help users mobilize cash to pay for such cost, for example via bonds/equity release schemes (as in Australia, Ireland), public measures to defer payments (United States, United Kingdom), and private-sector products, such as reverse-mortgage schemes and combinations of life and LTC insurance policies. It is a crucial problem how to widen the resource of LTCI budget.

An appropriate mix of formal and informal services

The recent European experiences of financial crisis teach us that social protection, including LTC is among the most widely targeted area for public expenditure cuts. This policy is often coupled with the de-institutionalization of LTC care. This requires a more contribution of informal sectors, such as family member and community members (friends and volunteers). As shown in another article in this issue[7], this is happening in several communities in Japan. Considering the actual economic and demographic situation, the public LTCI cannot cover all the needs that the frail aged have. Although the LTCI scheme intends to socialize the care giving for the dependent aged, care giving by family members will be the main bulk of long-term care in Japan. Our previous study suggested that living arrangement as classified by the ability to receive informal care affects survival among elderly men[9]. It is a key aspect for the LTCI sustainability how to support family carers. It will require a mix of measures such as cash benefits, flexible leave options for working family carers and other support forms, such as information, training, respite services and peer support. However, it is difficult for a family care-giver to well organizes formal and informal cares. This is the task of care manager. In this meaning, it will be crucial issues to equip the high quality care management system and to prepare enough volume of community care resources.

Reconfirmation of principle of LTCI scheme among the citizens

If there is no countermeasure, LTC expenditure rapidly becomes unaffordable for even relatively well-off people. Colombo predicted that LTC expenditure can represent as much as 60% of disposable income for all but those in the upper quintile of the income distribution for those requiring a large range of services[8]. Their concern is critical for the current Japanese LTCI scheme. As mentioned earlier, there is a 4 times of difference in amount of premium between the wealthiest insured and the poorest insured. Our previous research clarified that the wealthier insured tends to be healthier and less use the LTCI services[10]. This negative correlation might cause a negative feeling for LTCI scheme among the wealthy population, if the solidarity principle is not fully understood by the insured. The government should pay more attention to the population relationship activities in order that the citizens have a rational understanding for the LTCI scheme.

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